HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

IOWA RELEASES STATEWIDE MEDICAID MANAGED CARE RFP

This week, our *In Focus* section reviews the Iowa High Quality Healthcare Initiative Request for Proposals (RFP), which seeks to award two to four statewide Medicaid managed care contracts to begin serving nearly all of Iowa's 570,000 Medicaid beneficiaries in January of 2016. Iowa has historically had limited geographic and population penetration of managed care. Meridian Health Plan, the state's loan Medicaid MCO, had around 41,000 individuals enrolled across 23 counties as of early 2014.[1] Iowa's Governor, Terry Branstad, is targeting $51 million in savings through managed care in the first six months of 2016.

[1] http://dhs.iowa.gov/sites/default/files/IowaMedicaid_ManagedCare_FactSheet.pdf

RFP Overview

- **Note on RFP:** Since this is a brand new program, bidders are encouraged to offer comments about the design of the managed care program by the end of February. DHS may amend the RFP based on comments received. As such, the details of the following summary are subject to change.
- **Scope:** In 2014, a little more than 40,000 individuals in Iowa Medicaid were served in a capitated managed care structure, with less than $100 million in estimated spending. This RFP would expand Medicaid managed care enrollment to at least 550,000 individuals with more than $3.5 billion in annual spending.
- **Covered Populations:** Contracts awarded in response to the RFP would cover nearly all Medicaid beneficiaries in Iowa, including dual eligibles, users of long-term supports and services (LTSS) in both nursing facilities and in home and community based (HCBS) settings, and foster care populations. The Iowa Health and Wellness Program expansion population is also included under the RFP.
- **Excluded Populations:** Undocumented immigrants receiving temporary coverage, voluntary enrollments in the Program of All-Inclusive Care for the Elderly (PACE), and individuals covered by the Health Insurance Premium Payment (HIPP) program are excluded from managed care enrollment. Native American populations will have the option to voluntarily enroll in managed care.
- **Contract Awards/Term of Contract:** Iowa DHS intends to award between two and four statewide managed care contracts. Bidders may not bid to serve only a selected geography. Additionally, at least one bidder will be awarded a contract to provide substance abuse services provided under the Iowa Department of Public Health (IDPH). Initial contract terms will run for three years, from January 1, 2016 through December 31, 2018. Two optional contract extensions of two years each may be awarded by the state, taking the potential full contract term through 2022.
- **Rate Setting and Risk Adjustment:** There is no price component to the bid. Awarded MCOs must accept the state's actuarially certified capitation rates, which will be published on April 13, 2015, prior to the due date for proposals. Rates will be risk adjusted for each MCO based on morbidity of their enrolled members relative to all enrolled members. Risk adjustment for LTSS populations will be calculated separately, and the state intends to blend institutional and HCBS LTSS rate cells into one LTSS rate cell to incentivize delivery of LTSS in the least restrictive environment.
- **Medical Loss Ratio (MLR):** The RFP indicates that plans will be required to maintain a minimum MLR of 85 percent, with the state retaining the right to recoup a portion of payments from plans not meeting the MLR requirement.

RFP Timeline

Comments from prospective bidders are due on February 25, 2015. A non-mandatory letter of intent to bid is due on March 11, however, questions will not

be accepted in either round of Q&A from parties that have not submitted a letter of intent. As noted above, capitation rates are scheduled to be released on April 13, with proposals due on May 8. A notice of intent to award is tentatively planned for July 31, 2015, with a go-live of January 1, 2016.

Timeline	Date
RFP Released	February 16, 2015
Bidder Comments on RFP Due	February 25, 2015
Capitation Rate Data Book	March 10, 2015
Letter of Intent to Bid Due	March 11, 2015
First Round Questions Due	March 11, 2015
First Round Answers Posted	March 26, 2015
Second Round Questions Due	April 2, 2015
Second Round Answers Posted	April 10, 2015
Capitation Rates Released	April 13, 2015
Proposals Due	**May 8, 2015**
Notice of Intent to Award	**July 31, 2015**
Implementation	**January 1, 2016**

Estimated Managed Care Market Size

There is no data on population size or spending presented in the RFP documents at this time, although we anticipate some data will be available in the capitation rate data book, to be released on March 10. Absent offical data, we have used publicly available sources to estimate the market size of the managed care population in Iowa.

As of the November 2014 CMS Medicaid enrollment report, there were around 570,000 Medicaid and CHIP enrollees in Iowa. Without enrollment details on excluded populations, we conservatively estimate the managed care eligible population at 550,000.

Based on federal data from FY 2012, we estimate the eligible managed care population to be around 75 percent adults and children, 20 percent aged and persons with disabilities, 2 percent children in foster care, and 3 percent other or unknown.

Eligibility	Enrollees (Estimated)	Annual Spending (Estimated)	PMPM (Estimated)
Adults/Children	412,500	$923,571,000	$187
Aged/Disabled	110,000	$2,377,709,000	$1,801
Foster Care	11,000	$72,933,000	$553
Other/Unknown	16,500	$125,787,000	$635
Total Managed Care Population	**550,000**	**$3,500,000,000**	**$530**

Source: HMA estimates based on federal spending data by category of eligibility

Iowa ranks in the bottom half of states in terms of the share of LTSS spending in HCBS. Out of $1.57 billion in Medicaid LTSS spending in FY 2012, only 43.4% was in HCBS settings.[2]

Assuming an even distribution across health plans, an awarded contract in Iowa under this RFP could equate to 137,500 to 275,000 in new membership and $875 million to $1.75 billion in annual revenue, depending on whether DHS awards two, three, or four plans.

[2] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/LTSS-Expenditures-2012.pdf

HMA Medicaid Roundup

Alaska

Gov. Bill Walker Proposes Medicaid Expansion. On February 15, 2015, *InsuranceNewsNet.com* reported that Governor Bill Walker unveiled his Medicaid Expansion plan. Walker predicts expansion will enroll 20,000 people and save the state $6.1 million in 2016. In 2021, although the state will need to match funds of $19.5 million, it can still save $3.3 million from increased federal grant opportunities, according to the report by the Department of Health and Social Services, The Healthy Alaska Plan: A Catalyst for Reform. Read More

Arkansas

Arkansas Private Option for the Poor to End in 2017. On February 12, *Reuters* reported that Governor Asa Hutchinson has signed off to end the alternative Medicaid plan that takes federal funds and uses them to buy insurance for low income residents. This private option plan is set to end in 2017. A task force will study healthcare spending and offer alternatives to the program. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Los Angeles County Fails to Report One in Three Cases of Foster Care and Delinquent Children Taking Prescribed Drugs. On February 16, 2015, *The Los Angeles Times* reported that children in the juvenile delinquency system and in foster care are being widely prescribed strong antipsychotic drugs. In 2013, Los Angeles County failed to report 1,056 children on drugs – nearly one third of all children prescribed medication. However, state law requires a judge's approval before the medication is prescribed to the child. Furthermore, many of the children are being prescribed strong new antipsychotic medications which have strong sedative powers, can cause severe weight gain, increase risk of diabetes, and can result in adverse effects such as movement disorders. In 2009, 49 percent of prescriptions for these antipsychotics to children were for hyperactivity or disruptive behavior, which are not approved uses according to the FDA. Read More

Low Income Californians' Health Care Satisfaction up Five Percentage Points Since ACA. On February 11, 2015, *Kaiser Health News* reported that 53 percent of low income California patients have reported their quality of care as either "excellent" or "good." This is an increase of 400,000 patients since 2011. The largest gains in satisfaction were seen in community health centers, most visibly in courtesy and cleanliness. However, wait times were still long, there was

difficulty scheduling evening or weekend appointments, and difficulty scheduling an appointment with a specialist. Read More

California Reports on Cal MediConnect HRAs. California released statistics on Health Risk Assessments completed within 90 days. Within this time, the state was able to complete 78 percent of the HRAs. Community Health Group and Inland Empire Health Plan had 100 percent completion, while Health Plan of San Mateo had the lowest at 50 percent. Read More

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Medicaid Patients Struggle to Find Dental Providers. On February 15, 2015, *USA Today* reported that although the state expanded dental coverage last year for Medicaid patients, many are struggling to find providers that will accept their coverage. Dentists are reluctant to participate because provider payments can be as low as half of what private insurance pays. A study by the Colorado health Institute found that the number eligible for Medicaid dental coverage has tripled to a million while the number of dentists who accept Medicaid has only gone up by 17 percent. Read More

Connecticut

Mental Health Providers Losing Over $5 Million Waiting for Medicaid Rate Approval. On February 17, 2015, *The CT Mirror* reported that mental health and substance abuse treatment providers are still waiting for the federal government to approve higher Medicaid rates. The delay is causing them to lose over $5 million budgeted this year. Officials say the approval process to change rates is complex and the delay is also in part due to a separate incomplete rate request from 2012. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Committee Approves Telemedicine Bill in Effort to Compromise Between Senate and House. On February 18, 2015, *Health News Florida* reported that the Senate and House are moving closer to a compromise on telehealth. On February 17, the Senate House Policy Committee approved a bill that will help the move the two bills closer together. In the new bill, the Senate eliminated a part of their initial proposal that would have given authority to medical boards to adopt rules to carry out the law in addition to using the House's "telehealth" label. Read More

DOC Chief Reworking Private Health Care Prison Contracts. On February 11, 2015, *PalmBeachPost.com* reported that following the widespread deaths and poor treatment of prison inmates, the Department of Corrections Chief Julie Jones said she will renegotiate or rebid the private health care contracts. The current contracts are with Corizon Prison Health Management, worth $1.2 billion, and Wexford Health Sources, worth $240 million. Jones hopes to improve prescription drug delivery and mental health services, and increase the number of available registered nurses. Reorganizing the contracts may take

years, but the two companies claim they are open to working out short term improvements. Read More

Florida Faces Specialty Doctor Shortage. On February 17, 2015, *Orlando Sentinel* reported that based on a study by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida, the state is seeing a shortage of specialty physicians, causing longer wait times, lower quality care, and higher costs. Representative Matt Hudson hopes to use the study to develop a budget that incorporates the issues on a more local and regional basis. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Department of Community Health Board Meeting. The DCH Board met on February 12, 2015. Commissioner Clyde Reese gave his report, highlighted below:

- The DCH budget process is ongoing in the Legislature. The FY2015 budget has been presented to both the House and Senate. The FY2016 budget has been presented to the House, and will be presented to the Senate next week.
- The high cost of Hepatitis C drugs is recognized in the budget. There are approximately 6,000 Georgia Medicaid members with Hepatitis C, of whom 800 are eligible for treatment with the new drugs, at a cost of $118,000/person.
- Several pieces of CON legislation have just been introduced in the Legislature.
- There have been several promising interviews for the recently vacated position of Medicaid Chief.
- The Medicaid Care Management Organization (CMO) procurement has been released. DCH expects to make an award by July 1, 2015, with a one-year "transition" period.
- Commissioner Reese reminded the Board that DCH had previously made the decision not to include the ABD population in managed care at this time. DCH has $12.1 million allocated in the FY16 budget to select and implement one statewide vendor for the Voluntary Care/Case Management program, and anticipates releasing the RFP after July 1, 2015 if it is approved. DCH is anticipating $18 million in savings in FY17 from this activity.
- DCH will amend the HP contract to add the Credentials Verification Organization function. This has been presented to CMS for approval.
- DCH will establish a Task Force to mitigate the reductions in DSH payments. A report of the findings is due to the General Assembly in August.
- The Rural Hospital Stabilization Committee, which has no sunset, met four times and will soon make a recommendation for a mitigation solution which will utilize telemedicine and local EMS.

A public notice regarding revisions to state regulations for hospice care was offered for initial adoption and was unanimously approved. Even though

hospice eligibility was expanded from a life expectancy of six month to two years, Commissioner Reese pointed out that DCH was not expanding Medicaid payment policy to be in line with that.

DFCS Switching Out of Flawed Call-In System for Medicaid and Food Stamps. On February 17, 2015, Georgia's Division of Family and Children Services will be switching out of its call-in system for Medicaid and food stamps to a new system that allows people to visit the department for some services. The previous system had long wait times and dropped calls. Since 2013, thousands of calls went unanswered every month and the average wait time was 41 minutes. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Governor's Budget Proposes Nearly $1.5 Billion in Medicaid Savings Measures. On February 18, 2015, Illinois Governor Bruce Rauner released his FY 2016 budget proposal as the state faces a reported multi-billion dollar budget shortfall for the upcoming fiscal year. Although short on details of the cuts and savings measures proposed, the following are included as part of nearly $1.5 billion in combined cuts and savings for the Medicaid program:

- Renewed push to review Medicaid rolls and remove ineligible recipients, as well as new techniques for detection and elimination of provider fraud and waste (combined $75 million in savings).
- Transitioning certain individuals from Medicaid to Exchange coverage (estimated $41 million in savings).
- Elimination of non-mandatory services, such as dental and podiatry; rolling back reimbursement rates to SMART Act implementation levels in instances where SMART Act cuts have expired or were eliminated (combined $320 million in savings).
- Elimination of certain fixed supplemental payments to hospitals, as well as diversion of a portion of hospital assessments to general Medicaid funds (no estimated savings given).
- Continued move of Medicaid beneficiaries into managed care, with a target of 60 percent of Medicaid population enrolled in managed care by the end of 2015 (no estimated savings given).

Governor Rauner stated that the ball is now in the legislature's court on the budget. Both chambers of the legislature have veto-proof democratic majorities and initial reactions to the Governor's proposed budget from democrats were not positive. Read more

Illinois Marketplace Enrollments Top 347,000, as Director Steps Down. On February 18, 2015, Crain's Chicago Business reported that according to federal HHS enrollment figures, Illinois' health insurance Marketplace known as Get Covered Illinois has enrolled more than 347,000 individuals, with an estimated 175,000 new sign-ups for 2015. Meanwhile, it was announced that Jennifer Koehler, the executive director of Get Covered Illinois would be stepping down this month. No replacement has been named at this time. Read more

Indiana

Indiana HIP 2.0 Program Evaluation RFP Released. The state of Indiana released the HIP 2.0 Program Evaluation Request for Proposals (RFP). Responses are due March 11, 2015. The purpose of the RFP is to select a vendor that can satisfy the State's need for reporting and evaluations of the HIP 2.0 Waiver 1115 Demonstration. It is the intent of FSSA to contract with a vendor that provides quality services for conducting evaluations and drafting reports for FSSA. The Bidders Conference will be February 24, 2015 and questions are due February 25, 2015. Read More

Kentucky

Study Backs State's Medicaid Expansion. On February 12, 2015, *The New York Times* reported that Kentucky Governor Steven L. Beshear released a study by Deloitte Consulting and the Urban Studies Institute that predicts expansion will generate almost $1 billion for the state in the next seven years. The report states that the cost of covering new Medicaid enrollees will be $74 million in 2017 and grow to $363 million in 2021. However, it found that these costs will be offset by the positive economic effects, including nearly a billion to health care providers in 2014 and the creation of new jobs. The study also found that the newly eligible under expansion seek medical treatment at a higher rate, especially for chronic conditions. This report comes after Republican warnings that expansion will be a great burden to taxpayers. Read More

Louisiana

Louisiana Medicaid Enrollment and Eligibility System RFP Released. On February 14, 2015, the state of Indiana released the Medicaid Enrollment and Eligibility System Request for Proposals (RFP). The purpose of this RFP is to solicit proposals for the Office of Technology Services for services to design, implement, and provide on-going maintenance and operation of a best-practice, cost-effective, Medicaid Eligibility and Enrollment solution for the state. Proposals are due on April 3, 2015, with anticipated awards by May 1, 2015. Contracts are set to go live on June 1, 2015. Read more

Maine

Gov. LePage Appeals to Court to Remove 19 and 20 Year Olds from Medicaid. On Friday February 13, 2015, *Reuters* reported that Governor Paul LePage has appealed to the Supreme Court after a lower court rejected the state's plan to remove 19 and 20 year olds from Medicaid. The court ruled that the move would violate the healthcare reform law, which states children will not lose healthcare during the transition of ACA Medicaid. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Gov. Baker Aims for Sustainable MassHealth by 2017. On February 12, 2015, *WWLP*.com reported that the Massachusetts' Department of Health and Human Services is aiming for the MassHealth program to become "sustainable" by 2017. MassHealth spending has increased by 11 percent between 2014 and 2015 and this year it is experiencing a 13 percent growth. HHS Secretary Marylou Sudders said her proposal will be around six percent growth over 2015. Read More

Missouri

Medicaid Program Working On Enrollment Delays. On February 18, 2015, *St. Louis Public Radio* reported that Missouri's Medicaid program is working on fixing massive delays and has currently reduced the number of pending applications to 13,000. The delays were caused by staff reductions, an expensive computer system overhaul, and a push of new applications. In the past four weeks, the number of pending applications for children, pregnant women, and parents has dropped by 7,000. These applications were processed in a matter of days after a simple computer problem was fixed. Read More

New Hampshire

DHHS Commissioner Confident of Expansion Approval. On February 16, 2015, *NHPR* reported that the state's health and human services commissioner stated that he is confident the federal government will approve the Medicaid expansion waiver. The authorizing legislation, which passed last year, uses federal funds to buy private insurance for people under the 138 percent federal poverty limit. Read More

As State Transitions to Medicaid Managed Care, Concerns Raised About Quality of Care. On February 13, 2015, *Concord Monitor* reported that families and advocates are raising questions about the overall effect on the quality of care of the state's transition into Medicaid managed care. New Hampshire began the process to shift from fee-for-service to what it calls a "whole person approach" in December 2013. It contracted with New Hampshire Healthy Families and with Well Sense Health Plan. Enrollment will begin July 1, 2015 and managed care coverage for people receiving waiver services will begin January 1, 2016. Coverage for nursing facilities was delayed until July 1, 2016. Read More

New Jersey

Karen Brodsky (Email Karen)

Department of Human Services Commissioner to leave post. On February 18, 2015 the Department of Human Services (DHS) issued a press release to announce that Jennifer Velez, New Jersey's longest serving Commissioner of DHS will leave her post following eight years in the position. On February 27, 2015 she leaves the state to join Barnabas Health as their Senior Vice President for Strategy and Planning. Elizabeth Connolly, Velez's chief of staff, has been selected by Governor Christie to serve as acting commissioner until a permanent replacement is found. Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

NY State of Health Enrollment Extension. The deadline for individuals and families to enroll in a qualified health plan through NY State of Health, the NYS health exchange, was February 15, 2015. Marketplace officials indicate that those who begin filling out their application on the health insurance exchange but have been unable to complete the enrollment process before the deadline will have until the end of the month to complete it and enroll in a health insurance plan. Applications and enrollments in health plans must be completed by the end of the day on February 28, 2015. Those who complete their enrollment after February 15, 2015, but before February 28, 2015, will have coverage starting on April 1, 2015.

Nursing Home Carve-In. The transition of the nursing home population and benefit into Medicaid managed care began in NYC on February 1, 2015. Phase 1 includes all of NYC; Phase 2, including the suburban counties of Nassau, Suffolk and Westchester, is scheduled to begin in April, with the rest of the state included in Phase 3 with a July start-up. Upon implementation of the carve-in, all beneficiaries in need of long stay/custodial placement will be required to enroll in care management, either through a mainstream Medicaid managed care plan, or through an MLTC. Beneficiaries currently in skilled nursing facilities will not be required to enroll. They will remain in fee-for-service, with the option of enrolling on a voluntary basis. In a letter approving the waiver amendment request CMS included a number of contingencies:

- New York will implement conflict-free long term services and supports (LTSS) assessments via an enrollment broker.
- New York will have an Independent Consumer Support Program in place 30 days prior to making the long term nursing facility benefits available in any geographic area that has demonstrated readiness.
- New York will submit nursing home contract amendments to CMS for review and approval 30 days prior to implementation of the nursing home benefit into managed care.
- New York continues with its comprehensive outreach with managed care organizations (MCO), providers, beneficiaries and stakeholders.
- New York ensures that educational procedures related to MCO plan choice are in accordance with the special terms and conditions (STCs).
- CMS and New York will determine appropriate quality measures related to long term nursing facility services for non-duals in the 1115 demonstration, including measures similar to those under the state's currently approved Fully-Integrated Dual Advantage (FIDA) demonstration.

The CMS letter approving the amendment can be found here.

Behavioral Health. The Medicaid Redesign Team (MRT) recommended transitioning care for individuals with substance use disorder and mental health treatment needs from the current fee for service system to Medicaid managed care. The behavioral health carve-in has been delayed several times as the state works with plans on readiness review and finalizes plan approvals. The state also awaits federal approval for the new services and benefits proposed as part

of the carve-in. CMS has committed to work with NYS to achieve waiver approval by the end of March. Outstanding issues include conflict-free care management, compliance with HCBS settings rule, and payment rates for the new services and benefits and premiums. Implementation is scheduled to be effective July 2015 in NYC and six months later in the rest of the state.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Governor's Budget Proposes Medicaid Premiums for Certain Adults. Governor John Kasich's budget includes health care premiums for about 100,000 adults who would be covered by Medicaid and whose income, for a single adult, would be at or above $11,670. The premiums are expected to be about $15 to $37, depending on income. Ohio already requires some participants to pay copays for some services. Premiums would go into effect in January if approved by the federal government. Several states have already implemented cost-sharing responsibilities in their Medicaid programs. Read More 2

Cleveland Clinic, Five Other Systems form Statewide Provider Collaborative. The Midwest Health Collaborative is a coalition designed to control health care costs and improve quality in response to insurers to meet quality and cost goals. The hospital systems will remain independent, but will collaborate to share information intended to control cost and improve quality. Members of the Collaborative include the Cleveland Clinic, Columbus-based OhioHealth, Canton-based Aultman Hospital, Dayton-based Premier Health, Toledo-based ProMedica and Cincinnati-based TriHealth. These institutions have been working together on collaboration since November of 2013. Read More

Medicaid Income Change Notification, Eligibility Reviews Resume. In Ohio, the federal government approved suspending the renewal process last year because of the implementation of the new federal health care law and a new computer system for applying for and determining Medicaid eligibility. Now that 2015 is here, renewals of Medicaid eligibility are once again required and there is some concern that not everyone will get the word. County departments and State officials are working to ensure Medicaid renewals happen timely. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Three Pennsylvania Systems to Work Together On Population Health. Two Primary care networks affiliated with DaVita Health Partners and Independence Blue Cross will partner with Holy Redeemer Health System to share risk in managing patients. The partnership brings the three organizations closer to a population health model according the article in Modern Healthcare. The agreement will enable patient access to a full continuum of services and the ability for providers to share data in real time as well as leverage analytic tools across the systems. Read More

Rural Pennsylvania Facing Health Care Provider Shortage. An article in the Bradford Era states that Pennsylvanians are facing a shortage of health care providers especially those living in rural areas. One legislative solution being considered is to remove the requirement that nurse practitioners need to enter

into collaborative agreements with two physicians. The Pennsylvania Medical Society believes the most effective way to address the provider shortage is to develop loan forgiveness and increasing state funded residency programs. Read More

More For-Profit Health Chains in Pennsylvania Means More Tax Revenue for Local Governments. A number of communities are benefiting from non-profit health care systems transitioning to for-profit status explains an article in the Pittsburgh Post-Gazette. Examples are provided from across the state about how struggling local municipalities are enjoying the infusion of tax revenue that the new for profit health systems are providing. Even though there are fewer acute care hospitals in Pennsylvania overall, there may be a trend to a higher proportion of for-profit acute hospitals. Read More

Rite Aid Spends $2B On Push into Pharmacy Benefit Management. Camp Hill, Pennsylvania based Rite Aid is re-entering Pharmacy Benefit Management (PBM) services by purchasing EnvisionRx. The Philadelphia Inquirer article explains that by acquiring the PBM, Rite Aid positions itself to become a participant in the effort to reduce health care costs for health insurance plans and employers. Rite Aid will compete with other retail pharmacies like CVS who are also providing PBM services. Read More

Vermont

RI Secretary of HHS Appointed as Commissioner of DVHA. On February 9, 2015, Governor Peter Shumlin announced that Steven Costantino has been appointed as the new commissioner of the Department of Vermont Health Access (DVHA). Constantino was the former Secretary of Rhode Island's Executive Office of Health and Human Services. He will be taking over for Mark Lanson who will step down in March. Read More

Virginia

Virginia MMIS RFI Released. On February 13, 2015, the state of Virginia released the Medicaid Management Information System (MMIS) Request for Information (RFI). Responses are due April 1, 2015. Phase 1 of the program will be implemented August 2015, and the remaining programs will be implemented March 2016. Read More

Wisconsin

Medicaid Expansion Could Bring $345 Million in Savings if Enacted. On February 17, 2015, *The Wisconsin State Journal* reported that according to the Legislative Fiscal Bureau, the state can save $345 million. This new estimate is $30 million to $84 million higher than the previous estimate published in August. This is largely due to increased enrollment by poor, childless adults. By June 2015, the report predicts 152,000 will enroll. If Wisconsin does not fully expand Medicaid but still approves a waiver similar to the Iowa model expansion, as proposed by Sen. Jon Erpenbach and Rep. Daniel Riemer, the state will save $241 million. Read More

Wyoming

Budget Amendments May Open Medicaid Expansion for Debate Again. On February *Casper Star Tribune* reported that House Speaker Rep. Kermit Brown said that House members will bring up budget amendments that seek to expand Medicaid. However, he states that the amendments do not call for anything that wasn't already debated previously. Senate President Sen. Phil Nicholas does not believe the Senate will change its mind. Read More

National

Marketplace Enrollment Hits 11.4 Million in 2015. On February 17, 2015, *The Washington Post* reported that HHS announced 11.4 million people have signed up for qualified health plans in the state-based and federally facilitated Marketplaces, beating the 2015 goal. The administration hopes to keep at least 9.1 million enrollees through 2015. The deadline for enrollment was February 15, but anyone who began an application prior to the date has until Sunday to complete it. Read More

U.S. State Tax Revenues See Growth Third Quarter Following a Decline. The Nelson A. Rockefeller Institute of Government released the State Revenue Report. Their findings show that state tax revenues grew 4.4 percent in the third quarter after a decline in the second quarter, attributed to policy changes in federal law. Third quarter growth was seen in all of the major sources of state tax revenues. The report predicts continued growth for the rest of fiscal year 2015. Read More

Some States Will Not Support Obamacare if Court Ruling Ends Subsidies. On February 17, 2015, *Reuters* reported that if King vs. Burwell rules an end to subsidies in 34 exchanges, some Republican states will refuse to rescue Obamacare. Louisiana, Mississippi, Nebraska, South Carolina and Wisconsin all reported to *Reuters* that they would not create state-run exchanges to continue subsidies. Other states said that the opposition from Republican legislatures will make it impossible to create a new exchange. Health policy experts say the most likely fix will be to create partnerships with the federal government or between states. Read More

Government to Change Rating System of Nursing Homes. On February 12, 2015, *The New York Times* reported that the federal government will change the rating system used for nursing homes, making it more difficult to achieve four and five star ratings. Scores are predicted to fall for many homes. The new ratings will be made public February 20. CMS states that this was an effort to raise the standard of homes and rebalance the ratings. Prior to the change, the system relied heavily on unverified information coming from the homes rather than government audits. In addition, the ratings will for the first time consider antipsychotic drug use, which have historically been misused on the elderly with dementia. Read More

Industry News

Anthem Completes Acquisition of Simply Healthcare. On February 18, 2015, Anthem, Inc. announced the completion of its previously announced acquisition of Simply Health Care Holdings. Simply Healthcare operates plans in both the Florida Medicaid managed care program (under the Simply Healthcare, Better Health, and Clear Health Alliance plans) and Medicare Advantage, with around 177,000 Medicaid and 21,000 Medicare Advantage members, according to Anthem's press release. Combined with its Amerigroup plan, Anthem now serves more than 500,000 Medicaid members in Florida. Read more

North American Health Care Files for Bankruptcy Protection. On February 17, 2015, *The New York Times* reported that the nursing home operator, North American Health Care, is filing for bankruptcy protection amidst fines for substandard care and multiple lawsuits by patients and families. Bankruptcy in the industry has risen 38 percent between 2010 and 2014. However, Chapter 11 bankruptcy protection fell by 60 percent. North American operates 30 homes throughout the California and other Western states. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
February 16, 2015	Iowa	RFP Release	550,000
February/March, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
March 1, 2015	Michigan Duals	Implementation	70,000
March 2, 2015	Florida Healthy Kids	Proposals Due	185,000
March 27, 2015	Mississippi CHIP	Proposals Due	50,300
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 4, 2015	Georgia	Proposals Due	1,300,000
May 8, 2015	Iowa	Proposals Due	550,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	178,000	Application			8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the five states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
California	15,322	17,846	39,731	42,473	44,804	48,976	51,527	58,945	122,908
Illinois	2,831	19,461	37,248	48,114	46,870	49,060	49,253	57,967	63,731
Massachusetts	13,274	13,409	18,836	18,067	17,739	17,465	18,104	17,918	17,867
Ohio									68,262
Virginia			11,169	11,983	21,958	28,642	29,648	27,701	27,527
Total Fully Integrated	**31,427**	**50,716**	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**162,531**	**300,295**

Source: State enrollment reporting compiled by HMA

HMA News

HMA Webinar: *"Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards"*

Thursday, March 12, 2015
1:00pm Eastern
Link to Webinar Registration

HMA Information Services (HMAIS) will present the webinar, "Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards" at 1 p.m. EST Thursday, March 12.

The time for culturally responsive health care is now. Not only is it the right thing to do, but key elements are mandated by the federal CLAS standards (Culturally and Linguistically Appropriate Services). There is also a strong business case for culturally responsive health care; it drives patient satisfaction, helps improve outcomes, and brings a degree of economic viability to what is essentially an unfunded mandate. Unfortunately, many healthcare organizations find themselves either unfamiliar with the standards or lagging in the development and implementation of strategies for full compliance.

During this webinar, Health Management Associates Principal Dr. Jeff Ring will make the case for socially responsive health care and show your organization how to take the necessary steps to make it work for your patients and your organization.