HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 13, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MICHIGAN RELEASES MEDICAID MANAGED CARE REQUEST FOR PROPOSALS (RFP)

This week, our *In Focus* section reviews the Medicaid managed care request for proposals (RFP) issued by the Michigan Department of Health and Human Services (MDHHS) on Friday, May 8, 2015. MDHHS is rebidding its Medicaid managed care contracts across all 10 regions of the state, covering more than 1.6 million Medicaid lives as of April 2015. While the RFP is built upon the existing managed care program, it represents a shift in bidder evaluation toward population health management, payment reform, and other goals of Michigan's State Innovation Model (SIM) initiative. These health reform goals are not only the basis of selecting successful bidders but are also reflected in many new requirements that bidders must meet, either at the time new contracts begin or within specified timeframes. Additionally, the RFP presents the possibility for a reduction in the number of contracted health plans. A total of 13 plans currently serve the Medicaid managed care population, with four plans holding around two-thirds of the market share. Bids are due to the state in August 2015, with an implementation date of January 1, 2016.

RFP Overview

Scope: As of April 2015, there were just under 1.61 million individuals enrolled in a Medicaid health plan across 10 regions covering the entire state, which includes close to 450,000 Healthy Michigan Plan (HMP) enrollees in the state's Medicaid expansion plan. Also included in the 1.61 million are more than 55,000 dual eligibles enrolled in Medicaid health plans for their Medicaid services. Federal fiscal year 2014 Medicaid managed care spending in Michigan exceeded $5.4 billion, with average per member per month spending of around $335.

Covered Populations: Populations mandatorily enrolled in Medicaid managed care in Michigan include traditional populations of children, families, and pregnant women, as well as the aged, blind, and disabled (ABD) populations, children in foster care, the HMP population, and persons enrolled in the Children's Special Health Care Services (CSHCS) program. Migrants, Native Americans, and dual eligibles may voluntarily enroll in managed care.

Those populations excluded from managed care enrollment include individuals residing in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or state psychiatric hospital; individuals authorized to receive private duty nursing or being served under a home and community based services waiver; individuals enrolled in the Program of All-inclusive Care for the Elderly; individuals enrolled in the state's dual eligible financial alignment demonstration, MI Health Link; as well as select other populations detailed in the RFP.

Behavioral Health Integration: Under the RFP, awarded health plans must agree to work with MDHHS to develop initiatives to better integrate behavioral health services covered by either the health plan or the one of the ten managed mental health care plans (prepaid inpatient health plans (PIHPs)), including the provision of incentives to primary care providers to support behavioral health integration, facilitate the placement of PCPs in community mental health centers, and facilitate placement of behavioral health clinicians in primary care settings. Additionally, health plans are required to have provider agreements in place with all PIHPs in the regions they wish to serve.

Contract Awards/Term of Contract: The regional configuration for this RFP is new, based on Governor Snyder's "Prosperity Regions". This regional structure is significantly different than the current Medicaid managed care regional configuration. Bidders may bid on any combination of regions in the state (with the exception that plans wishing to bid on either Region 2 or Region 3 must bid on both of those regions), but must cover all counties in a region. This is a new requirement that has resulted in significant activity by the health plans to contract with providers in additional counties.

MDHHS has listed a proposed number of awards to be made in each region (detailed in table below). However, HMA notes that in past procurements, Michigan has awarded more than the proposed number of contracts per region and this should not be taken as a guarantee of a reduction of the number of health plan contracts awarded under this RFP.

Region	Proposed Contract Awards	Current Contracts
1	1	1
2	2 to 3	4
3	2 to 3	3
4	3 to 5	6
5	2 to 3	6
6	3 to 5	8
7	2 to 3	4
8	3 to 5	6
9	3 to 5	7
10	5 to 7	9

All 13 incumbent plans are expected to bid on this RFP. In addition there is a strong possibility of bids from one or more national plans not currently serving Michigan Medicaid enrollees. Competition will likely be most intense in Region 10 where there are nine incumbent plans, a tenth plan that has already been approved to serve counties in the region and at least one more bidder expected to enter the market.

Contracts will go live on January 1, 2016, with a five-year contract term through December 31, 2020. Additionally, the state may optionally extend contracts for up to three additional years, taking the potential life of the contract out through December 31, 2023.

Rate Setting and Risk Adjustment: MDHHS will establish actuarially sound capitation rates and intends to post rate information for bidders on May 29, 2015. Capitation rates will be risk-adjusted based on case mix. Additionally, the state may implement risk-mitigation strategies for the HMP population.

Quality Withhold: The state will withhold 1 percent of capitation payments, which may be earned back through performance bonus awards. The criteria for awards is yet to be finalized, but will include assessment of performance in quality, access, enrollee satisfaction, and administrative functions.

Evaluation Criteria

The technical evaluation criteria under this RFP lean heavily on the narrative responses worth 50 percent of the total possible points. Parts of the narrative address significant health reform goals, including some which are aligned with the state's SIM initiative. The five narrative submission sections address:

I. **Population health management**, including quality assessment and performance improvement, care management, and behavioral health integration. This section also includes items related to social determinants of health, data analytics on population health management, and community collaboration.

II. **Patient-Centered Medical Homes (PCMH)** including the approach to encouraging primary care providers to transition to PCMHs, as well as experience contracting with accountable systems of care, such as risk-bearing provider entities.

III. **Health Information Exchange (HIE) and Health Information Technology (HIT)**.

IV. **Provider network,** including details on provider availability and enrollee access to culturally appropriate services.

V. **Payment reform**, including details on current value-based payment arrangements and the bidder's intentions to expand value-based reimbursement in Michigan if awarded a contract.

Technical Evaluation Criteria	Points	% of Total
Exhibit B – General Proposal Requirements	10	1.0%
Exhibit E – Narrative Submission	510	50.0%
Exhibit F – Contracted Primary Care Providers by Region	125	12.3%
Exhibit G – Contracted Specialist Providers by Region	25	2.5%
Exhibit H – Contracted Adult Specialists Statewide	25	2.5%
Exhibit I – Contracted Pediatric Subspecialists Statewide	25	2.5%
Exhibit J – Geo-Access Study Maps and Access to Services	100	9.8%
Exhibit K – Health Effectiveness Data and Information Set (HEDIS) Quality Measures	100	9.8%
Exhibit L – HIE and HIT Capabilities	90	8.8%
Exhibit M – Bidder Organizational Profile	10	1.0%
Total Points Possible	**1,020**	

In addition to the scored provisions there are many additional requirements that are pass/fail items to which the bidder must attest current or future compliance. Significant among the new requirements are working with the state on development of payment reform initiatives, behavioral health integration initiatives, and population healthy initiatives. Bidders are also required to provide or arrange for the provision of community health workers (CHWs) to enrollees who have significant behavioral health issues and complex physical co-morbidities. Each successful bidder must maintain a CHW to enrollee ratio of at least one CHW for every 20,000 Medicaid enrollees.

RFP Timeline

Bidders may submit written questions on the RFP this month, with questions on rate information due in early June; questions will be answered by MDHHS by the end of June. Proposals are due on August 3, 2015, with the date of contract award announcements to be determined. Contracts are scheduled to go live on January 1, 2016.

Timeline Event	Date
Deadline for Written Questions	May 26, 2015
Rate Information Posted	May 29, 2015
Deadline for Rate Questions	June 11, 2015
Anticipated Posting of Answers to Questions	June 29, 2015
Proposals Due	August 3, 2015
Contract Awards	TBD
Implementation	January 1, 2016

Incumbent Market Landscape

The Michigan Medicaid managed care program is currently served by 13 health plans. The Upper Peninsula Health Plan is the lone plan in Region 1, which covers the entirety of the Upper Peninsula. Two of the four largest health plans in the state – Meridian and McLaren – currently serve the majority of counties in all nine regions in the Lower Peninsula and each has recently been approved to serve the entire Lower Peninsula by the Insurance Commissioner. There is significant participation from a number of provider-owned health plans, with only three publicly traded health plans in the state (United, Molina, and Aetna), and one other large multi-state health plan (Meridian).

Health Plan	Region 1	2	3	4	5	6	7	8	9	10	Total (All Regions)
Meridian Health Plan		20,009	16,588	65,670	15,280	38,264	12,012	74,307	55,676	111,390	**409,196**
UnitedHealthcare				11,545	7,075	13,426		36,876	12,594	175,649	**257,165**
Molina Healthcare		5,816	7,037	39,531	23,561	7,106	2,137	916	3,359	143,932	**233,395**
McLaren Health Plan		8,401	14,092	10,723	23,385	41,167	31,358	13,022	1,234	21,920	**165,302**
Priority Health Choice		6,408		91,139				1,444	4,851		**103,842**
HAP Midwest						1,164			10,286	82,783	**94,233**
HealthPlus Partners					26,870	61,354					**88,224**
Blue Cross Complete									24,607	59,046	**83,653**
Total Health Care						5,407				59,614	**65,021**
CoventryCares (Aetna)								2,768		38,661	**41,429**
Upper Peninsula Health Plan	41,093										**41,093**
Sparrow PHP				651	210	686	18,729				**20,276**
Harbor Health Plan										6,683	**6,683**
Total (All Plans)	**41,093**	**40,634**	**37,717**	**219,259**	**96,381**	**168,574**	**64,236**	**129,333**	**112,607**	**699,678**	**1,609,512**

Note: Enrollment by region in the table above is based on county specific enrollment applied to the new regional structure. Health plans may not be serving all counties within a given region currently.

Link to RFP, More Information

The RFP and related documents are available on the Buy4Michigan.com web portal, available here.

For more information on Medicaid and managed care in Michigan, please see the HMA Michigan Update, available here.

HMA Medicaid Roundup

Alabama

Governor Hints at Medicaid Expansion. On May 11, 2015, *AL.com* reported that Governor Robert Bentley stated that the state may seek expansion under a waiver. However, his administration is waiting to hear on the Supreme Court ruling before proceeding on any formal action. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Proposed Bill to Divert Inmates with Mental Health Issues from Jails. On May 8, 2015, *California Healthline* reported that a new bill seeks to increase funding by $13 million to state programs that divert inmates with mental health issues out of jails. The text of the bill can be found here. Read More

Study Finds ER Visits Increase after Medicaid Dental Benefits Slashed. On May 8, 2015, *Reuters* reported that a *Health Affairs* study found that ER visits for adults enrolled in Medicaid (called Medi-Cal in California) rose after dental benefits were removed. The study looked at ER visits between 2006 and 2011 for 113,309 adults on Medi-Cal. During these six years, there were 121,869 dental-related ER visits. Dental ER visits increased by 33 percent after benefits were removed. This translates to an extra 1,800 ER visits each year for the total adult California Medi-Cal population. The cost of dental ER visits increased by 68 percent after the policy change. Read More

Blue Shield of California's Proposed Acquisition of Care1st to have Hearing. On May 7, 2015, *Los Angeles Times* reported that state regulators will hold a hearing on June 8 regarding the proposed $1.25 billion acquisition of Care1st. The hearing will be open to public comments. Read More

Proposal Seeks to Expand Incentive Pay for Hospitals and Introduce Shared Savings to Medicaid MCOs. On May 11, 2015, *California Healthline* reported that a proposal under the state's 1115 waiver is looking to expand incentive pay for providers and introduce shared savings for Medicaid managed care plans. The proposed waiver hopes to hold Medi-Cal providers accountable for patient outcomes and encourages collaboration among specialties and systems to receive funding. Additionally, the DSRIP program would be re-branded and expanded to include another 42 hospitals. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Gov. Scott Appoints Nine to Hospital Panel; none are Hospital Executives. On May 12, 2015, *Health News Florida* reported that Governor Rick Scott assigned nine people to the Commission on Healthcare and Hospital Funding. However, none chosen were hospital executives. Tony Carvalho, president of the Safety Net Hospital Alliance of Florida, claims the members are still very competent despite not being health care executives. Scott has asked the commission to deliberate on three hospital revenue sharing models later this month. Read More

Gov. Scott Asks Hospitals to Share $3.7 Billion in Profits to Help Each Other. On May 11, 2015, *Health News Florida* reported that Governor Rick Scott sent a letter to hospitals across Florida asking them to help draw up a plan to use approximately $3.7 billion in collected profits to help struggling hospitals. Profit sharing would include all hospitals receiving taxpayer help. Read More

No Resolution over LIP after Meeting with Gov. Scott and HHS Secretary Burwell. On May 6, 2015, *Kaiser Health News* reported that Governor Rick Scott was unable to resolve Florida's low income pool (LIP) funding during his trip to meet with Health and Human Services Secretary, Sylvia Burwell. Burwell stated that Florida's request does not meet key principles used in considering proposals for uncompensated care programs and that funding is not based on the state's decision to not expand Medicaid. Read More

Broward County Public Hospitals Prepare for $180 Million Federal Funding Loss. On May 11, 2015, the *Miami Herald* reported that as the state struggles with a budget and funding agreement, public hospitals in Broward County are preparing for the potential loss in federal funds. Broward Health and Memorial Health Care System are considering reductions to non-critical programs. Meanwhile, Memorial Health leadership stated they were certain patient access would suffer. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Considers 1115 Waiver for Rural and Safety Net Hospitals, not Expansion. On May 7, 2015, *Kaiser Health News* reported that to help the state's struggling rural hospitals and its big safety net hospitals, Georgia included authorization for an 1115 waiver in the state budget. However, Georgia still opposes the Affordable Care Act and calls the state's plan an "experiment," not Medicaid expansion. It will begin crafting and filing the waiver within weeks. Read More

Audit Finds Access Easier to Costly Nursing Homes than to Home and Community-Based Services. On May 8, 2015, T*he Atlanta Journal Constitution* reported that a review by the Georgia Department of Audits and Accounts found that fewer elderly and disabled persons received home and community-based services in 2013 than in 2011. Additionally, the audit found that one-third of nursing homes did not make any referrals to programs that discuss patient options. Read More

Hawaii

Judy Mohr Peterson Named New Medicaid Director. On May 11, 2015, the *Star Advertiser* reported that Judy Mohr Peterson has been named Hawaii's new Medicaid Director. Mohr Peterson will start as administrator of the state Department of Human Services Med-QUEST Division on July 1. She previously served as Oregon's Medicaid Director. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Care Coordination Enrollment Tops 2 Million. In updated April 2015 enrollment figures posted this week by the Illinois Department of Healthcare and Family Services (HFS), enrollment in the three care coordination programs (managed care) have topped 2 million, up from less than 75,000 in April 2014. More than 1.8 million individuals are enrolled in the Family Health Program (FHP)/ACA program, which serves children, families, and the Medicaid expansion population. Just under 120,000 non-dual eligible seniors and persons with disabilities (SPDs) are enrolled in the Integrated Care Program (ICP), while more than 58,000 are enrolled in the Medicare-Medicaid Alignment Initiative (MMAI), the state's dual eligible demonstration.

Governor's Budget Proposal Fails to Get Single Vote in House. On May 6, 2015, the *Chicago Tribune* reported that Governor Bruce Rauner's FY 2016 budget, which reduces Medicaid and related health care funding by more than $2 billion, failed to receive a single yes vote in the House. In a move that has been labeled political by several Republicans, Democratic House Speaker Michael Madigan sponsored the bill that was voted on, with House democrats all opposed and House republicans voting present. Read More

Chicago Mental Health Provider C4 in Acquisition Talks. On May 7, 2015, the *Chicago Sun-Times* reported that Eileen Durkin, president and CEO of Community Counseling Centers of Chicago, also known as C4, told staff that the provider is in talks to be acquired ahead of a planned closure on May 31, 2015. A potential buyer is unknown at this time. It was previously reported that C4 would be forced to close at the end of May due to financial issues. C4 provides mental health services to nearly 10,000 Chicagoans each year. Read More

Iowa

Senate Approves Budget That Puts Limits on Medicaid Managed Care. On May 8, 2015, *AJMC* reported that the Senate approved a state budget that includes provisions on the state's upcoming Medicaid managed care program. The budget calls for a cap on profits for managed care contractors, with limits on administrative costs; creation of a commission to oversee the transition into managed care; a ban on finding savings by cutting provider rates; and a reversal of a plan to close two state-run mental health institutes. The state is currently accepting bids on a transition to a statewide, nearly comprehensive Medicaid managed care program. Read More

United Plans to Enter State Exchange. On May 11, 2015, the *Des Moines Register* reported that UnitedHealthcare is planning on selling policies on the state's health insurance Marketplace next year. Iowans will be able to choose from two

companies. This year, Aetna's Coventry plans were the only health plans in the Marketplace after CoOportunity dissolved. Wellmark, the state's largest insurer, has declined to enter the exchange for the third year in a row. Read More

Kansas

Mental Health Drug Proposal Passes Final Legislative Hurdle. On May 8, 2015, *Kansas Health Institute News Service* reported that a proposal requested by Gov. Brownback to allow prior authorizations for Medicaid reimbursements on mental health drugs passed the House 82-31 and Senate 31-6. The bill is expected to save $8 million. Brownback must still sign the measure for it to go into effect. Read More

Kentucky

Kentucky Hospital Association: Hospitals Losing Money under ACA. On May 8, 2015, *USA Today* reported that according to a report by the Kentucky Hospital Association, hospitals will lose more money under the ACA than they will gain in revenues from expanded coverage. By 2024, payment cuts are estimated to reach nearly $7 million. As a result, there have been lay-offs and service shut downs. According to officials, hospitals are suffering a net loss due to the majority of the newly-insured having signed up for Medicaid. Read More

Maine

Feds Urge Supreme Court to Reject Governor's Medicaid Case. On May 6, 2015, the *Belleville News-Democrat* reported that the federal government is urging the Supreme Court to reject Gov. LePage's request to remove as many as 6,000 19 to 20-year-olds from Medicaid. The federal government stated that Maine's arguments lack merit and there is no disagreement between lower courts to be settled. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Feds Subpoena Health Connector Records. On May 7, 2015, *The Boston Globe* reported that the federal government subpoenaed Health Connector records dating back to 2010. The Health Connector administration stated that it is cooperating with the Department of Justice. The website has been experiencing difficulties for many years. Read More

Partners Signs Three Urgent Care Leases. On May 6, 2015, *Boston Business Journal* reported that a joint venture between Partners HealthCare and Texas-based MedSpring Urgent Care signed three new leases for urgent care centers to open this fall. Partners remains on the lookout for more locations in Boston. Read More

Missouri

Gov. Nixon Signs $26 Billion Budget, Expands Medicaid Managed Care. On May 8, 2015, *St. Louis Post-Dispatch* reported that Governor Jay Nixon signed a $26 billion budget. The budget includes shifting 200,000 parents and children who receive traditional Medicaid to privatized managed care, excluding individuals who are elderly, blind, or disabled. It was reported that current managed care contracts will need to be rebid. Additionally, the budget made $40 million in cuts to the departments of Mental Health, Health and Senior Services, and Social Services. Read More

Committee Votes to Delay Home Health Worker's Wage Plan. On May 13, 2015, the *St. Louis Post-Dispatch* reported that a committee voted to delay a wage plan for home health workers. Lawmakers now have until next year to decide whether to approve the proposal. The Missouri Home Care Union has been trying to raise the minimum pay for approximately 10,000 workers since last year. Read More

Montana

Gov. Bullock to Close Montana Developmental Center. On May 7, 2015, *The Baltimore Sun* reported that Gov. Steve Bullock signed Senate Bill 411 to close the Montana Developmental Center. Most of the residents will be moved to community-based settings within two years. Bullock believes the state will need a facility for those who are not ready for community-based placements. Read More

Nebraska

Nebraska Officials Take Over Two Nursing Homes. On May 8, 2015, the *Associated Press* reported that Nebraska has taken control of two nursing homes owned by Utah-based Deseret Health Group. According to the state, Deseret has been unable to pay staff, and the facilities have been taken over to protect the health and welfare of their residents. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Human Services (DHS) Provides 2016 Budget Testimony. On May 5, 2015, DHS Acting Commissioner, Elizabeth Connelly, testified before the Senate Budget and Appropriations Committee, representing eight divisions. Highlights from the report include:

- The Division of Medical Assistance and Health Services (DMAHS) projects that 21,000 individuals will receive managed long term services and supports (MLTSS) in state fiscal year (SFY) 2016 under the program that was implemented in July 2014. This represents a 64 percent increase in MLTSS enrollment over SFY 15.
- DMAHS plans to increase reimbursement rates for certain Medicaid providers to address challenges enrollees face in finding specialists who will serve them.

- This summer, the DMHAS will launch a "single point of entry" for individuals with substance abuse disorders whereby Rutgers University Behavioral Health Care will serve as an Interim Managing Entity that will coordinate services and care for this population and their families.
- DHS has hired a consultant to perform a functional and technical assessment to determine the potential reuse of the Consolidated Assistance for Social Services (CASS) deliverables and options going forward. CASS was the planned integrated eligibility determination system for county workers to use to determine eligibility for programs like Medicaid and SNAP that experienced implementation delays.

A full copy of the testimony can be found here.

DHS Maintains that Adults with Disabilities in Out-of-state Placements Should Return to New Jersey. On May 6, 2015, *NJ Spotlight* reported that New Jersey currently supports 382 adults with disabilities who reside in out-of-state placements, and who entered those placements for educational needs when they were children. Legislators urged state officials to reconsider plans to bring these individuals back to New Jersey, and instead grandfather them in and accept them from the Return Home New Jersey program. New Jersey is spending $48.3 million on these out-of-state placements, but would become eligible for $22.8 million in federal Medicaid matching funds if these adults returned to New Jersey. Read More

CMS Approved Reduction of 12 "Stage 4" Measures from New Jersey DSRIP. On May 4, 2015, the state's Department of Health released a letter from Elliot Fishman, CMS Director of the Children and Adults Health Programs Group, approving a request from the New Jersey Hospital Association to reduce the number of Stage 4 measures required under New Jersey's Delivery System Reform Incentive Payment Program (DSRIP). The request to reduce the number of reporting measures came from DSRIP hospitals that experienced significant reporting burdens. The following Stage 4 measures have been approved for deletion:

Measure Count	Stage 4 Measure Name
1	Inpatient utilization – general hospital / acute care
3	Pneumococcal immunization (PPV 23)
4	Prophylactic antibiotic selection for surgical patients - overall rate
5	Prophylactic antibiotics discontinued within 24 hours after surgery end time – overall rate
6	Urinary catheter removed on post-operative day 1 or post-operative day 2 of surgery being day 0
7	Venous thromboembolism prophylaxis
8	Intensive care unit venous thromboembolism prophylaxis
9	Venous thromboembolism patients receiving unfractionated heparin with dosages / platelet count monitoring by protocol or nonogram
10	Venous thromboembolism warfarin therapy discharge instructions
14	Ischemic vascular disease (IVD) : Use of aspirin or another antithrombotic
15	Preventive care and screening: high blood pressure
22	Gap in HIV visits

A copy of the letter can be found here .

New York

HMA Roundup – Denise Soffel (Email Denise)

New York DOH Working with CMS to Revise FIDA Rates. According to an update from the Division of Long Term Care, dated April 23, 2015, New York State's Department of Health (DOH) is working with CMS to revise the Fully Integrated Duals Advantage (FIDA) rates for the 2015-2016 fiscal year. FIDA is the state's dual eligible financial alignment demonstration program. According to LeadingAge New York, DOH anticipates a 4.5 to 5.6 percent increase in FIDA Medicaid rates. As of April 1, 2015, there were 4,158 FIDA enrollees, with nearly 42,000 program opt-outs. Read More

Commissioner of Health Confirmed. Dr. Howard Zucker was confirmed as Commissioner of Health by the New York State Senate. Dr. Zucker had been serving as Acting Commissioner since May of last year, when former Commissioner Nirav Shah joined Kaiser Permanente Southern California as senior vice president and chief operating officer for Clinical Operations. Dr. Zucker, trained in pediatrics, anesthesiology and critical care medicine, also has a law degree. Dr. Zucker's bio can be found here.

DSRIP Valuation Delay. Performing Provider Systems participating in New York State's Delivery System Reform Incentive Payment program were informed on May 8 of their PPS's valuation, the maximum amount of incentive payments available to the PPS. The state had scheduled a webinar for that afternoon to share valuation information with the public. The webinar was abruptly cancelled on Friday morning with no explanation; it was to be rescheduled for early this week, but has not yet happened. New York is scheduled to receive $6.4 billion in DSRIP payments over the next five years. Half of that amount is directed to the five public hospital systems in the state; the remainder will be divided among the 20 other PPSs.

Federal Cuts to Hurt NYC Hospitals Caring for Poor and Insured. On May 10, 2015, *The New York Times* reported that according to a report by city comptroller, Scott Stringer, New York City hospitals serving the poor and uninsured will feel financial pressure when federal disproportionate share hospital subsidy cuts go into effect in 2017. The cuts are based on the theory that since the ACA will insure millions of new people, hospitals will no longer need the same amount of subsidies for uncompensated care. However, New York City's hospital system sees a high proportion of undocumented immigrants who are not eligible for coverage. The report states that there have not been enough newly insured patients to cover the costs. In 2017, the 11 hospitals in the city are expected to face a deficit of over $1 billion. The comptroller calls for the federal government to delay cuts until impact can be better assessed. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

150,000 Ohioans Regain Medicaid in Settlement. Between January 1 and March 31, 2015, Ohio Medicaid, which is putting up a new computer system, was not able to conduct annual federally required passive redeterminations using information already in state and federal databases. Under federal guidelines, states must confirm an individual's continued eligibility yearly or remove them from Medicaid. As a result, more than 150,000 people on Medicaid were

removed from the program. Legal Aid Society of Columbus filed a lawsuit on behalf of several people who lost coverage and that lawsuit has now resulted in a settlement. Under the settlement, individuals who lost coverage due to the terms of the suit will be reinstated and required redeterminations will be conducted. Additional settlement provisions under the settlement are intended to improve the redetermination process going forward. Read More

Ohio Continues Work to Simplify and Align Eligibility: Ohio, one of a handful of states that has maintained a state specific eligibility process for individuals who are also being evaluated for federal disability benefits, continues to work on the simplifying eligibility by moving to accept federal determinations for most applicants. To ease the transition, which includes eliminating spend down for individuals who are over income, Ohio is realigning some existing eligibility groups and services. Federally required public notice and request for comments were posted on the Ohio Department of Medicaid website on May 6. Comments will be received until June 6. A summary level document and the detailed draft of the State Plan Amendment is available here.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Highmark Agrees to Pay All Unpaid UPMC Claims Since January. Pennsylvania Gov., Tom Wolf, who has taken a vocal role in the dispute between rivals Highmark and University of Pittsburg Medical Center (UPMC), has announced that Highmark has agreed to pay all outstanding claims from UPMC providers and facilities since January 1, 2015. Highmark will consider the claims as in-network so that patients will not be balance-billed for their care. Of the more than 900,000 claims that were filed on behalf of Highmark insurance customers using UPMC providers, nearly 97 percent were already paid as expected. The remaining 30,000 claims had not yet been paid due to the dispute between the two health care organizations. The companies worked with the Pennsylvania Insurance Department to resolve the issue. Read More

Neighborhood Health Centers to Expand. Neighborhood Health Centers of the Lehigh Valley has been awarded a $692,000 federal grant to open a medical office in south Bethlehem. The grant was one of three the Department of Health and Human Services (HHS) awarded Tuesday to Pennsylvania health centers that serve mostly low-income and uninsured individuals. In the last four years, more than 550 health center sites, nationally, have opened as a result of the Affordable Care Act, HHS reported. This includes 42 centers with more than 238 service delivery sites providing care to 680,000 patients in Pennsylvania. Neighborhood Health Centers of the Lehigh Valley was created in 2004 and was recognized as a federally qualified health center in 2012, giving it access to more federal funding, including higher Medicare and Medicaid reimbursement. Read More

Vermont

Senate Passes $11 Million Health Care Package. On May 7, 2015, *VTDigger.com* reported that the Vermont Senate approved a health care package that would restore exchange subsidies that were cut and fund initiatives for primary care and mental health services in the budget. The $11 million will come from an increase to the employer assessment, which is a quarterly tax on full-time equivalent employees (FTEs) who are not offered a health benefit, don't use their employer's health coverage, or are covered by Medicaid. The current flat rate of $140 per FTE would increase based on a firm's size. Businesses with 50 or fewer FTEs are exempt. Read More

Washington

Lower Rate Increase and Greater Choice Proposed for 2016 Health Exchange. On May 11, 2015, *The Seattle Times* reported that submissions to the state Office of the Insurance Commissioner for the 2016 health Exchange reveal more plans and carriers and a 5.4 percent rate increase, the lowest increase in recent years. Three new insurers, United, Regence, and Health Alliance, hope to participate in next year's exchange, increasing the number of carriers to 13. Read More

Wyoming

Wyoming Department of Health to Take Over Two Nursing Homes. On May 8, 2015, *The Charlotte Observer* reported that the Wyoming Department of Health will take over temporary management of two troubled nursing homes**.** Utah-based Deseret Health Group gave the notice that it will close both facilities, leading to concerns about patient care and the company's ability to pay employees. The state will continue to work to resolve the issue. Residents will be moved to different facilities. Read More

National

MACPAC Meeting to be Held May 14 and May 15. The next Medicaid and CHIP Payments and Access Commission public meeting will be held on Thursday, May 14, and Friday, May 15. Topics to be covered include:

- Planning for MACPAC Mandated Study on Disproportionate Share Hospital (DSH) Payments
- Safety Net Accountable Care Organizations
- Update on the Financial Alignment Initiative Demonstration
- Results from Focus Groups with Enrollees in the Financial Alignment Initiative Demonstration in California, Massachusetts, and Ohio
- Proposed Rule for the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, CHIP, and Alternative Benefit Plans
- Update on Trends in Medicaid Spending and State Budgets
- Proposed Rule for Extension of the 90/10 Matching Rate for Eligibility and Enrollment Systems

- Design Considerations for the Future of Children's Coverage, The Impact of Cost Sharing on Access and Use of Services, Eligibility under Federal Low-Income Assistance Programs
- Medicaid Estate Recovery Policy
- Issues in Medicaid Managed Care Rate Setting Read More

Study Finds 17 Million Gain Insurance from ACA; All Types of Insurance Expand. On May 6, 2015, *Los Angeles Times* reported that a Rand Corp. study of the Affordable Care Act found that 17 million more people have health insurance coverage since expansion began; 22.8 million were newly insured and 5.9 million lost coverage. Furthermore, gains were seen across all types of health insurance – employer, Medicaid, and exchange. The largest growth was seen in the insurance exchange marketplaces, with 11 million adult customers. Medicaid grew by nearly 10 million people. Employer-provided coverage grew by 8 million. Read More

Administration to Address Consumer Complaints of ACA. On May 8, 2015, *The New York Times* reported that the Obama administration will make attempts to address inaccurate doctor directories and unexpected bills for costs not covered by insurance. Insurers will need to update and correct provider directories at least once a month and provide an out-of-pocket cost calculator, taking into account premiums, subsidies, co-payments, deductibles, and other out-of-pocket costs. The administration is also taking steps to increase the accuracy of doctor directories in Medicare. Insurers say that the problems might not be easy to fix, and that doctors are partly to blame for the directory errors. Read More

GAO Finds Medicaid Payments to Providers Hampered by Inaccurate and Incomplete Data. On May 11, 2015, the U.S. Government Accountability Office (GAO) released a report detailing how Medicaid payments to hospitals in Illinois, New York, and California are hampered by insufficient information and a lack of a policies and processes for assessing payments. Payments showed inconclusive trends and some payments exceeded costs by a large amount, raising questions as to whether the payments were in fact for Medicaid purposes. GAO recommends that "CMS take steps to ensure states report provider-specific payment data, establish criteria for assessing payments to individual providers, develop a process to identify and review payments to individual providers, and expedite its review of the appropriateness of New York's hospital payments." Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
May 8, 2015	Michigan	RFP Release	1,600,000
May 14, 2015	Georgia	Proposals Due	1,300,000
May 19, 2015	Iowa	Proposals Due	550,000
May 22, 2015	Kentucky	Proposals Due	1,100,000
May, 2015	Mississippi CHIP	Contract Awards	50,300
May, 2015	Florida Healthy Kids	Contract Awards	185,000
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
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 3, 2015	Michigan	Proposals Due	1,600,000
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	1,600,000
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; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; 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 (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	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	Anthem (Amerigroup), Health Spring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***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 states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
California	48,976	51,527	58,945	122,908	123,079	124,239	122,520
Illinois	49,060	49,253	57,967	63,731	64,199	60,684	58,594
Massachusetts	17,465	18,104	17,918	17,867	17,763	17,797	17,474
New York				17	406	539	6,660
Ohio				68,262	66,892	65,657	63,625
South Carolina					83	1,205	1,398
Texas						20	15,141
Virginia	28,642	29,648	27,701	27,333	26,877	27,765	25,563
Total Duals Demo Enrollment	**144,143**	**148,532**	**162,531**	**300,118**	**299,299**	**297,906**	**310,975**

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA NEWS

HMA Upcoming Webinar: *"New York State's Ambitious DSRIP Program: A Case Study"*

Thursday, May 28, 2015
1:00 PM Eastern
Register Here

New York has by far the most ambitious Delivery System Reform Incentive Payment (DSRIP) Program in the nation. The program has a clear focus on full health system transformation and payment reform. The state will invest $6.4 billion to incentivize collaboration among health care providers, social service providers, and community-based organizations to dramatically alter the way health care is delivered to Medicaid recipients. The primary goal: a 25% reduction in avoidable hospital use over five years. Getting there will require huge investments in community-based care, improvements in key quality metrics like hospital readmissions, and the continued shift from traditional fee-for-service payment models to value-based care.

During this webinar, you'll hear from Health Management Associates Principal Denise Soffel, PhD, who has been on the front lines helping New York plan, develop, and implement its DSRIP initiative.