HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

VIRGINIA SOLICITS COMMENTS ON MEDICAID MLTSS DESIGN

This week, our *In Focus* section reviews Virginia's proposed plans for implementing statewide Medicaid managed long-term supports and services (MLTSS) and statewide managed care for dual eligible individuals. Virginia is the third state we have reviewed in as many weeks taking action toward implementing Medicaid managed care for users of LTSS and including other complex Medicaid populations into capitated risk-based managed care. Virginia has proposed to transition approximately 107,000 users of LTSS and dual eligibles into managed care through a phased approach, with a targeted implementation of mid-2016 for the first phase and mid-2017 for the second phase. Below, we review Virginia's proposed MLTSS approach and provide an overview of the state's existing Medicaid managed care markets.

Target Populations

Phase 1 - Dual Eligible Opt-Out Population. The first proposed phase of Virginia's MLTSS implementation is the mandatory enrollment of dual eligibles who have opted out of the dual eligible financial alignment demonstration into a managed care plan for their Medicaid-only services. Virginia's dual eligible demonstration, known as Commonwealth Coordinated Care (CCC), launched last year and has enrolled just under 31,000 out of an eligible 66,200 duals as of May 6, 2015. The state's MLTSS design presentation estimates approximately 37,000 CCC opt-outs would be transitioned during this phase. Based on a Medicaid-only per-member per-month (PMPM) rate of $1,350, this population could amount to more than $600 million in annual capitation payments.

Phase 2, Component 1 – Non-Demonstration Eligible Duals. The proposed first component of Phase 2 is the dual eligible population excluded from the CCC program. This includes duals under the age of 21, duals in regions outside the CCC program, and select individuals receiving HCBS waiver services. The state estimates approximately 50,000 dual eligibles in this non-demonstration eligible population who would be mandatorily enrolled for their Medicaid-only benefits. Assuming a similar $1,350 PMPM, this population could amount to around $810 million in annual capitation payments.

Phase 2, Component 2 – Medicaid-Only Individuals Receiving LTSS. The proposed second component of Phase 2 is the non-dual (Medicaid-only) LTSS population. As proposed, the state intends to exclude individuals residing in an intermediate care facility for individuals with intellectual disabilities (ICF/ID), although other exclusions are under consideration. At this time, the only services considered for exclusion (carve-out) are services for individuals with intellectual or developmental disabilities (ID/DD), as well as day support, dental, and school services. Virginia estimates the Medicaid-only LTSS population at roughly 20,000. Although there is limited data on spending for the Medicaid-only LTSS population at this time, it would not be unreasonable to assume annual capitation payments for this population of upwards of $700 million.

Phase	Timing	Population	Estimated Enrollment	Estimated Annual $
Phase 1	Mid-2016	CCC (Duals) Opt-Outs	37,000	$600 Million
Phase 2	Mid-2017	Non-CCC-Eligible Duals	50,000	$810 Million
Phase 2	Mid-2017	Medicaid-Only LTSS	20,000	$700 Million
Total All Phases			**107,000**	**$2.1 Billion**

Key MLTSS Program Elements

Phase 1 – Contract Awards. Virginia is proposing to implement Phase 1, the CCC program opt-outs, through the existing CCC health plans. Virginia Premier, Anthem HealthKeepers, and Humana would have their contracts amended or be awarded new contracts to mandatorily provide managed Medicaid-only services to these estimated 37,000 members.

Phase 2 – Procurement. Virginia has proposed to award health plans for the non-CCC-eligible duals population and the Medicaid-only LTSS population through a competitive RFP process. There is no proposed timing for the RFP process, but given a mid-2017 implementation, a RFP release in late 2015 or the first half of 2016 seems likely.

D-SNP Requirement. As proposed, interested health plans would be required to be approved or be seeking approval to operate as a Dual Eligible Special Needs Plan (D-SNP) to be eligible for contract award.

Current Medicaid Managed Care Market

Three Medicaid health plans have a market share of at least 20 percent – Anthem HealthKeepers, Virginia Premier, and Sentara Healthcare's Optima Health Plan. The two largest health plans, Anthem HealthKeepers and Virginia Premier, as well as 2014 newcomer Humana also serve the CCC program.

Health Plan	Medallion 3.0 Enrollment (December 2014) #	%	CCC Enrollment (May 2015) #	%	Total Managed Care Enrollment #	%
Anthem HealthKeepers	245,129	33.8%	12,925	41.9%	258,054	34.1%
Virginia Premier	190,106	26.2%	6,226	20.2%	196,332	26.0%
Sentara/Optima Health Plan	171,971	23.7%			171,971	22.8%
INTotal Health	57,911	8.0%			57,911	7.7%
Aetna	41,534	5.7%			41,534	5.5%
Humana	12,541	1.7%	11,726	38.0%	24,267	3.2%
Kaiser Foundation Health Plan	5,707	0.8%			5,707	0.8%
Total Enrollment	**724,899**		**30,877**		**755,776**	

Source: HMA Information Services; State CCC Enrollment Report

Link to Virginia MLTSS Information

http://dmasva.dmas.virginia.gov/Content_pgs/mltss-home.aspx

HMA Medicaid Roundup

California

HMA Roundup – Warren Lyons (Email Warren)

Governor, Legislature Agree on State-Funded Immigrant Health Program as Part of $117.5 Billion Approved Budget. On June 17, 2015, the *Associated Press* reported that Governor Jerry Brown and California legislative leaders have reached an agreement on the first state-funded health care program for children in the country illegally. The deal is part of the state's approved $117.5 billion budget, passed earlier this week. The program is expected to cost $40 million in the upcoming fiscal year, eventually growing to $132 million annually. Read More

Auditor Criticizes Medi-Cal Managed Care Oversight. On June 16, 2015, *Kaiser Health News* reported that California's state auditor issued a report this week severely criticizing oversight of California's Medi-Cal (Medicaid) managed care plans. The report found an average of 12,500 calls to the ombudsman's office going unanswered each month, as well as significantly inaccurate or missing data in provider network files. The report claims that state health officials had no way of knowing if plans had adequate networks in place. In response to the report, one California senator cited lack of adequate funding for Medi-Cal as a key factor. Read More

***Governing* Reports on California Plan to Curb Overmedication of Foster Kids.** On June 16, 2015, *Governing* reported on the California Senate's unanimous approval of a package of bills aimed at reducing the high rate of psychotropic drug prescriptions among the foster care population. National advocates are praising the legislative package as "comprehensive" in its addressing the issue. Though the legislation has encountered little opposition, the bills have yet to be approved by the California Assembly. Read More

Advocates Claim Medi-Cal Autism Care Lacking. On June 11, 2015, *California Healthline* reported that children's health advocates are claiming that children covered by Medi-Cal with autism spectrum disorder are not receiving the care they need. The claim centers around a specific service, applied behavioral analysis, which despite becoming a covered service in September 2014, has only been provided to 1,123 children out of an estimated 76,000 children in Medi-Cal with autism spectrum disorder. State Medi-Cal officials have indicated that Medi-Cal MCOs will be taking on responsibility for these services later this year, adding that the number of individuals accessing these services is in line with other states' experiences. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Ballot Initiative Aims for $25 Billion Single-Payer System in Colorado. The Denver Post reported on the efforts of a group called ColoradoCare, which is targeting a 2016 ballot initiative to establish universal health coverage under a state-run single-payer system. The system would be established under a Section 1332 waiver, and governed by a 21-member board of trustees as a state entity. The estimated annual cost of the program stands at $25 billion. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Legislators Agree on $2 Billion LIP Deal. On June 13, 2015, *Health News Florida* reported that Florida House and Senate budget negotiators had finalized a deal, including $400 million of state tax dollars, to fund the Low Income Pool (LIP). The deal comes in a special session required after the House and Senate were unable to agree on the issue of Medicaid expansion during the regular session. Although the LIP deal may still mean reimbursement cuts to some hospitals, one official said it would not noticeably affect services. Read More

Florida MCOs Struggle to Meet Solvency Requirements. On June 17, 2015, *SaintPetersBlog* reported that Florida's Medicaid MCOs are struggling to meet state financial solvency requirements as cumulative losses totaled more than $540 million in 2014, with little improvement shown in the first quarter of 2015. The Florida Office of Insurance Regulation has signed consent agreements with WellCare and Molina requiring commitments of capital infusions to meet minimum financial surplus requirements, although no plan is barred from accepting new enrollments. This report comes in the wake of a push from MCOs for $400 million in new funding for rate increases, which did not occur. AHCA Secretary Liz Dudek told the plans that rate increases weren't necessary. Read More. On June 16, it was reported that despite an additional $300 million added to the budget the previous day, an effort to add $57 million in "grants and donations" that would have meant a $110 million increase for MCOs with the additional federal match. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Fallon Total Care Announces Will Exit Duals Demonstration. On June 17, 2015, the Massachusetts Executive Office of Health and Human Services (EOHHS) announced that Fallon Total Care has decided to exit the duals demonstration, One Care, as of September 30, 2015. According to EOHHS, Fallon serves nearly 5,500 One Care enrollees in Hampden, Hampshire, and Worcester counties.

Audit Report Finds $500 Million in Improper, Unnecessary Medicaid Payments. On June 16, 2015, the *Boston Globe* reported that the Massachusetts State Auditor found more than $500 million in Medicaid payments over a five year period were improper and/or unnecessary. The services paid for directly by the state should have been covered by the state's Medicaid managed care

plans, said the report. MassHealth officials have countered that only $60 million of the payments made were improper. The $500 million is approximately 1 percent of all Medicaid spending from October 2009 through September 2014. Read More

Nevada

Governor Signs Bill Allowing ABD, LTSS Managed Care Transition. On June 11, 2015, the *Las Vegas Review-Journal* reported that Nevada Governor Brian Sandoval signed SB 514 into law, which would allow the state to potentially implement Medicaid managed care for individuals using long-term supports and services (LTSS) and individuals who are aged, blind, and disabled (ABD). However, any such move would require approval by the state's Interim Finance Committee as well as receive CMS approval. Read More

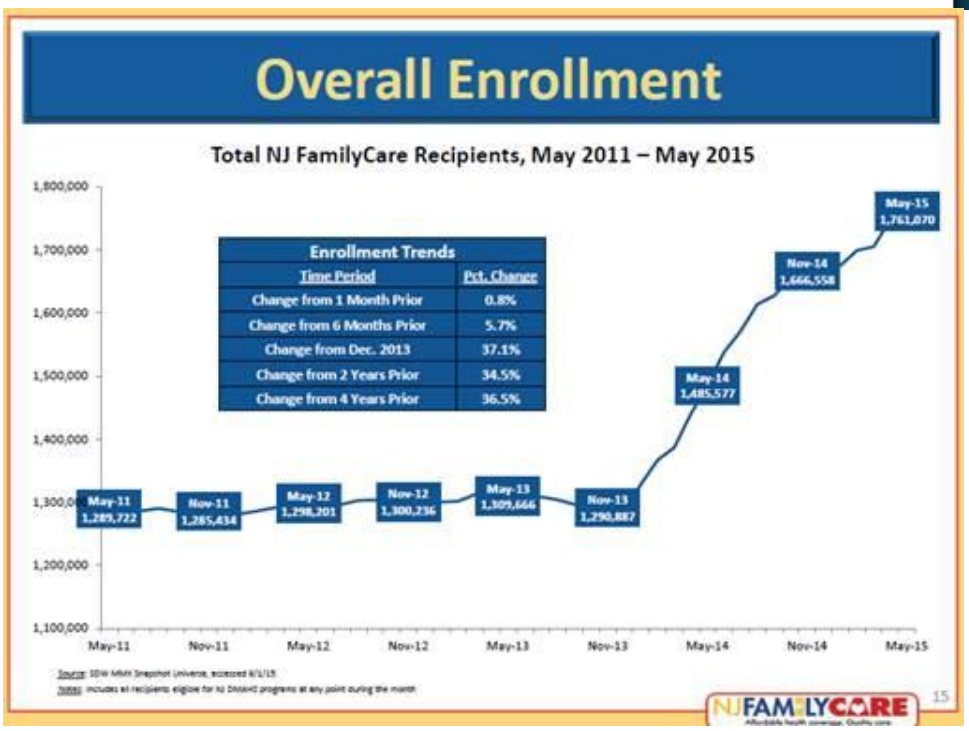
New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

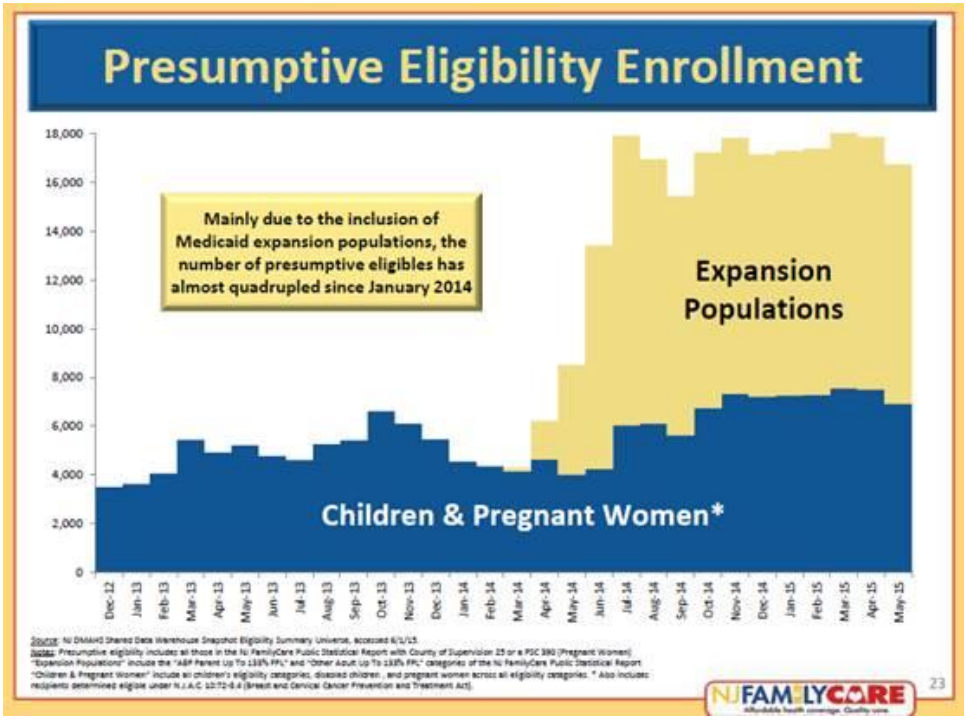
New Jersey Medicaid Agency cancels plans for a Behavioral Health ASO RFP. On June 15, 2015 the Division of Medical Assistance and Health Services (DMAHS) provided an update on the status of the administrative services organization (ASO) RFP that had been developed and under review by state agencies for release this spring. DMAHS announced at its quarterly Medical Assistance Advisory Council (MAAC) meeting that it has discontinued plans to release an ASO RFP. Instead, DMAHS is completing an analysis of fiscal and utilization data to inform their decision for whether to initiate managed behavioral health care. Among the options under consideration are a managed behavioral health care contract or a carve-in of behavioral health services under the existing managed care organization contract.

In the meantime, DMAHS, in coordination with the Division of Mental Health and Addiction Services is proceeding with the implementation of the Interim Management Entity (IME) contract with Rutgers University Behavioral Health Care (UBHC) to manage state, block grant and NJ FamilyCare IME services beginning July 1, 2015. Additional information about the UBHC roll-out can be found on the MAAC meeting slides beginning on slide 1.

NJ FamilyCare expansion enrollment update. On June 15, 2015 New Jersey's Medicaid Director Valerie Harr provided MAAC members with an update on the Medicaid program's expansion enrollment experience. As of May 2015 the state had a total of 476,589 new enrollees with 382,746 due to Medicaid expansion and 97,380 from the corresponding "woodwork" effect. This represents a total increase of 37.1% in Medicaid enrollment in the state since December 2013. Monthly enrollment increases are stabilizing at an average rate of 2.9 percent between January – August 2014, and 1 percent between September 2014 and May 2015. A total of 19.7 percent of New Jersey residents are now enrolled in the Medicaid program. The enrollment trends are provided:



In addition, the number of individuals determined to be presumptively eligible for New Jersey Medicaid almost quadrupled from January 2014.



The state's 2014 Consumer Assessment of Healthcare Provider and Systems (CAHPS) surveys, inclusive of the Medicaid expansion enrollment, reported high enrollee satisfaction ratings under the Medicaid managed care program:

NJ Medicaid CAHPS Survey Results, 2014	
Survey Category	**Percent**
Adult overall rating of health care	84
Child overall rating of health care	92
Adult personal doctor satisfaction rate	91
Child personal doctor satisfaction rate	94

Managed Long Term Services and Supports (MLTSSS) program update. On June 15, 2015, Deputy Commissioner Lowell Arye provided the MAAC with an update on the state's MLTSS program. As of April 2015 New Jersey had 39,909 Medicaid enrollees receiving long term care. These represent 14,460 enrolled in MLTSS and 25,449 under Medicaid fee-for-service. The majority of individuals receiving long term care under Medicaid FFS were exempt from MLTSS enrollment at the time of implementation due to their status as a resident in an institutional setting or enrollment in the state's PACE program. Of the 39,909 enrollees, 32.5 percent are receiving home and community based services, a three percent increase since August 2014. The state reports a decrease in its nursing facility population of over 1,500 since MLTSS began in July 2015. The state's total MLTSS population has increased from 11,229 to 14,460 since August 2014.

DMAHS has been tracking member appeals since the MLTSS implementation and reported that the bulk of appeals activity between January and March 2015 occurred under the home health service category (76 out of 120) of which 10 appeals were either overturned or partially overturned. The state's MLTSS Quality Monitoring Unit received 153 inquiries during the same time period. The top three reasons for inquiries were related to claims payment, care management and eligibility/enrollment/disenrollment for the following top four services: assisted living, MLTSS/HCBS services, nursing facility services and personal care attendant services.

In addition, the Medicaid managed care organizations (MCO) are beginning to implement a retro-active processing of provider claims that covered services between July 1, 2014 to December 31, 2014 for assisted living and nursing facility providers based on corrections to the Patient Pay Liability (PPL) amount. Providers should have received or will be receiving shortly communications from the MCOs. Each MCO has a different internal process and timeline to accomplish claims retro-activity. The PPL correction process also applies to future claims that may need to be adjusted due to a correction in PPL by the County Welfare Agency (CCW). If there is a change in the PPL by CWA for individual members at any time during the year, this change will be reflected in the cost share information that the state shares with the MCO. The individual MCOs will apply the updated amount to future claims.

Additional MLTSS updates are available in the MAAC meeting slides beginning on slide 36.

New York

HMA Roundup – Denise Soffel (Email Denise)

Waiver Population Carve-Ins Delayed. The Alliance of TBI & NHTD Waiver Providers today reported that the transition for Traumatic Brain Injury and Nursing Home Transition and Diversion waiver benefits into managed care has been delayed. The Department of Health remains committed to developing policies and procedures that will promote a smooth transition of these benefits into managed care. To that end, the Department is extending the implementation date from January 1, 2016 (for NHTD services) and April 1, 2016 (for TBI services) to January 1, 2017. The Health Department will convene a stakeholder work group in order to ensure the thoughtful development of a transition plan. The work group is expected to be convened shortly with recommendations to be submitted by August 1, 2016. The Department has also agreed that in order to minimize disruption, the current fee-for-service reimbursement rates that NHTD and TBI waiver providers currently receive will be maintained for 2 years after transition.

Cuts in Home Care Rates. The methodology for reimbursement to Certified Home Health Agencies was revised in 2011 to an Episodic Payment System, with a rebasing of the reimbursement rates every three years beginning in 2015. In anticipation of rate rebasing, this year's budget included an aggregate cut in reimbursement of $30 million. The state recently posted new rates, effective April 1, 2015, reflecting a 12 percent across the board reduction in rates. The Department of Health plans to replace the 12 percent cut with a full rebasing, including a re-weighting of the episodic payment groups, in October 2015. The Department has further announced that it expects rebasing to produce cuts well beyond the $30 million amount that was projected in the 2015-16 state fiscal plan. The Home Care Association of NYS has had legislation introduced in both houses of the legislature that would limit any cuts that exceed to the budgeted amount. HCA has joined allied associations LeadingAge New York and the New York State Association of Health Care Providers, on a memorandum supporting amendments to the rebasing process. The memo, available here, goes on to note that the myriad changes, new policies and models being implemented by the state directly depend on home care services, and will require additional investments in home care rather than cutbacks.

New Superintendent of Financial Services. Benjamin Lawsky, the Superintendent of Financial Services, is stepping down. His Chief of Staff, Anthony Albanese, will succeed him on an interim basis as Governor Cuomo conducts a search for a permanent replacement. The Department of Financial Services supervises all insurance companies that do business in New York, including health insurance companies both on and off the health exchange, New York State of Health. For more information see here.

FIDA Toolkit. The Medicare Rights Center has prepared a toolkit for providers participating in the Fully Integrated Duals Advantage (FIDA) program. The toolkit materials are intended to help providers understand FIDA's goals, provider roles in the program, and how providers can help their patients make appropriate choices. The toolkit includes a presentation on helping patients understand FIDA; FAQs for providers; provider handouts; and links to additional resources. The toolkit can be found on the MRC website.

Assessment Tool for Health and Recovery Plan Members. The Office of Mental Health and the Office of Substance Abuse Services have circulated two tools developed by interRAI. The assessments are meant to be conducted in person in a conversational manner. One assessment will be used for HARP eligible members to determine whether they are eligible for any of the home and community based services that are part of the enhanced benefit package. The other is for those who have been found eligible for HCBS, supports a Full Assessment. These assessment tools will be used by qualified health home care managers in assessing HARP member eligibility and the development of the individual care plan. All health home care managers will have to undergo training on how to use the new assessment tools. Medicaid beneficiaries potentially eligible for HARP enrollment will be transitioned into a HARP plan between October and December 2015; HCBS services will be available as appropriate beginning in January 2016. Copies of the assessments are available upon request.

Children's Health Homes Announced. The New York State Health Home Program was launched in 2012. While children who meet the health home eligibility requirements have been eligible for enrollment since that time, it has been the intent of the State to tailor the model in recognition of the differences in the approach to care management and planning for children and adults. The state plans to phase in the enrollment of children in health homes beginning October 1, 2015. Twenty two agencies completed an application to serve as a children's health home, and 16 applications were approved. The six health homes that failed to be designated are all located in New York City; five of the six were new applicants that do not currently operate a health home serving adults. The NYC Health and Hospitals Corporation was the only agency currently operating a health home that was not designated as a children's health home. The list of health homes designated to serve children is available upon request.

North Carolina

House and Senate at Odds over Medicaid Reform Design. On June 14, 2015, the *Associated Press/WNCN* reported that House and Senate republicans are facing the same argument over Medicaid redesign as they did last summer. House republicans favor a managed care model limited to provider-led entities organized by hospitals, health systems, and other providers. However, the Senate republican leadership insists that traditional managed care organizations be allowed to participate as well. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Another Run at Personal Responsibility and Paying into Health Care. Able bodied adults above 100% of the federal poverty level would be required to enroll in coverage with premiums and health care savings accounts in the third version of budget language which would require enrollees to pay money toward their health care. The Department of Medicaid expects the premium would likely be around $20 per month for newly eligible Medicaid enrollees between 100% and 138% of poverty. Read More

Ohio Hospital for Psychiatry Expands. *Columbus Business First* reports that construction has begun on an expansion for the facility, first planned in 2012. The addition provides 40 rooms specifically for patients aged 65 and older who are expected to have medical needs besides mental illness. The addition takes the total bed count to 130 beds. Parent company Acadia Healthcare Company' Division President Roxanne Jividen points to an obvious need for more beds. Ohio Hospital for Psychiatry started 11 years ago with just 14 beds for children and adolescents. Central Ohio continues to struggle with a shortage of psychiatric beds. Recently there have been reports that the future of the psychiatric wing at Mount Carmel West is in question because parent Mount Carmel Health System may not be transferring that service when it moves inpatient services from the Franklinton campus to a new hospital campus it is building in Grove City. Read More

Senate Aiming to Maintain Medicaid Eligibility for Pregnant Women as Part of Goal to Reduce Infant Mortality. In an *Akron Beacon Journal* editorial, State Representative Emilia Sykes, an Akron Democrat and others successfully advocated for a proposal in the Senate version which would maintain expanded Medicaid coverage for pregnant women with low incomes. The Administration's As Introduced version and the House version proposed to reduce eligibility from 200% of poverty to 138%. It was anticipated that pregnant women above 138% would be able to apply for coverage through the federal exchange and receive subsidies. Representatives of the Governor's Office of Health Transformation have also been advocates of revising the reduced income thresholds since the ACA does not recognize pregnancy as a qualifying event for purchasing insurance outside of an open enrollment period on the exchange. This issue is vital given that the national infant mortality rate, or the number of infants dying before their first birthday, is roughly six per 1,000 live births. The rate in Ohio is eight, and 15.5 among blacks, the worst in the country. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

HHS Conditionally Approves Pennsylvania Exchange. The Obama administration on Monday gave Pennsylvania and Delaware a head start in the scramble to save residents from losing health insurance coverage, the possible result of a U.S. Supreme Court ruling expected this month. The action - conditional approval to establish state-based insurance marketplaces - moves forward both states' efforts to preserve health insurance subsidies for their citizens. Pennsylvania is the only state that replaced a Republican governor with a Democrat last year, and Gov. Wolf decided that a state-based marketplace would be the best way to proceed, officials said. Pennsylvania met the June 1 deadline to submit applications for exchanges this year. The Department of Health and Human Services had until Monday to respond. HHS Secretary Sylvia M. Burwell sent letters to the governors of each state granting conditional approval, which is just one step in a lengthy process. Among other things, legislative approval will likely be required. Republicans in Harrisburg have kept their distance from the proposal, saying there was no reason to act until the Supreme Court ruled. Read More

Advocates Urge State to Move Slowly on Changing Long-Term Care Services. State officials preparing to embark on a major shift in how long-term care services are administered to needy older and disabled adults in Pennsylvania received a series of cautions at a packed public hearing Thursday. The governor wants to create a system over the next few years, starting in Western Pennsylvania in January 2017, in which managed care operators would contract with the state to oversee the health care and supportive social services provided to several hundred thousand low-income individuals who qualify for both Medicaid and Medicare, along with some others in need. The intent is to create a system with financial incentives and more proactive personal oversight that would minimize use of institutions while easing access to assistance in consumers' own homes. No one objected to the idea of more home service opportunities, but Cabinet secretaries from the departments of Human Services, Aging and Health heard some concerns. Read More

Pennsylvania Accused of Lax Regulation of Nursing Homes. A new report from Community Legal Services of Philadelphia accused the Pennsylvania Department of Health of failing to properly investigate complaints about nursing homes or enforce regulations that are designed to protect residents' safety. The report said the department dismissed 92 percent of complaints from 2012 through 2014 for about 46 nursing homes that operated in Philadelphia. It also said the department minimized the severity of violations, and never found violations in follow-up inspections. In a statement, Health Secretary Dr. Karen Murphy did not dispute the findings, comment on them or say whether she had read the report. But she noted that the activity occurred under the prior administration. Read More

Rhode Island

House Budget Provides Slight Relief to Nursing Homes in Medicaid Reform Bill. On June 14, 2015, the *Providence Journal* reported that the House Finance Committee reduced proposed cuts to nursing home reimbursement from 2.5 percent to just 2 percent, although hospital cuts were held at 2.5 percent. The cuts are part of Governor Raimondo's Reinventing Medicaid Act of 2015, which would also permit savings from Medicaid reimbursement cuts to be used for incentive payments for quality improvement and cost reduction. Read More

West Virginia

State Supreme Court Allows Challenged Medicaid MCO Expansion to Continue. On June 16, 2015, the *Charleston Daily Mail* reported that the West Virginia Supreme Court granted an emergency motion this week to block the ruling of a County Judge last week that prevented the expansion of Medicaid managed care under contracts that were not competitively bid. The approved emergency motion claimed that blocking the expansion would cost the state tens of millions of dollars and potentially disrupt access to services. Opponents of the expansion have filed a separate legal effort to force the state to competitively rebid MCO contracts. As it stands, the state will expand Medicaid managed care beginning July 1 to more than 150,000 new beneficiaries. Read More

National

Arkansas, Delaware, Pennsylvania State Exchanges Approved. On June 15, 2015, the *Associated Press* reported that three states – Arkansas, Delaware, and Pennsylvania – were granted conditional federal approved to expand their roles in the Exchanges in their states, moving toward a state-run Exchange. The move comes as states await the Supreme Court's ruling on King v Burwell. Delaware and Pennsylvania received conditional approval to run marketplaces for individual and small business coverage plans beginning in 2016. Arkansas received the conditional approval to run the small business marketplace in 2016 and the individual marketplace in 2017. Read More

Reports of Large Premium Increases on Exchange Potentially Overstated. On June 12, 2015, *Kaiser Health News/Montana Public Radio* reported on the potential that criticism of proposed Exchange rate increases for 2016 may be an overreaction. While many news outlets are reporting on double-digit rate increase requests, insurers are not necessarily requesting across-the-board increases, and the significant premium hikes may be for plans with very limited enrollment. The article cites a case in Montana where Blue Cross Blue Shield is reportedly requesting a 23 percent rate increase. However, evaluation of this proposed increase reveals it is only for 2 out of 50 plans offered by Blue Cross Blue Shield in Montana. Read More

Industry News

Five Major Insurers Discussed in Potential Merger, Acquisition Deals. On June 16, 2015, the *Wall Street Journal* recapped the continued rumors and reports of potential deals as health insurers look to consolidate. It has been reported in recent weeks that Humana is exploring a sale, while UnitedHealth has reportedly approached Aetna, and Anthem is in talks to acquire Cigna. Analysts are expecting consolidation from five large publicly traded insurers to just three in the coming years. Read More

CVS Health to Acquire Target Pharmacy, Clinic Business. It was announced on June 15, 2015, that Target will sell its pharmacy and clinic lines of business to CVS Health for a reported $1.9 billion. When finalized, CVS will run Target's in-store clinics, pharmacies, and other health operations, with plans to expand offerings to consumers as part of the deal. Target currently has more than 1,660 in-store pharmacies and 80 clinic locations, with plans for 20 additional clinics in the next three years. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
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
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (Phase I)	450,000

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.*

HMA News

New this week on the HMA Information Services website:

- Updated Florida managed care market share data
- NJ System Administrator for the Children's System of Care RFI Responses
- PA to Release RFPs for Medicaid Managed Care and MLTSS Programs

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Helps Produce "Strong Start" Annual Report

Link to Report

HMA's Jennifer Edwards, Sharon Silow-Carroll and Diana Rodin are part of a team that prepared the Year 1 annual report for the Strong Start for Mothers and Newborns initiative.

The Strong Start initiative, funded by the Affordable Care Act, was designed to improve maternal and infant outcomes for pregnancies covered by Medicaid and the Children's Health Insurance Program (CHIP). HMA, American Institutes for Research, and Briljent are working with the Urban Institute to conduct a five-year study that evaluates the initiative's implementation and impact on health care delivery, outcomes and cost of care.

"*Strong Start for Mothers and Newborns Evaluation: Year 1 Annual Report*" was designed to provide early evaluation findings, summarize the status of the evaluation's research efforts, and present a plan for the next year's work.