HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 12, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CMS REPORTS ON LONG TERM SUPPORTS AND SERVICES (LTSS)

This week, our *In Focus* section reviews key takeaways from the Centers for Medicare & Medicaid Services (CMS) report published recently on Medicaid long term supports and services (LTSS) expenditures in fiscal year 2013. The report, Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013, is published annually by CMS and provides a detailed overview of Medicaid LTSS spending across the states. For the first time, in FY 2013, home and community based LTSS (HCBS) surpassed institutional LTSS in terms of a

share of total Medicaid LTSS spending. In total, Medicaid spending for LTSS topped $146 billion in FY 2013, or 34 percent of all state and federal spending on Medicaid.

HCBS Surpasses Institutional LTSS

Out of the $146 billion in total LTSS spending in FY 2013, HCBS spending accounted for more than 50 percent for the first time in Medicaid's history, with $75 billion in reported expenditures. Institutional LTSS spending accounted for the remaining $71 billion, or 49 percent of total, down from 82 percent of all LTSS spending 20 years ago in 1995. However, significant variation exists on the state level, with Mississippi at the low end (around 25 percent of LTSS spending in HCBS) and Oregon at the high end (nearly 80 percent of LTSS spending in HCBS).

Additionally, the CMS report highlights the top ten states in terms of HCBS expenditure growth from FY 2011 to FY 2013, as detailed in the table below.

State	HCBS Spending (FY 2013)	HCBS Pct. of LTSS (FY 2013)	Pct. Growth in HCBS Share of LTSS (FY 2011-2013)
Missouri	$1,595,224,958	54.5%	11.4%
New Hampshire	$385,139,380	53.7%	9.0%
Iowa	$950,827,665	49.1%	6.9%
District of Columbia	$474,994,786	59.3%	6.5%
New York	$12,714,978,762	55.2%	6.0%
Ohio	$2,882,722,111	43.3%	5.7%
Tennessee	$1,206,897,650	50.4%	5.1%
Massachusetts	$2,671,163,212	59.8%	5.0%
Pennsylvania	$3,485,699,002	41.9%	4.6%
New Jersey	$1,502,804,753	33.5%	4.6%

Growth in LTSS Expenditures Slows

FY 2013 Medicaid spending on LTSS grew 3.4 percent over the previous year, with average annual growth of 1.6 percent from FY 2011 to FY 2013. This represents a significant slowdown in LTSS spending growth, which grew by 5.5 percent annually from 1996 through 2000, 7.1 percent annually from 2001 through 2005, and 5.4 percent annually from 2006 through 2010. As a percentage of total Medicaid spending, LTSS expenditures have held steady around 34 percent of all Medicaid spending, down from a peak of 40 percent in 1997-1998.

Medicaid LTSS Spending by Category of Eligibility

LTSS spending for older individuals and individuals with intellectual and developmental disabilities (IDD) represent the bulk of LTSS spending in Medicaid, but are growing at less than half the rate of LTSS spending for individuals with severe mental illness (SMI) or severe emotional disturbance (SED) and other populations.

Population	Total LTSS Spending $000s (FY 2013)	HCBS Spending $000s (FY 2013)	Average Annual Growth Rate
Older Individuals	$88,853,012	$33,679,828	2.9%
Individuals with IDD	$42,958,797	$31,056,032	3.5%
Individuals with SMI/SED	$9,184,409	$3,326,869	6.0%
Other	$4,861,644	$4,765,447	7.0%

Total LTSS	**$145,857,862**	**$72,828,176**	**3.4%**

Growth of Managed LTSS

Spending on managed LTSS (MLTSS) has grown significantly in the five years from 2008 through 2013, as new states have implemented MLTSS and existing states have expanded programs. CMS conservatively estimates that $14.4 billion of MLTSS was delivered in FY 2013, up 44 percent from the prior year and up from just $5.3 billion in 2008. CMS notes that this number is very conservative and may be understated due to the difficulties in collecting MLTSS expenditure data from states.

Note on data from CMS

This report is the latest in a series of annual Medicaid LTSS expenditure reports. The data come primarily from CMS-64 reports, which states use to claim federal matching funds for their Medicaid expenditures. The CMS-64 data are supplemented with managed care data collected directly from states that have managed LTSS programs, although not all managed care states have provided data for all years.

Link to CMS LTSS Report

http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf

HMA Medicaid Roundup

Alabama

Head of Alabama Department of Public Health, Don Williamson, Leaving for Private Group. On August 5, 2015, *The Baltimore Sun* reported that Dr. Don Williamson, head of the Alabama Department of Public Health, is leaving to become president of the Alabama Hospital Association. Williamson will leave the department around November. He stated the last three years have been challenging leading Public Health and the Medicaid overhaul simultaneously. His retirement will give him the opportunity to work on issues he cares about, including rural hospitals and covering the poor. Read More

House Rejects General Fund Budget. On August 10, 2015, *AL.com* reported that the state House rejected a budget which would have cut $185 million from the General Fund. The budget, proposed by Governor Bentley, originally sought to increase taxes by $302 million and spend $1.9 billion from the General Fund. After passing through the Senate, it was approved for $1.65 billion instead. The House rejected it 92-2. Before sending the budget to the Senate the previous week, The House had cut $156 million from Medicaid. The Senate then restored most of it. Read More

Arizona

Arizona to Launch Technology Outreach Strategy to Help Medicaid Beneficiaries. On August 5, 2015, *Modern Healthcare* reported that Arizona is launching a technology outreach strategy consisting of mobile apps, texts, and an online portal. Patients will receive reminders about appointments, access chronic disease management tools, and find primary care doctors or urgent care locations. However, experts say implementing an online system and mobile apps is not the best way to go. They state that the majority of Medicaid patients have economic issues and may not have a smartphone in order to use the app. In Michigan, where a similar strategy was enacted, out of the two million people enrolled in Medicaid and CHIP, 3,500 downloaded the app, and only 1,500 actively used it. Read More

Arkansas

State Ending 'In Home Services' Home Health Program. On August 10, 2015, *The Baltimore Sun* reported that the Arkansas Department of Health director, Nathaniel Smith, announced the state will be phasing out the In Home Services program, which provides health care and hospice to 13,000 recipients. The state

will explore opportunities to move the program to a provider sector provider. The decision comes after the program's revenues and enrollment have been decreasing. Governor Asa Hutchinson stated that the program is no longer sustainable and can be ended because the private sector will meet the demand. Read More

California

HMA Roundup – Varsha Chauhan (Email Varsha)

Study Finds Medi-Cal Access Difficult for Many. On August 8, 2015, *Associated Press* reported that a California HealthCare Foundation report found that 36 percent of Spanish-speaking Medi-Cal beneficiaries have been told that a physician would not take them, compared to 7 percent of the overall Medi-Cal population. Public policy officials say the biggest challenge is finding physicians willing to take the lower Medi-Cal payments.. Read More

Los Angeles County Approves Plan to Move 1,000 Inmates to Treatment Programs; Build Jail for Mental Health Treatment. On August 11, 2015, *Los Angeles Times* reported that the Los Angeles County jail system Board of Supervisors approved a plan to move approximately 1,000 inmates with mental illnesses out of lockups and build a jail focused on mental health treatment. Currently 20 percent of inmates in the county have a mental illness. The new jail, consisting of 3,885 beds, will replace Men's Central Jail and will be geared toward inmates with mental health and substance abuse issues. It will take six to eight years to build. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Medical Home Model Gaining Traction. More Colorado health clinics are adopting medical home or coordinated care models, with nearly 200 recognized medical homes in the state covering nearly 40% of residents, according to the Colorado Health Foundation. The model can save money and improve care, but barriers to adoption include creating a team culture, integrating data and settling on a reimbursement structure, the report says. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Healthy Kids (FHK) Dental Benefits Rebid Planned. The Florida Healthy Kids Corporation plans to re-bid the dental benefits coverage contracts for the Florida Healthy Kids component of the Florida KidCare program. A tentative schedule reflects a draft invitation to negotiate (ITN) to be released for comments on September 1, 2015 with the final ITN to be out October 26, 2015. Responses to the ITN will be due on November 20, 2015. Awards are scheduled to be announced January 2016. The new contracts will be effective July 1, 2016.

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

State Medicaid Agency Finds Waiver Proposal Too Expensive. On August 5, 2015, *Georgia Health News* reported that the Georgia Department of Community Health found the current Medicaid waiver proposal "cost-prohibitive" to the state. The waiver sets up pilot sites to provide coverage to the uninsured. Grady Health System, Memorial Health, and a small group of rural hospitals would serve as the initial sites in the program. The waiver is modeled after the Cleveland MetroHealth Care Plus program in Ohio, which a study found to result in lower costs. Read More

Illinois

Cook County Health and Hospital System Looks to Re-bid Medicaid Managed Care TPA Contract. On August 6, 2015, *Crain's Chicago Business* reported that Cook County Health and Hospitals System will rebid for its Medicaid managed care plan. In 2014, the contract was awarded to IlliniCare Health Plan, although it was the only bidder. The health system is requesting bids for a new company or companies to serve as a third party administrator (TPA), provide case management, and manage pharmacy, dental, vision and transportation benefits for CountyCare members. Read More

Undercover Source Finds Home Physician Services Involved in Medicare Fraud. On August 6, 2015, *Chicago Tribune* reported that Henry Smilie, CEO of Home Physician Services was arrested for billing Medicare up to $1.2 million in fraudulent or nonexistent services to the elderly and homebound. An undercover confidential source for federal agents gathered months of evidence of alleged improper billing practices. Search warrants were also executed at the company's offices in Chicago and Schaumburg. Read More

Iowa

Iowa Ending Premium Assistance for Private Plans; Seeks Expansion Waiver for Traditional Medicaid. On August 6, 2015, *Modern Healthcare* reported that Iowa will end premium assistance for private plans under Medicaid expansion. Instead the state is seeking a waiver to move beneficiaries to its traditional Medicaid program. Through the waiver, the state hopes to make enrollees in the Marketplace Choice Plan eligible for the Health Insurance Marketplace. Currently, under the Marketplace Choice Plan, adults with income from 101 percent to 133 percent FPL receive coverage through insurers on the marketplace and the state pays the premiums. The new waiver will also seek to allow the Iowa Wellness Plan to become an exclusively managed-care program. Earlier in the year, Iowa released an RFP for two to four insurers to manage the Medicaid population. The state expects to make a decision by August 17. Read More

Louisiana

LTC Medicaid Privatization Decision Delayed for New Administration. On August 6, 2015, *The Advocate* reported that the state was unable to receive all the

necessary federal approvals to privatize long-term care prior to a new administration. Medical and behavioral health has already transitioned to managed care. Long-term care would be the final installment of Governor Bobby Jindal's plan to privatize Medicaid. However, the industry's objections had stalled the release of a RFP. Meanwhile, advocates for the elderly have criticized Jindal for his choice to delay. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Legislation Would Allow Price Limits on Drugs. On August 10, 2015, the *Boston Globe* reported on legislation that would force biotech and pharmaceutical companies to disclose information on research, production, and marketing, but would also allow the state's Health Policy Commission to limit the price of drugs deemed too costly. While other states have introduced transparency bills, Massachusetts is the first to seek the power to limit prices. Read More

Minnesota

UCare Opposes States Decision to End Its 2016 Medicaid Contracts. On August 10, 2015, *MPR News* reported that Minnesota has elected to terminate UCare's Medicaid contracts, which represent 70 percent of the plan's business. UCare officials are meeting with the Department of Human Services and hope to make their case to Governor Mark Dayton. UCare's did not score as high as competition on cost and quality measures. DHS Assistant Commissioner Nathan Moracco promises a smooth transition for current UCare clients. Read More

New Hampshire

HMA Roundup – Rob Buchanan (Email Rob)

Managed Care Contracts Renewed With Expansion Planned. On August 5, 2015, the New Hampshire Union Leader reported that the state's Executive Council has renewed the Medicaid managed care contracts of N.H. Healthy Families and Well Sense Health Plan, with an estimated total value of $1.6 billion. The renewed contract will also cover the expansion of managed care to individuals in foster care, children with disabilities, and dual eligibles on September 1 of this year, with users of HCBS to be carved in on January 1, 2016. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

RFP Released for Fiscal Intermediary and Financial Cash and Counseling Services. On August 4, 2015, the New Jersey Department of Treasury, on behalf of the Department of Human Services, issued an RFP for a contractor to provide statewide fiscal management, administrative, and financial counseling services for individuals enrolled in qualifying DHS programs. This includes programs within the Divisions of Disability Services (DDS), Aging Services (DOAS), Developmental Disabilities (DDD), and Medical Assistance and Health Services

(DMAHS). Proposals are due on September 9, 2015. Implementation is effective January 1, 2016. Read More

Division of Aging issues MIPPA 2015 RFP. On August 11, 2015 the Department of Human Services, Division of Aging Services released a Request for Proposals to provide Medicare Special Benefits Outreach and Enrollment Assistance. The Medicare Improvements for Patients and Providers Act (MIPPA) 2015 RFP intends to increase the number of low-income Medicare beneficiaries in the state who know about and apply for Medicare Part D, the Medicare Part D Low Income Subsidy (LIS), and/or a Medicare Savings Program (MSP). It also seeks to increase beneficiaries' awareness of free and reduced-cost preventive benefits under Medicare Part B. Up to ten Area Agencies on Aging (AAAs), Aging and Disability Resource Connections (ADRCs) and State Health Insurance Assistance Programs (SHIP) lead agencies may qualify for this one-year grant opportunity for up to $40,000 per grant. Interested applicants should submit a Letter of Interest to the Division of Aging by 3:00 pm on August 24, 2015. The Division of Aging Services will hold a technical assistance conference call with interested parties on August 26, 2015. Proposals are due September 11, 2015 by 3:00 pm through the state's SAGE online system at www.sage.nj.gov. Final awards will be made on September 30, 2015 with an anticipated October 1, 2015 contract start date.

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment Timeline. The DSRIP Year 1 Timeline has again been updated, reflecting recent changes to key DSRIP deliverables. The updates include the extension for submission, review and approval of the PPS First Quarterly Reports which cover the time period April 1 – June 30. They are now due on August 7, as are the Project Implementation Plans. Quarterly reports will be posted to the DSRIP website in October.

DSRIP Learning Symposium. The Department of Health has announced the first DSRIP Learning Symposium for September 17-18, 2015. The symposium has a number of objectives, including enhancing collaboration within each PPS with broad group of partners, including downstream providers, community-based organizations and consumer advocates; as well as developing partnerships across PPSs and mechanisms to share emerging best practices and evidence-based approaches to successfully complete project deliverables.

Session topics include:

- Strategies for scaling care transformation efforts to develop integrated delivery systems
- Techniques to address workforce challenges and reconfigure care teams
- Provider engagement efforts and consumer/patient perspectives on DSRIP
- Overview of data collection and reporting frameworks and available resources
- Practical guidance around implementation of value-based purchasing roadmap

More information can be found on the Medicaid Redesign Team website.

Capital Restructuring Financing Program RFA Re-Opened. The Department of Health has re-opened the Capital Restructuring Financing Program (CRFP) Request for Applications (RFA) due to a high rate of disqualifications for technical and process-related requirements. This undermines the primary statutory intent of the CRFP, which is to provide financing for capital projects necessary to facilitate the statewide implementation of DSRIP. Accordingly, the Department is re-opening this procurement opportunity to allow any eligible entity to submit or resubmit a proposal. All applicants that were disqualified must resubmit their proposal. In addition, applicants that were not disqualified can take the opportunity to update their application, and applicants can submit new applications. Applications are due on August 28. Information can be found on the Department website.

North Carolina

Senate Approves Medicaid Privatization Bill. On August 11, 2015, it was reported that the Senate approved its Medicaid privatization bill, which would replace the current fee-for-service system and use a mix of commercial insurers and local health care providers. The bill now returns to the House for consideration. Read More The bill was first tentatively approved a day prior. Read More

Resignation of State Health Secretary Aldona Wos May Lead to Medicaid Reform. On August 5, 2015, *Winston-Salem Journal* reported that under Aldona Wos' oversight as the state health secretary, the Department of Health and Human Services struggled with major inefficiency issues, specifically the Medicaid program. Wos will be replaced by Rochard Brajer, a private-sector health care executive. Policy analyst, Mitch Kokai, said the replacement represents a fresh start for Governor Pat McCrory's administration. Furthermore, her resignation could make the Senate more willing to keep Medicaid in DHHS. Read More

No Agreement Yet Between House and Senate on Medicaid Compromise Bill. On August 7, 2015, *North Carolina Health News* reported that House Speaker Tim Moore said the Senate Medicaid compromise bill is a work in progress and that there is still a long way to go. The bill, passed by the Senate Health Care committee, would create a new department to run the Medicaid program, with a cabinet-level secretary approved by both chambers of the General Assembly. If approved, the framework of the new agency would be put into place by January 2016 and the system would start operating no earlier than January 2019. The new plan would also emphasize local providers over national companies. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Fewer Ohioans Uninsured. The *Dayton Daily News,* citing a recent Gallup Poll, reports the percentage of uninsured Ohioans has been cut by more than half since the implementation of the Affordable Care Act (ACA) and Ohio's Medicaid expansion. Ohio's uninsured rate for individuals 18 and older fell from 13.9 percent in 2013 to 6.1 percent through the first six months of this year.

Ohio was one of 22 states with both expanded Medicaid and a state based or federally operated health insurance exchange. 595,000 Ohioans are reported to have enrolled in Medicaid under the ACA's expanded guidelines and more than 188,000 have signed up for commercial coverage through the state's federally-operated health insurance marketplace. Read More

Physician Groups Partner to Compete within Consolidated Market. Five Ohio independent physician groups have formed a statewide collaborative to better compete with some of the major players in Ohio's health care market. *Crain's Cleveland Business* reports that the business, named the Ohio Independent Collaborative, has brought together more than 400 primary care providers and specialists so far, with more members being recruited from the Dayton and Columbus areas. Dr. Gary Pinta is president of the collaborative and a physician with Pioneer Physicians Network in Cuyahoga Falls. Read More

The Ohio Department of Medicaid 2015 Annual Report is Out: With over 2.9 million Ohioans insured through Medicaid at some point during SFY 15, the program is Ohio's largest health care payer. This well designed report makes the state's accomplishments easy to find and understand. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

PA Human Services to Increase Data Analysis of Payments. Ted Dallas, secretary of the Pennsylvania Department of Human Services, wants to improve his agency's efforts to block improper and fraudulent payments by using sophisticated data analysis. The DHS, which administers medical assistance benefits and other programs, said it avoided or recovered $582 million in improper payments in the year ended June 30. Nearly three quarters of that amount, or $431 million, was money paid to health care and other providers, rather than the department's 2.8 million beneficiaries, the DHS said. In the fall, DHS plans to solicit ideas from prospective data management contractors on how it can use data analysis to track provider payments and identify patterns that warrant investigation. Read More

Texas

Therapy Providers and Families of Disabled Children Sue Texas Over Medicaid Cuts. On August 11, 2015, *The Texas Tribune* reported that families of disabled children are joining therapy providers in a lawsuit to stop the Texas Health and Human Services Commission from implementing the Medicaid therapy cuts on September 1. Providers and families say the cuts will hurt thousands of children and cause "irreparable injury." A hearing is scheduled for August 24 for the state to make a case justifying the cuts. Read More

Child Therapy Providers Fight Over Medicaid Cuts. On August 8, 2015, *The Texas Tribune* reported that outpatient rehabilitation facilities and home health agencies are fighting over who will shoulder the bulk of the proposed Medicaid therapy cuts. Rehabilitation facilities are saying that Medicaid spending on them increased only five percent between 2009 and 2013 to $188 million, while spending on home health agencies grew over 230 percent to $328 million. Some owners claim they have carried the burden of all rate cuts. However, home

health providers believe that rate cuts cannot be compared because they provide different services to patients with different needs. Read More

Virginia

Fairfax County to Divert Nonviolent Offenders Experiencing Crises to Treatment Not Jail. On August 8, 2015, *The Washington Post* reported that Fairfax County is launching a program to reduce the number of inmates with mental illnesses in jails. Nonviolent offenders will be taken into treatment rather than be incarcerated. Currently, 40 percent of the county's inmates suffer from a mental illness, drug or alcohol addiction, or both. The program, called Diversion First, is scheduled to begin January 1 and will take three to five years to implement. The move comes after a woman with schizophrenia died earlier this year at the jail after repeatedly being struck by a Taser. Read More

Washington

Washington to Re-Bid Apple Health Medicaid Managed Care Program for Southwest Region. The RFP covers Medicaid beneficiaries in Clark and Skamania counties only as the state is moving to a regional contracting model. Letters of intent are due August 21, 2015 and proposals are due September 30, 2015. The contract will run from April 1, 2016 through December 31, 2017 with anticipated annual renewal through December 31, 2019. In conjunction with the new contract terms, responsibility for the provision of behavioral health services will be transitioned from Regional Support Networks to Medicaid managed care organizations. Look for more details in next week's *Weekly Roundup*. Read More

Five-Year Pilot Program to Curb Medicaid Costs. On August 6, 2015, *The Spokesman-Review* reported that officials from the Health Care Authority and the state Department of Social and Health Services unveiled a five-year pilot program aimed at reducing Medicaid treatment costs, streamlining primary care services, and reducing patient demand in emergency rooms, psychiatric hospitals, and nursing facilities. The window for public comments will close August 23. Read More

National

Number of Uninsured Drops by 15.8 Million Since 2013. On August 12, 2015, *The New York Times* reported that the number of people who are uninsured has dropped by 15.8 million since 2013, according to the National Center for Health Statistics. In the first quarter of this year, the proportion of uninsured was 9.2 percent, compared to 14.4 percent in 2013. This is largely due to Medicaid expansion and subsidies for private insurance, as enacted by the Affordable Care Act. Additionally, the economy has improved in the last two years and unemployment rates have declined. Read More

Audit Finds Not All Systems Effectively Determine Eligibility on HealthCare.gov. On August 10, 2015, *The Wall Street Journal* reported that the Health and Human Services' Office of Inspector General found that not all internal controls were effective in determining applicants' eligibility for health insurance or subsidies on the federal exchange. Problems with inconsistencies of applicant information and federal data were also found. The report was based

on audits and a review of two different samples of 45 applicants. It stated that without properly verifying eligibility and resolving inconsistencies, the federal exchange could not ensure applicants were meeting requirements for subsidies or that the subsidies were the right amount. Read More

Study Finds Super-Utilizers Use Services Intensely for Brief Period of Time. On August 7, 2015, *Kaiser Health News* reported that a study by Denver Health found that patients who use health care services intensely, known as "super-utilizers," do so for a relatively short period of time. At the end of the first year, only 28 percent of 1,682 patients who were originally identified as super-utilizers still met the criteria, and only 14 percent remained at the end of two years. Furthermore, 42 percent of high-cost patients with frequent hospital stays had multiple chronic conditions and 41 percent had serious mental health diagnoses. Read More

Study Finds Medicaid Dental Care Expansion Will Not Reduce ER Visits. On August 6, 2015, *The Washington Post* reported that a Health Affairs study found that expanding dental care under Medicaid does not reduce ER visits for minor dental problems. Based on ER visits from 29 states for non-traumatic dental care, areas with expanded Medicaid dental coverage, especially urban areas, did not have fewer ER visits. In rural areas with many dental providers, ER visits did drop when dental care was expanded. The study stated the issue lies with finding access to care and providers willing to accept Medicaid patients. The study stresses to treat dental care as preventative care to avoid costly procedures. Furthermore, to reduce ER visits, the study suggests dental clinics create their own emergency departments and expand dental coverage that is less expensive (e.g. telehealth, hygienists). Read More

Providers Terminated From State Medicaid Programs Still Billing Other States Three Years Later. On August 5, 2015, *Modern Healthcare* reported that 295 providers terminated from the Medicaid program for fraud, integrity, or quality issues in 2011, were still billing other states in 2014. Under the health law, states are required to pull providers from their Medicaid rolls if they are removed from another state's program. According to a report released by the HHS' Office of Inspector General, 94 of the 295 providers received $7.4 million from Medicaid after they were terminated. The OIG is recommending that CMS require state Medicaid agencies to report all terminations. Read More

Industry Research

GAO Report Finds Four Key Issues Facing Medicaid Program. A report from the U.S. Government Accountability Office identified four key issues facing the Medicaid program based on the last 10 years.

- Medicaid beneficiaries reported comparable access to care as that of privately insured individuals.
- Lack of complete and reliable data on states' spending has hindered federal oversight.
- The program is vulnerable to fraud and improper payments.
- Automatic federal assistance during economic downturns and more equitable federal allocations of Medicaid funds to states could offer greater fiscal stability. Read More

Industry News

Florida True Health to Acquire Prestige Health Choice. On August 10, 2015, Florida Blue and AmeriHealth Caritas announced that Florida True Health entered a definitive agreement to acquire Prestige Health Choice. Florida True Health is a joint venture of the two companies, providing Medicaid managed care. Read More

UnitedHealthcare Launches Health4Me Mobile App for Medicaid and CHIP Beneficiaries. On August 11, 2015, UnitedHealthcare announced that the company is launching a mobile app called Health4Me to Medicaid recipients in 17 states. The app allows beneficiaries to access important healthcare information, including personal health coverage details, care history, and claims. The app will also be able to locate nearby physicians, hospitals, and medical facilities and obtain health information from a nurse. Read More

James M. Lindstrom Appointed CEO of the Providence Service Corporation. On August 6, 2015, the Providence Service Corporation announced that the company's Board of Directors appointed James M. Lindstrom as President and Chief Executive Officer. Lindstrom was Chief Financial Officer since January 2015. David Shackelton, Vice President, Head of Corporate Development, was appointed interim CFO. Read More

Gateway Health, naviHealth Reveal New Post-Acute Care Program. Gateway Health and naviHealth have partnered to have naviHealth manage certain post-acute care services for Gateway Health's Medicare Advantage members in Pennsylvania, the firms announced today from Nashville and Pittsburgh. The program will utilize naviHealth's decision-support technology, post-acute analytics platform, and network of field-based clinicians to support Gateway Health members following hospital discharge. According to Kaiser Health News, post-acute care cost $110 billion in Medicare dollars annually and is the factor most responsible for regional variance in spending. Read More

Centene CFO Bill Scheffel to Retire in 2016. On August 12, 2015 Centene announced that William N. Scheffel, Executive Vice President and Chief Financial Officer, advised the company of his intention to retire in early 2016. It is his intent to step down in February after the filing of the Form 10-K, or when the Health Net transaction is completed, whichever is later. Centene's Board has designated Jeffrey A. Schwaneke, Senior Vice President, Corporate Controller and Chief Accounting Officer as Chief Financial Officer when Mr. Scheffel steps down.

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
August 17, 2015	Iowa	Contract Awards	550,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September, 2015	Georgia	Contract Awards	1,300,000
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Montana Expansion (TPA)	Contract Awards	70,000
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; Cigna-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 (*exiting demo*); 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	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
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), Cigna-HealthSpring, 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***			***12***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
California	122,908	123,079	124,239	122,520	122,798	122,846
Illinois	63,731	64,199	60,684	58,338	55,672	53,328
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705
Michigan					9,216	14,867
New York	17	406	539	6,660	7,215	5,031
Ohio	68,262	66,892	65,657	63,625	63,446	62,958
South Carolina		83	1,205	1,398	1,366	1,317
Texas			58	15,335	27,589	37,805
Virginia	27,333	26,877	27,765	27,349	30,877	29,970
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,827**

HMA News

New this week on the HMA Information Services website:

- Washington Medicaid Managed Care Enrollment Share by Plan, Jun-15 Data
- Kentucky Medicaid and CHIP Enrollment is Up 90.3 percent, Apr-15 Data
- Arizona Medicaid MCO Enrollment is Up 6.4 percent, Aug-15 Data
- Plus public documents including the Rhode Island Phase II Dual Demo MOU and the GAO Report on Medicaid Expansion's Effect on Behavioral Health

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.

Four HMA Presentations Featured at MESC 2015

HMA staff will be featured in four presentations at the upcoming Medicaid Enterprise Systems Conference (MESC) from August 17th to 20th, in Des Moines, Iowa. MESC is an annual meeting for State, Federal and private sector individuals to provide opportunities for the exchange of ideas related to Medicaid systems and heath policy affected by those systems. More Info

"State Perspectives for Achieving Compliance with ACA and Improving Provider Enrollment"
HMA Speaker: Stephanie Denning
Tuesday, August 18th, 9:30am – 10:30am

"Enterprise System Integrator: A Better Way to Manage Your Medicaid IT Portfolio"
HMA Speaker: Sandy Berger
Tuesday, August 18th, 3:00pm – 4:00pm

"Leveraging Health Information Exchange to Enhance Interagency Data Sharing"
HMA Speaker: Matt McGeorge
Tuesday, August 18th, 3:00pm – 4:00pm

"Actionable Quality Data: Validating, Aligning and Effectively Using"
HMA Speaker: Izanne Leonard-Haak
Wednesday, August 19th, 8:00am – 9:00am

HMA will also have a booth in the MESC 2015 Exhibit Hall; booth #25.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Pacific Northwest; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.