

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... November 30, 2016



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THIS WEEK

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IN FOCUS

REVISITING CONGRESSMAN TOM PRICE'S ACA REPEAL LEGISLATION

This week, our *In Focus* section revisits 2015 legislation introduced by Georgia Congressman Tom Price, who was announced this week as President-elect Donald Trump's nominee for Secretary of the U.S. Department of Health & Human Services (HHS). Representative Price's 2015 bill, H.R. 2300, known as the "Empowering Patients First Act," included a full repeal of the Affordable Care Act (ACA) as well as all health care provisions in the related Health Care and Education Reconciliation Act passed in 2010. A version of the Empowering Patients First Act has been introduced in Congress every year since 2009. Below, we review Representative Price's proposed replacement plans around insurance coverage, and provide brief summaries of some of the other provisions in the legislation.

Medicaid Coverage

The Empowering Patients First Act would fully repeal the Medicaid expansion and, as written, offers no replacement Medicaid coverage options for the newly

eligible category of assistance. Individuals impacted by the repeal of the Medicaid expansion would likely be eligible for tax credits in the individual insurance market, as detailed below. However, as Chairman of the U.S. House of Representatives Committee on the Budget, Representative Price's 2016 budget framework, "*A Balanced Budget for a Stronger America*," proposed changing Medicaid to a block grant program, referred to as "State Flexibility Funds."¹

It is also worth noting that President-elect Trump's pick to lead the Centers for Medicare & Medicaid Services (CMS), Seema Verma, worked under Vice President-elect Mike Pence in Indiana, and was involved in the development of the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion model. HIP 2.0 expanded Medicaid up to 138 percent of the federal poverty level (FPL), requiring member contributions to health savings accounts (HSAs), and limiting benefits or disenrolling members for non-payment.

Individual Market Affordability Provisions

Representative Price's proposal would preserve the concept of an advanced premium tax credit for individual insurance market coverage, although the structure of the premium tax credit would be altered significantly. Under the ACA, the advanced premium tax credit is tied to an enrollee's income level, setting a maximum income-based premium payment, and allowing the associated credit, pegged to the second-lowest priced Silver tier plan in the region, to be applied to most Marketplace plan selections.

The Empowering Patients First Act would base tax credits exclusively on age, regardless of income, adjusting annual credit amounts annually for inflation based on cost of living factors. The annual tax credits range from \$1,200 for individuals between ages 18 and 35, up to \$3,000 for individuals over the age of 50.

Age Rating Band	Annual Tax Credit	Monthly Tax Credit
Individuals Ages 18-35	\$1,200	\$100
Individuals Ages 35-50	\$2,100	\$175
Individuals Ages 50 and Older	\$3,000	\$250
Each Child Under Age 18	\$900	\$75

Given the full repeal of the ACA, individual market health plans would no longer be required to offer the Essential Health Benefits package, allowing for individual plans to offer limited benefit plans. In the event that an enrollee's tax credit exceeds the monthly or annual premium amount, the excess funds may be rolled into a HSA-like account.

Additionally, the Empowering Patients First Act allows individuals in Medicare, Medicaid, TRICARE, and those receiving Veterans Affairs benefits to opt-out of existing coverage and take the tax credit to purchase coverage in the individual market.

Preexisting Conditions and High Risk Pools

While Representative Price's bill does not include guaranteed issue or community rating mandates (like the ACA), the bill would prevent insurers from imposing preexisting condition coverage exclusions if an enrollee has had continuous insurance coverage for the 18 months prior to the date of enrollment.

¹ http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf

If a prospective enrollee does not have continuous coverage for the 18 months prior, the Act allows for a 150 percent premium surcharge to the “applicable standard rate” for a period of two years. The Act further provides that standard premium rates may not be based on health status-related factors (further delineated in the Act).

To provide coverage for individuals with preexisting conditions or other high-cost conditions, the Empowering Patients First Act would fund state high risk pools for three years, with \$1 billion in federal funds to be divided among states each year. This funding is available to existing, as well as new, high risk and reinsurance pools. States would be eligible to receive bonus grants for things like reduction in premium rate trends or broadening the pool of high risk individuals eligible.

Other Provisions of Note

There are a number of additional provisions in the Empowering Patients First Act that go beyond the main coverage provisions described above. Several provisions of note follow. The full text of the bill and a section-by-section overview are available at the link below.

- **Independent Health Pools (IHPs) and Association Health Plans (AHPs).** The Act would establish IHPs as non-profit entities established with the purpose of forming an insurance risk pool for its members. Members can be individuals or an employer. AHPs would allow small business owners to purchase insurance within their state or across state lines through membership in a trade or professional association.
- **Purchase of Insurance Coverage across State Lines.** The Act would allow individuals to purchase health insurance offered in another state, provided the insurer meets some basic requirements.
- **Expansion of Health Savings Accounts (HSAs).** Incentivizes HSAs through a one-time tax credit and amends rules around HSAs, including increased contribution limits, account rollover to families, bankruptcy protections, and other incentives.

[Link to Empowering Patients First Act](https://tomprice.house.gov/HR2300)

<https://tomprice.house.gov/HR2300>



HMA MEDICAID ROUNDUP

Illinois

Nursing Facilities File Lawsuits over Medicaid Application Backlog. Law firm sb2 Inc. announced on November 30, 2016, that more than 160 nursing home providers, representing hundreds of residents, filed seven different lawsuits against the Illinois Department of Healthcare and Family Services (HFS) over issues around the state's Medicaid application backlog. The suits argue that HFS' failure to implement an electronic asset verification program, as required under federal law, is jeopardizing patient care. Currently, there are 7,000 pending Medicaid eligibility cases that have been delayed for up to a year or longer. [Read More](#)

Indiana

Indiana Medicaid Again Cleared to Waive Coverage of NEMT Services. *Modern Healthcare* reported on November 28, 2016, that the Centers for Medicare & Medicaid Services (CMS) renewed existing Medicaid waivers from Indiana and Iowa, allowing each state to continue to forego provision of non-emergency medical transportation (NEMT) services. The Indiana waiver renewal runs through January 2018, and the Iowa renewal through December 2019. Both states received approval of the NEMT waivers under broader waivers that included Medicaid expansion. [Read More](#)

Kentucky

Medicaid Overhaul More Likely to Be Approved Under Trump Administration, Governor Says. *The Daily Progress* reported on November 29, 2016, that Kentucky Governor Matt Bevin believes his plan to overhaul the state's Medicaid program is more likely to receive federal approval under the Trump Administration. The plan, called Kentucky HEALTH, is a Medicaid waiver that was submitted to the Centers for Medicare & Medicaid Services (CMS) earlier this year. Under Kentucky HEALTH, many beneficiaries would need to pay monthly premiums and participate in employment assistance programs. Governor Bevin said that he has had discussions with President-elect Trump and Vice President-elect Mike Pence on broader policy issues and believes the odds of getting the waiver approved are improved under the incoming administration. [Read More](#)

Massachusetts

MassHealth Chooses Six Provider Networks for Medicaid ACO Pilot. *Boston Globe* reported on November 29, 2016, that the Massachusetts Medicaid program, MassHealth, has chosen six provider networks to participate in a new accountable care organization (ACO) pilot program, initially covering around 160,000 members. Participants include some of the largest hospitals and health systems in the state, including Partners HealthCare, Steward Health Care System, UMass Memorial Health Care, Boston Medical Center, and Boston Children's Hospital. Community Care Cooperative, a newly formed network of community health centers, will also participate in the ACO pilot. Participants will be responsible for establishing networks of doctors, hospitals, and other providers to manage care under an alternate payment system. The state received federal approval for its ACO program earlier this month. [Read More](#)

Nebraska

Heritage Health Open Enrollment Deadline Approaches. The *Omaha World-Herald* reported on November 26, 2016, that Nebraska Medicaid enrollees have until December 1 to choose a managed care plan under the new Heritage Health program. An estimated 175,000, or 80 percent of eligible Medicaid beneficiaries, have yet to make a plan selection. United HealthCare Community Plan of Nebraska, Nebraska Total Care (Centene), and WellCare of Nebraska will provide physical, behavioral, and pharmacy benefits under Heritage Health beginning January 1, 2017. Those who do not make a selection will be auto-assigned. [Read More](#)

New Jersey

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

New Jersey Medicaid releases latest MCO contract with amendments. The Department of Human Services, Division of Medical Assistance and Health Services has posted the July 1, 2016 managed care contract as approved by CMS on its website. Material changes in the new contract are summarized below.

Health Information Technology. MCOs must now track and report on the number and percentage of providers in the network who use Electronic Health Record technology and that are connected to a Health Information Exchange.

Dental Services Reimbursement for Members in Transition. The contract provides greater specificity regarding dental service reimbursement for NJ FamilyCare enrollees who transition from Medicaid fee-for-service to an MCO.

Benefit Package. The contract limits substance use disorder services to opioid treatment services for individuals who qualify for managed long term services and supports (MLTSS) and also amends the list of behavioral health services not covered by the MCO.

Member Satisfaction Survey. The state transferred responsibility for performing the annual CAHPS survey to assess member satisfaction

with their MCO and provider services from the state to MCO contractors.

Timing of MLTSS Assessments and Plans of Care. MCOs now have 45 calendar days (changed from 30) to assess and develop plans of care for new members who qualify for MLTSS and received it prior to transitioning to a new MCO if the new MCO does not receive requested documents within five business days of enrollment.

MLTSS Any Willing Provider. The state extended the Any Willing Provider status through June 30, 2017 for the following MLTSS providers: nursing facilities, specialty care nursing facilities, assisted living, and community residential services providers.

MLTSS Voluntary Withdrawal. Revisions to the contract were made to clarify procedures the MCO and state offices will follow to process a member's election to withdraw from MLTSS, including members who decline to consent to reassessment.

MLTSS Critical Incidents. The list of events considered "critical incidents" was amended to add the following:

- Elopement/Wandering from home or facility
- Inaccessible for initial/on-site meeting
- Unable to contact
- Inappropriate or unprofessional conduct by a provider involving member
- Cancellation of utilities
- Eviction/loss of home
- Facility closure, with direct impact to member's health and welfare
- Natural disaster, with direct impact to member's health and welfare
- Operational breakdown
- Other

Capitation Rates. The managed care capitation rates by rate category were updated for the new rating period (7/1/2016 - 6/30/2017). The new rates are available on p. 892 of the contract. The contract can be found [here](#).

ACA Repeal May Lead to \$3 Billion Deficit in New Jersey, Report Finds. *NJSpotlight* reported on November 29, 2016, on the findings of a [New Jersey Policy Perspective \(NJPP\) report](#) that repealing Medicaid expansion as part of a repeal or major changes to the Affordable Care Act (ACA), could lead to a \$3 billion deficit in New Jersey's budget in the first year due to the loss of federal funds. The state experienced a significant increase in the number of residents with coverage under the ACA, roughly 700,000 (over 500,000 of those in Medicaid expansion), and could face enormous losses if the new administration repeals the ACA or eliminates the funding for it. NJPP predicts that one in ten adults in New Jersey would lose health care coverage. Additionally, the state could lose at least 24,000 healthcare workers, \$4 billion in economic activity statewide, and coverage for mental health, substance abuse, and preventive services for individuals with other insurance plans. As funding for charity care and Medicare dollars have been reduced since the implementation of the ACA, hospitals are concerned that they could go out of business. [Read More](#)

MLTSS Transition Raises Concerns over Access to Care. *Modern Healthcare* reported on November 28, 2016, that New Jersey is one of several states that has received complaints related to its transition to Managed long-term services and supports (MLTSS). The state, which began the transition to MLTSS in 2014, says that complaints concerning limits on access to care and reductions in services can be addressed through an appeals process. Overall, 20 states have shifted at least a portion of their long-term services and supports programs to managed care, up from eight in 2004. MLTSS programs covered 1.6 million Medicaid beneficiaries in 2014. [Read More](#)

Horizon to Fund Its Own Healthcare Advocacy Group. On November 22, 2016, *NJSpotlight* reported that Horizon Blue Cross Blue Shield, the largest health insurer in New Jersey, will be funding a new advocacy organization called Better Choices, Better Care NJ (Better Choices). Christine Stearns, Executive Director of the newly formed group of business and labor groups, intends for this organization to be a vehicle to educate consumers on New Jersey's volatile healthcare system and solicit public input on how to improve it. Despite the organization's intentions to improve consumers' understanding of the health care system, concerns have been expressed that Horizon is acting in its own self-interest since the formation of this advocacy group was prompted in part by the [controversy surrounding Horizon's OMNIA plan](#), which faced significant criticism from hospitals and many other groups that are concerned that Tier 2 providers would lose business to facilities in Horizon's top tiers and be forced out of business. [Read more.](#)

New York

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

GuildNet Freezing Managed Long-Term Care Enrollment Outside NYC. According to a report in *Politico New York*, GuildNet, New York State's largest Medicaid managed long-term care (MLTC) plan will no longer enroll members in Nassau, Suffolk and Westchester counties. The CEO of GuildNet informed the Department of Health that due to substantial deficits that the plan was incurring, it was no longer feasible to continue operations. He cited "a disconnect between program mandates such as the inappropriate use of the fair hearing process, mandating payment rates while failing to provide sufficient revenue, constant regulatory changes that add additional administrative burdens and otherwise failing to recognize operational challenges these changes impose" as causes of the financial challenge. GuildNet is freezing its enrollment immediately in these counties, which represents 21 percent of its 16,000 enrollees. GuildNet also operates in New York City, which represents the largest share of its enrollment. GuildNet is the second largest MLTC plan in the state; only Fidelis Care, which operates in every county across the state, has more members. [Read More](#)

Oklahoma

OHCA Releases SoonerHealth+ RFP. The Oklahoma Health Care Authority (OHCA) has released a statewide request for proposals (RFP) for the new SoonerHealth+ Program to serve the state's aged, blind, and disabled (ABD) populations. The RFP divides the state into two regions - East and West - and bidders may bid on one or both regions. The state intends to award three contracts per region, but may award as few as two and as many as four contracts. The program will be phased in beginning in January 2018 for dual eligibles and members who qualify for nursing-facility level of care and receive services through either the Advantage or Medically Fragile HCBS waivers. The individuals with intellectual disabilities (IID) waiver population is scheduled to be added in April 2019. Members residing in an institutional setting, as well as children in the custody of the Department of Human Services or Tribal custody, are scheduled to be enrolled in SoonerHealth+ in April 2020. The state estimates 154,795 eligible adults and children are in the ABD category as of June 2016. Round 1 questions are due December 9, 2016. Proposals are due February 28, 2017. [Read More](#)

Pennsylvania

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

Family Planning Options to Be More Accessible in Pennsylvania. Pennsylvania will fully reimburse hospitals for providing long-acting forms of birth control to Medicaid patients immediately after they give birth, effective December 1, 2016. The change, announced by Governor Tom Wolf's administration, is expected to increase the use of long-acting reversible contraception (LARC) by low-income women on Medicaid. Under current policy, Pennsylvania hospitals receive a bundled payment from Medicaid for all the costs of labor and delivery care, with that reimbursement often not able to cover the full cost of LARC. After December 1, hospitals will receive payments from Medicaid's fee-for-service program, in addition to the bundled payments for labor and delivery, in order to "eliminate the hurdle of high up-front costs of long-acting contraceptives" and to provide an incentive for hospitals to stock LARC devices. The Wolf administration estimates that over five years, the net savings to the state will be \$1.4 million. [Read More](#)

UPMC Health Plan in joint venture with Reading Health System. Pittsburgh based UPMC Health Plan and Reading Health System have finalized an agreement to form a provider-payer joint venture that will merge Reading's clinical capabilities with UPMC Health Plan's population health and risk management strategies and expand in-network coverage for Berks County. UPMC Health Plan and Reading Health will introduce a range of insurance options throughout 2017, including Medicare Advantage, Medicaid, individual, fully insured and self-insured group, special needs and children's health insurance plans. UPMC Health Plan will begin offering Medicare Advantage in the area with the open enrollment period that wraps up Dec. 7 and has offered Medicaid there for the past couple of years. Starting January 1, 2017 UPMC Health Plan will also provide third-party administrator and flexible spending account administration services for Reading Health's employee benefit plan serving 11,000 employees. [Read More](#)

Direct Care Worker (DCW) Policy Clarification. In response to requests for clarification, Governor Wolf's Administration issued a policy statement regarding the types of non-skilled, home care services and activities that DCWs can perform in home and community-based settings. The non-skilled activities are specialized care, a type of home care service unique to the consumer's care needs that are exempt from the licensure requirements under the Professional Nursing Law and Practical Nurse Law. DCWs may perform these services/activities, provided they do not represent or hold themselves out as being licensed nurses, licensed registered nurses, or registered nurses. [Read More](#)

Community HealthChoices Evaluation Plan Comments. Pennsylvania's Department of Human Services released the Community HealthChoices (CHC) evaluation plan for public comment earlier this year. CHC is Pennsylvania's new Medicaid Long-Term Services and Supports (LTSS) program. An internal evaluation work group has now reviewed all of the comments and worked closely with the University of Pittsburgh Health Policy Institute (University) to incorporate recommendations to the plan. A summary of key comment themes is listed on the DHS website, as well as the Department's responses. The University is also conducting a comprehensive multi-year evaluation of CHC. The evaluation will provide an independent assessment of the implementation and outcomes of the program to complement other oversight and quality assurance activities conducted by the Office of Long-Term Living. [Read More](#)

Rhode Island

Medicaid Waiver Implementation to Continue Despite Election Outcome. *Providence Journal* reported on November 28, 2016, that Rhode Island will continue with the implementation of a previously approved Medicaid redesign waiver, known as Reinventing Medicaid 2.0, despite uncertainty over the future of the Affordable Care Act (ACA). Governor Gina Raimondo announced that the state has received approval for \$130 million in federal matching funds to invest in the state's Medicaid delivery system as providers work to form Accountable Entities. The majority of the funds will be used to support providers as they update infrastructure and technology to adapt to alternative payment models and financial incentives aimed at improving care quality and reducing cost, a key component of the ACA. [Read More](#)

Texas

HHSC to Move Forward with Therapy Provider Payment Cuts. The *Texas Tribune* reported on November 28, 2016, that the Texas Health and Human Services Commission (HHSC) will proceed with \$350 million in planned payment cuts to Medicaid therapy providers beginning December 15, 2016. The Texas Supreme Court declined to hear a lawsuit filed by consumer advocates to block the reimbursement reductions. State officials have argued that the cuts will not reduce access to services and commissioned a study demonstrating that Medicaid therapy providers in Texas are overpaid. [Read More](#)

House Speaker Hopes to Restore Medicaid Therapy Provider Cuts in 2017. The *Texas Tribune* reported on November 29, 2016, that Texas House Speaker Joe Straus will seek to restore funding for in-home therapy services for children with disabilities during the upcoming legislative session. In 2015, Texas

lawmakers ordered a \$350 million cut to the amount that Medicaid pays speech, physical, and occupational therapists who serve children with disabilities. Implementation of the cuts has been tied up in a lawsuit for more than a year, but state officials recently announced that they will start reducing some therapy provider payments on December 15. Medicaid managed care organizations in the state have begun implementing their own pay cuts to providers. [Read More](#)

OPIC Releases 2016 HMO Quality Reports. The Texas Office of Public Insurance Counsel (OPIC) has released its annual Health Maintenance Organization (HMO) reports “*Comparing Texas HMOs 2016*” and “*The Guide to Texas HMO Quality: 2016*.” The first is OPIC’s annual HMO report card, which allows consumers to compare HMOs on the basis of providers, access, quality, and cost of care. The report is generated using Healthcare Effectiveness Data and Information Set (HEDIS) information. The second report is produced through an agreement between OPIC and the Department of State Health Services’ Texas Health Care Information Collection, and allows consumers to compare HMO performance in terms of quality of care for serious health conditions specific to individual health needs. [Read More](#); [Read More](#)

Wisconsin

Lakeland Care District to Shift from Public to Private Not-for-Profit Status. The *Fond du Lac Reporter* reported on November 28, 2016, that Lakeland Care District will shift from public to private not-for-profit status effective January 1, 2017. Lakeland provides managed long-term services and supports (MLTSS) to 4,400 seniors and individual with disabilities in the Wisconsin Family Care Medicaid MLTSS program. The shift is not expected to affect care plans, team assignments, or service providers. [Read More](#)

National

CMS Nominee Helped Develop Indiana Medicaid Expansion Waiver. *The Washington Post* reported on November 29, 2016, that Seema Verma, President-elect Donald Trump’s choice to lead the Centers for Medicare & Medicaid Services (CMS), has a background in state healthcare policy through the development of Indiana’s alternative Medicaid expansion waiver, an approach many believe she will try to bring to the federal level. Verma’s former colleagues note that she is open to compromise and well-versed in the detailed regulatory aspects of reform. As a consultant, Verma has helped Michigan, Tennessee, and Iowa, design Medicaid expansion plans similar to Indiana’s. The CMS administrator position requires Senate confirmation. [Read More](#)

Medicaid Innovation Accelerator Program National Webinar scheduled for December 12. As part of the Medicaid Innovation Accelerator Program’s (IAP) *Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs* [(BCN) also referred to as “Superutilizers”] program, CMCS has been working with five states (District of Columbia, New Jersey, Oregon, Texas, and Virginia) since October 2015. As work continues with these states, IAP BCN has launched a four-part national dissemination webinar series highlighting lessons learned and sharing resources. The next webinar in this series will be held on December 12, 2016, from 2:00 pm to 3:30 pm ET and focuses on *Factoring Social Determinants of Health into Strategies That Impact Medicaid Beneficiaries with Complex Care Needs and High Costs*. This webinar will provide participants with an overview of the

role social determinants of health play in Medicaid BCN initiatives; examples of approaches to integrating social determinants of health data; and lessons learned from state Medicaid agency representatives based on their successes and challenges in this area. This webinar is open to all states and interested stakeholders. HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Beneficiaries with Complex Needs and High Costs (BCN) track through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates. [Read More](#)



INDUSTRY NEWS

Tennessee-based Hospital Merger Opposed by FTC. *Modern Healthcare* reported on November 23, 2016, that the Federal Trade Commission and various health economists are urging Tennessee state officials to reject the merger of Mountain States Health Alliance and Wellmont Health System. The two hospitals systems have been working on a merger for 18 months. Combined, the systems would have 19 hospitals in Tennessee and Virginia and \$2 billion in annual revenues. Opponents argue that the merger would inflate costs for insurers and employers. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Washington, DC	RFP Release	200,000
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
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
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
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	Implementation	155,000
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.

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 Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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