HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

WASHINGTON ISSUES SOUTHWEST REGION FULLY INTEGRATED MANAGED CARE RFP

This week, our *In Focus* section reviews the Washington State Health Care Authority's (HCA's) request for proposal (RFP) for Apple Health – Fully Integrated Managed Care in the Southwest Washington (SWWA) regional service area, comprised of Clark and Skamania counties. This RFP is effectively a rebid of existing Apple Health managed care contracts with the addition of fully integrated behavioral health services and standalone behavioral health wraparound services funded through non-Medicaid sources. Clark and Skamania are the first two county authorities to pursue the fully integrated physical and behavioral health, as initiated by 2014 legislation that also transitioned to a regional procurement model, with HCA anticipating statewide integration by 2020.

Target Population

The RFP indicates that nearly all Medicaid beneficiaries in Clark and Skamania counties will be covered under the Apple Health – Fully Integrated managed care program. Apple Health currently covers most populations, including individuals who are aged, blind, and disabled (ABD) and HCBS waiver beneficiaries.

Additionally covered under the Apple Health – Fully Integrated program will be select individuals receiving behavioral health services only through their choice of MCO, but receive medical services through HCA's fee-for-service system. These behavioral-health-services-only (BHSO) eligibility categories include:

- Dual eligibles
- Apple Health foster care children
- American Indians/Alaskan Natives
- Individuals residing in an IMD
- Medically needy spenddown enrollees, pregnant women who are not citizens of the U.S., and individuals with other health coverage, but eligible for BHSO

Behavioral Health Integration

Successful bidders will be awarded two contracts: one for Apple Health – Fully Integrated managed care and one for the Behavioral Health Services Wraparound contract. The Behavioral Health Services Wraparound contract integrates non-Medicaid funded mental health and substance use disorder (SUC) services funded by block grants and state-only funds, which are currently provided by the behavioral health Regional Service Network, the county, or SUD residential treatment providers. A full list of mental health/SUD services is provided in the sample Wraparound contract.

RFP Requirements

At this time, HCA is accepting bids only from health plans with current Apple Health contracts, although plans are not required to currently serve enrollees in the SWWA region. Additionally, a non-binding letter of intent must be submitted to HCA by Friday, August 21, 2015. Finally, eligible bidders must have a contracted provider network covering the entire SWWA region, including essential providers as described in the RFP/same contracts.

RFP Timeline

Per the timeline below, a mandatory letter of intent is due to HCA by August 21, 2015, with final proposals due by September 30, 2015. At this time, HCA anticipates announcing apparent successful bidders on November 17, 2015, with a goal of finalizing contracts by the end of the year. Contracts go live on April 1, 2016.

RFP Timeline	Date
Letter of Intent (LOI) Due	August 21, 2015
Bidder Conference	September 2, 2015
Bidder Questions Due	September 4, 2015
HCA Responses to Questions	September 22, 2015
Proposals Due	September 30, 2015
Anticipated Award Announcement	November 17, 2015
Contract Start Date	April 1, 2016

RFP Evaluation Criteria

The three points of evaluation weighted the heaviest in evaluating bidders are behavioral health access (18.7 percent of total points), care coordination (16.3 percent), and the medical/mental health network adequacy (12 percent). Full criteria are detailed in the table below.

Evaluation Criteria	Points	% Total
RFP Compliance	***Pass/Fail***	
Mandatory Management Review	***Pass/Fail***	
Management/Technical Proposal		
Management	*90*	*10.8%*
Behavioral Health Access	*155*	*18.7%*
Network Description	*60*	*7.2%*
Community Linkages	*40*	*4.8%*
Quality Assessment and Performance Improvement	*40*	*4.8%*
Information Systems/Claims	*45*	*5.4%*
Utilization Management/Authorization of Services	*35*	*4.2%*
Care Coordination	*135*	*16.3%*
Total Management/Technical Proposal	**600**	**72.3%**
Network Adequacy Submission		
Apple Health - Fully Integrated: Medical/Mental Health	100	12.0%
Apple Health - Fully Integrated: SUD Providers	75	9.0%
Behavioral Health Wraparound Network	25	3.0%
Total Network Adequacy Submission	**200**	**24.1%**
Business References	**30**	**3.6%**
Total Points Available	**830**	

Contract Awards/Term of Contract

HCA intends to award contracts to two MCOs, with a contract term of April 1, 2016, through December 31, 2017. HCA anticipates annual contract renewal through the end of 2019 (an additional two years) but reserves the right to extend renewals beyond this date.

Existing Apple Health Market

Columbia United Providers and Molina Healthcare are the two largest Apple Health MCOs in the SWWA region at this time, together covering more than 80 percent of the nearly 100,000 enrollees. Community Health Plan of Washington and United/Optum are also active in the region. The two other major Apple Health MCOs not currently enrolling individuals in the SWWA region but eligible to bid are Amerigroup (Anthem) and Centene's Coordinated Care Corporation health plan. Enrollment in the table below is as of August, 2015.

Health Plan	Clark Co.	Skamania Co.	Total SWWA	%	Total Statewide	%
Columbia United Providers	55,275		55,275	57%	55,387	4%
Molina Healthcare of Washington	24,042	106	24,148	25%	544,729	38%
Community Health Plan of Washington	16,316	1	16,317	17%	298,045	21%
United Health Care/OptumHealth	1,957	65	2,022	2%	207,624	14%
Total SWWA MCOs	**97,590**	**172**	**97,762**		**1,105,785**	**76%**
Amerigroup Washington (Anthem)					140,948	10%
Coordinated Care Corp. (Centene)					179,406	12%
Other Regional/Tribal Authorities					*20,372*	*1%*
Total All MCOs					**1,446,511**	

Link to RFP, Additional Documents

http://www.hca.wa.gov/contracts_procurements/Pages/index.aspx

HMA Medicaid Roundup

Alaska

Legislature to Sue Governor Walker Over Expansion; Cost Approved for $450,000. On August 18, 2015, *Alaska Dispatch News* reported that the legislature announced it will sue Governor Bill Walker for going forward to expand Medicaid without the lawmakers' approval. The House-Senate committee voted to spend up to $450,000 on legal costs. Read More

House-Senate Committee to Examine if Gov. Walker's Executive Power To Expand Medicaid Can Be Challenged. On August 17, 2015, *Alaska Dispatch News* reported that a House-Senate joint committee will investigate to determine if they can legally challenge Governor Bill Walker's move to expand Medicaid. After lawmakers rejected expansion, Governor Walker said he would use his executive power to expand despite the rejection. The joint committee meeting will see if Walker has the ability to unilaterally expand and whether not or not Legislature has the grounds to make a challenge. The legislative Budget and Audit Committee has the authority to review the proposal and make recommendations but not to block it. Expansion is set to take effect September 1. Read More

Arizona

Gov. Ducey's Medicaid Overhaul Plan Met with Doubt. On August 17, 2015, *The Arizona Republic* reported that critics doubt Governor Doug Ducey's plan to overhaul the Medicaid program will meet federal approval. Ducey's proposed waiver will seek to establish premiums equal to 2 percent of income, copayments of up to 3 percent of income, and require the recipient to either have a job or be actively looking for one. Critics don't believe the sweeping changes will be approved by CMS. The waiver request is due October 1. The Arizona Health Care Cost Containment System will hold six community forums to answer questions about the plan beginning this week. Read More

Arkansas

Medicaid Verifications and Terminations Re-Instated. On August 18, 2015, *Arkansas Online* reported that Medicaid verifications and terminations have been re-instated after they were suspended for two weeks by Governor Asa Hutchinson to allow the Department of Human Services to address reports that coverage was canceled for some Medicaid recipients who remained eligible. Additionally, pharmacy benefits will be provided for 30 days to certain individuals who have been sent a notice of termination. Read More

Consulting Group Finds Private Option to Net $438 Million for State Budget by 2021. On August 18, 2015, *UALR Public Radio* reported that a preliminary report by The Stephen Group, a consulting group hired by the Health Reform Task Force of the Arkansas Legislature, found that the Private Option will net $438 million by 2021 for the state budget. The Private Option expands Medicaid to cover adults with incomes at 138 percent of the federal poverty level. The net impact is as high as $156 million in 2017 and as low as $25 million in 2021. However, the consulting group warned that traditional Medicaid should also be reviewed for financial savings. Read More

California

HMA Roundup – Varsha Chauhan (Email Varsha)

CMS Approves Drug Medi-Cal Waiver. On August 18, 2015, *California Healthline* reported that CMS approved the waiver for the Drug Medi-Cal Organized Delivery System, which will change the way mental health services are delivered. It supports an integrated safety-net delivery system by better coordinating substance abuse, physical, and mental health services. Furthermore, the waiver will focus more on evidence-based treatment practices; transfer more control and accountability to the counties; promote stronger oversight; and use resources more efficiently. Read More

Transition of Fragile Children Into Medi-Cal Managed Care Proves to Be Controversial. On August 17, 2015, *Kaiser Health News* reported that parents and consumer advocates are skeptical of the transition of fragile children from California Children's Services into Medi-Cal managed care. The move of the $2 billion program, which serves approximately 180,000 children, is scheduled to begin next year. In 2017, about 31,000 children will shift to Medi-Cal managed care plans, and the remaining children will transition beginning in 2019. A June report from the California State Auditor found that the state could not assure the Medi-Cal managed care networks were adequate, which provided support for critics' fear the transition will lead to the destruction of the program. Read More

Debate Over Healthcare Taxes and Fees Begins in Legislative Session. On August 17, 2015, *Los Angeles Times* reported that a debate over new taxes and fees began as lawmakers returned to session. Democrats are calling for a new tax on health insurers to pay for Medi-Cal and other social services after federal officials stated the current tax needed to be changed or risk $1 billion in federal matching funds. The current tax on plans applies only to those accepting Medi-Cal patients. However, to comply with federal standards, it must be levied on all health plans. Plans have said the costs will most likely be passed onto consumers. Read More

California Looks to Reallocate CHIP Funding Under ACA. On August 15, 2015, *The Hill* reported that an Affordable Care Act provision that intended to prevent states from dropping Children's Health Insurance Program coverage by increasing the federal share of funding means that some states including California are planning to shift funding to other budget priorities. The provision under the ACA boosted reimbursement rates under CHIP by 23 percent, or by about $6 billion over two years. Because of the provision, 11 states and Washington, D.C., will have CHIP covered entirely by federal funding, and no state will pay more than 12 percent of its CHIP costs.

California has already said that they want to use funding previously dedicated to CHIP for other budget needs, such as providing tax cuts or working on roadways. For example, the provision allowed California Governor Jerry Brown (D) to reallocate about $381 million from the program in an upcoming budget. Read More

HHS Awards $29 Million to 48 Community Health Centers in California. On August 12, 2015 *California Healthline* reported that HHS this week awarded $169 million in ACA funds to 266 CHCs in rural and urban areas across 46 states, Washington, D.C., and Puerto Rico. Forty-eight new community health centers across California will receive more than $29 million to provide care access to more than 337,000 patients. Read More

Covered California Premiums to Increase 4 percent in 2016. Covered California officials say premiums for health plans will increase an average of 4 percent in 2016 and that two new insurers will be joining the Exchange. The premium increases will vary by region, with costs rising more in Northern California than in Southern California. Overall, the premium increases are slightly below the 4.2 percent increase in 2015. Rates for health plan members in Northern California will increase 7 percent in 2016 to an average premium of $384. In Southern California, rates will increase 1.8 percent to an average premium of $296. Premium increases will also vary by county. In Monterey, San Benito, and Santa Cruz counties, rates will jump 12.8 percent but will increase only 3.4 percent in San Francisco County. In Southern California, rates in San Diego County will increase 2.8 percent but will decrease 0.5 percent in Imperial County. Read More

California to Extend Full Medi-Cal Coverage to Pregnant Women. On August 15, 2015, *Modern Healthcare* reported that CMS has approved California's waiver to extend full Medi-Cal coverage to pregnant women. Medi-Cal is California's Medicaid program. Under the Affordable Care Act, California extended full Medi-Cal coverage to all women in households with family incomes up to 138 percent of the federal poverty level. However, a previous federal mandate that required states to cover pregnancy-related services also allowed them to cover less than the full range of Medicaid benefits for pregnant women. As a result, pregnant women who enrolled in Medi-Cal were given a limited set of benefits. Read More

Major Upgrades to Healthy San Francisco- 2.0. On August 4, 2015, a blog written by Rose Auguste and Judi Hilman of Health Access reported that San Francisco's Health Commission authorized the first major upgrades to Healthy San Francisco and City Option — the main platforms for universal coverage in San Francisco — since full implementation of the Affordable Care Act (ACA). Under the resolution, adopted with unanimous support, an estimated 3,000 additional residents will be able to use their Medical Reimbursement Accounts, one of the key components of Healthy SF, to subsidize Covered California insurance up to income levels exceeding the ACA limits. These additional subsidies would be available to households up to 500 percent of the federal poverty level (FPL), which is equivalent to $100,450 for a family of three. Subsidies on Covered California and most other health insurance exchanges only go up to 400 percent of the FPL. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Connect for Health Colorado Awards Five-Year Contract to CGI. Connect for Health Colorado – The State Based Marketplace for CO - awarded CGI a five-year contract for services that will improve call center performance, provide ongoing system maintenance and upgrades, and allow development of an online portal for health insurance brokers. Leveraging CGI's Atlas360 digital transformation solution, the Colorado health insurance Marketplace is projected to save approximately 33 percent in operating costs over five years, for a total savings of $39.6 million. Under an agreement that consolidates several previous vendor contracts, CGI will implement new customer service technologies that focus on self-help to reduce call center volumes and shorten average hold times. CGI will also work with Connect for Health Colorado to re-structure service locations, lower overall costs, and implement new workforce management tools. Read More

Colorado Medicaid Health Information of 1,622 Households Sent to Wrong Addresses. On August 17, 2015, *9 News* reported that protected Medicaid health information of 1,622 households was sent to the wrong addresses between May 25 and July 5. The information may have included names, address, state identification or Medicaid case numbers, names of family members in a household, employer name, income, amount of an Advanced Premium Tax Credit, and eligibility for services. The Department of Health Care Policy and Financing asked for the letters to be destroyed and is offering free credit monitoring services for those affected. However, the department stated that it does not believe anyone is at high risk for identity theft. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

31 Hospitals to Receive Audits for Medicaid Payments. On August 12, 2015, *Tampa Bay Times* reported that Elizabeth Dudek, Secretary of the state Agency for Health Care Administration, ordered audits for 31 hospitals that did not certify they were in compliance under state law for Medicaid payments. After private health plans requested a 12 percent rate increase, the state found insurers were overpaying hospitals and requested all hospitals to certify that payments were within the law by August 1. Those not meeting the deadline will receive audits. Read More

Idaho

Idaho Department of Correction to Remain under Court's Supervision for Misleading Medical Information. On August 12, 2015, *Idaho Statesman* reported that the state Department of Correction will remain under the court's supervision until at least fall 2017. Employees at the Idaho State Correctional Institution manipulated medical records and tried to mislead the court into thinking the medical and mental health care provided to inmates was better than it actually was. The state will continue to have the burden of proving that inmate healthcare meets constitutional standards. Read More

Iowa

Iowa Medicaid Managed Care Awards Announced. On August 17, 2015, the Iowa Department of Human Services announced the awards for the High Quality Health Care Initiative, the state's move to Medicaid managed care. The awards went to:

- Amerigroup Iowa, Inc.
- AmeriHealth Caritas Iowa, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- WellCare of Iowa, Inc.

The initiative is seeking to modernize Medicaid by improving quality and access, promoting accountability, and creating a more predictable and sustainable Medicaid budget. Implementation will begin Jan. 1, 2016. Read More

Department of Human Services States Mental Health System Improving After Overhaul. On August 13, 2015, *Newton Daily News* reported that state officials stated that Iowa is providing better mental health care after an effort to remake the system was implemented last year. Department of Human Services Director Chuck Palmer said that the state's mental health system is serving more people and providing more modern care. Public and private services have been coordinated by regional levels instead of by county. A new tracking system was developed to track the availability of psychiatric beds. However, Governor Terry Branstad is being criticized for shutting down two state-run mental health institutes. A patient passed away after being moved to a private nursing home. Read More

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Michigan Discloses Medicaid Managed Care Bidders, Regions. In the May 13, 2015 edition of the *HMA Weekly Roundup* we provided an overview of the Request for Proposals (RFP) released by the Michigan Department of Health and Human Services (MDHHS) on May 8 to rebid its Medicaid managed care contracts. The current contracts have been in place since 2009 and expire December 31, 2015. The new contracts, which begin on January 1, 2016, are for five years, with three possible "option years" in addition. Bidder responses were due on August 3, 2015.

At this time there are more than 1.6 million Michigan Medicaid beneficiaries enrolled in 13 HMOs to receive their Medicaid services. About 475,000 of these beneficiaries are eligible for Medicaid through the state's ACA-authorized expansion program called the Healthy Michigan Plan. All 1.6 million beneficiaries will be served by the contractors selected through this procurement. MDHHS has also indicated its intent to request federal approval to transition children from the state's existing stand-alone Children's Health Insurance Program, called MIChild, into a proposed Medicaid expansion program. If the proposal is approved, these children – about 40,000 currently – will be enrolled with the HMOs awarded contracts through this procurement.

The state restructured the regions for the Medicaid HMO reprocurement, using Governor Rick Snyder's 10 Prosperity Regions, and required bidders to bid on entire regions. This action prompted several of the incumbent HMOs to request

service area expansion approval from the state's Department of Insurance and Financial Services in order to preserve counties where the plans have had a "footprint." The size and duration of this procurement also led several HMOs to bid on additional regions of the state. The Upper Peninsula of the state has federal "Rural Exception" authority, permitting a single HMO to serve all counties. The RFP required that Regions 2 and 3 – the two regions covering the upper half of the Lower Peninsula and encompassing 21 counties – had to be bid together. Note that there are four HMOs bidding to serve the entire Lower Peninsula. Note as well that all bidders are incumbents, if one grants Michigan Complete Health that status through its participation in the MI Health Link Medicaid/Medicare integrated care demonstration. The table below shows the bidders by region.

Plan / Region	1	2	3	4	5	6	7	8	9	10
Anticipated Awards by Region Specified in the RFP	*1*	*2-3*	*2-3*	*3-5*	*2-3*	*3-5*	*2-3*	*3-5*	*3-5*	*5-7*
Bidding Plans by Region	1	5	5	6	5	6	6	6	9	10
Aetna Better Health (CoventryCares)					X			X	X	X
Blue Cross Complete				X		X	X		X	X
HAP Midwest Health Plan						X			X	X
Harbor Health Plan										X
McLaren Health Plan		X	X	X	X	X	X	X	X	X
Meridian Health Plan		X	X	X	X	X	X	X	X	X
Michigan Complete Health (Centene/Fidelis)									X	X
Molina Healthcare		X	X	X	X	X	X	X	X	X
Priority Health Choice		X	X	X				X	X	
Sparrow PHP							X			
Total Health Care										X
UnitedHealthcare Comm. Plan		X	X	X	X	X	X	X	X	X
Upper Peninsula Health Plan	X									

Note: HealthPlus Partners is an incumbent HMO but did not submit a proposal because its Medicaid and MIChild products were recently acquired by Molina Healthcare of Michigan.

As the table illustrates, other than for Region 1 there are more bidders for every region than the number of anticipated awards specified in the RFP. Whether the state will award more contracts than the anticipated number is unknown, although there is a historical precedent for doing so. It is expected that the state will announce recommended awards in October or early November. Protests are possible from bidders not scoring well on their narrative submissions, given the highly subjective nature of the reviews that will be required.

Bidders were required to submit narrative responses regarding their current activities and future approaches to address what the state has called the "four pillars" within its State Innovation Model (SIM) "Blueprint for Health Innovation": population health management, integration of care, payment for value, and structural transformation. The narratives required to address these activities are worth half of the total score for the submissions so are key to a successful response. The RFP also supports the SIM initiative, as it requires implementation and support of Patient-Centered Medical Homes (using the scope of the Michigan Primary Care Transformation – MiPCT – initiative as a foundation), integration/coordination with Prepaid Inpatient Health Plans (PIHPs) providing behavioral health care, participation with Accountable Systems of Care and community collaboration projects, and promotion and support of health information exchange and health information technology with network providers. Read More

Operating Income Rises 295 Percent for 12 Medicaid HMOs; Net Income Drops 20 Percent Overall. On August 12, 2015, *Crain's Detroit Business* reported that 12 Medicaid HMOs had operating income rise 295 percent to $163.1 million in 2014, with enrollment growing to 21 percent to 1.6 million. Overall, the total 19 HMOs grew 14.8 percent to nearly 3.1 million. Net income declined 20 percent to $170 million, while operating income nearly quadrupled to $163.1 million. Read More

Minnesota

UCare Fights to Win Back Medicaid Contracts. On August 18, 2015, *The Washington Times* reported that UCare met with state lawmakers to discuss the pending bid process, set to end all UCare Medicaid contracts, and force 360,000 consumers to pick a new plan. CEO Jim Eppel hopes to win back the contracts. Read More

Missouri

Panel To Review Managed Medicaid Services. On August 12, 2015, *Fox 2 News* reported that a House panel, which includes lawmakers, providers, and consumer group members, will review how to provide Medicaid through a managed care model. Chairwoman Representative Marsha Haefner intends to recommend the transition of Medicaid services to managed care. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

North Shore-LIJ and Empire BlueCross BlueShield Sign Agreement to Offer Integrated, Value-Based Health Care. North Shore-LIJ Health System and Empire BlueCross BlueShield announced an Accountable Care arrangement that will cover more than 33,000 commercial and Medicare Advantage members in a value-based collaboration. Under the agreement, North Shore-LIJ will coordinate care through North Shore-LIJ Premium, an integrated network of over 5,500 primary care and specialty physicians as well as other healthcare professionals in the New York metropolitan area, by creating, team-based, integrated care focused on the individual needs of members covered through Empire Blue Cross/Blue Shield. North Shore-LIJ operates an IPA in addition to the health system's Premium Network, as well as North Shore-LIJ Care Solutions, the health system's care management enterprise. Empire BlueCross BlueShield is the largest health insurer in New York, supporting nearly five million members and more than 38,000 business, union and small employers in New York. Here for more information.

Fully Integrated Dual Advantage (FIDA). FIDA implementation began on January 1, 2015. Individuals in Bronx, Kings, Nassau, New York, Queens, and Richmond counties are now able to join the FIDA demonstration on a voluntary basis; passive enrollment is being phased in. Four waves of passive enrollment have occurred: 4,158 in April; 3,152 on May 1; 2,599 more on July 1; and 2,701 on August 1. As of August 1, FIDA enrollment was 7,676. Two additional waves of passive enrollment have been scheduled for September and October, affecting 8,879 individuals. As of August 1, 54,287 individuals have opted out of FIDA.

Expansion of FIDA into Region II has not yet been finalized, although the state recently reported that it would be soon. Region II of the demonstration, including Suffolk and Westchester Counties, was scheduled for voluntary enrollment as of March 1 and passive enrollment as of July 1, 2015. CMS and the Department of Health have temporarily paused the implementation of Region II because of network deficiencies. No opt-in enrollments will be accepted as CMS and DoH continue to review the adequacy of provider networks in those counties. The state is looking for ways to generate provider interest and support in the program and have distributed a letter outlining the benefits to consumers of FIDA enrollment, as well as an FAQ about the program.

New York's Child Health Plus Program. A new United Hospital Fund report, *What's Next for New York's Child Health Plus Program?*, examines New York's Child Health Plus program. Federal funding has been extended through 2017, but prospects beyond 2017 are unknown, and New York policymakers face decisions about the program's future.

New York's Child Health Insurance Plan (later renamed Child Health Plus) was enacted in 1990, well before the federal program was created. The program subsidized a limited benefit package for children under the age of 13, ineligible for Medicaid, and living in families earning less than 185 percent of the federal poverty level. Age limits and income eligibility increased over time, and benefits were added. The establishment of the federal State Children's Health Insurance Program (SCHIP) in 1997 provided matching funds to support New York's program; the ACA provided additional funding support.

About 280,000 children are enrolled in New York's separate CHP program through 16 participating CHP managed care plans, a nearly one-third decline from a highwater mark of 416,000 in October 2011. However, much of this drop is attributed to increased enrollment of children in Medicaid due to increases in Medicaid eligibility levels for children. Overall, CHP covered about 6 percent of children in New York State in 2013, compared to 45 percent for employer-sponsored 39 percent for Medicaid

The report notes that the program, though small, is popular throughout the state. With an eye to a possible sunset of federal funding in 2017, the report clarifies decisions policymakers might face during the next funding cycle and compares key features of CHP to alternative sources of coverage, such as employer-based coverage or qualified health plans on New York's Health Insurance Exchange. The report notes that most families would experience significant increases in cost sharing and premiums if they sought coverage for children in the absence of CHP. The report also notes potential benefits of integrating CHP with new coverage options available under the Affordable Care Act, including convenience for families and improved risk pools for the plans to which CHP beneficiaries would migrate.

Patient-Centered Medical Homes in NYS. The United Hospital Fund has been tracking the adoption of the patient-centered medical home model in New York State. A new report, *Recent Trends and Future Directions for the Medical Home Model in New York*, provides an update.

Between 2013 and 2014, New York experienced nearly 20 percent growth in the number of health care providers formally recognized as Patient-Centered Medical Homes. New York continues to lead the nation in the adoption of the medical home model. NCQA data show that New York continues to have by far the largest number of practices and practitioners working in NCQA-recognized

PCMHs—over 14 percent of all PCMH practices and practitioners in the country. As of October 2014, there were 5,832 primary care providers working in practices recognized by NCQA as PCMHs, roughly evenly split between New York City and the rest of the state. The PCMH model is not evenly distributed across different types of practices, with larger practices – group practices, health centers, and institution-based providers – more likely to have adopted the model. The report also reviews the source of much of the recent model adoption – the implementation of the Hospital Medical Home program, a $250-million quality demonstration program involving teaching hospitals.

North Dakota

Medicaid Management Information System to Go Live in October. On August 16, 2015, *The Bismarck Tribune* reported that the Department of Human Services said the state's MMIS project is set to go live October 5 after failing to meet an October deadline last year. Costs for the system have risen from $62.5 million to over $97.9 million. A transition from the old system to the new began this month. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

State Medicaid Spending $2 Billion Below Estimates. On August 13, 2015, *The News-Herald* reported that Ohio's Medicaid spending was $23.5 billion for the fiscal year ending in June, 7.6 percent lower than projected. Medicaid Director John McCarthy stated some of the contributing factors for the savings were expanded managed care, expanded home-based care for seniors, shorter nursing-home stays, and capitated reimbursement policies. The state also began using a new automated system that more accurately determines the eligibility of applicants. Ohio expanded Medicaid in 2013 and now has nearly three million people enrolled in the Medicaid program. Read More

Medicaid Officials Release Report Card of Managed Care Plans. On August 18, 2015, *The Columbus Dispatch* reported that Medicaid officials released the state's first report card on all five managed care plans serving Medicaid members. The tool will help individuals choose coverage and create transparency and competition. The report card measures plans on five categories: access to care; doctors' communication and service; keeping kids healthy; helping those living with chronic illness; and women's care. It gives a star rating on each category. In addition, the state updated readmission rates for each hospital and managed-care plan in the state. Hospitals with higher rates of readmission will lose some Medicaid reimbursement or be fined beginning next year. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's Department of Human Services Settles Lawsuit Over Women's Health Coverage. Pennsylvania's DHS has settled a lawsuit brought by The Women's Law Project and Community Legal Services of Philadelphia earlier this year over transitioning 75,000 women from a Medicaid program that

covered gynecological and family planning services. SelectPlan for Women was a limited Medicaid program that covered women's health-related services at no cost for women with income below 214 percent of the federal poverty guidelines. Starting in January, many of the women enrolled in the program were eligible to receive a more comprehensive health care coverage under Medicaid or to purchase private coverage on the federal government's health insurance marketplace. The litigation alleged women were "being forced to wait up to six months to receive that coverage, or to navigate a complex, burdensome, and unnecessary application process," according to court filings. The lawsuit was filed in the last days of the administration of former Governor Tom Corbett. Ted Dallas, Secretary of the Department of Human Services, said Monday he did not see the case in an adversarial way. "From our perspective, we have been working since we got here to try to get that issue resolved," he said. Read More

Georgia-Based Pediatric Facility to Pay $2.4 Million to Pennsylvania for Allegedly Not Returning Medicaid Overpayments. Georgia-based Pediatric Services of America, Inc., will pay $2.4 million to the state of Pennsylvania as part of a national settlement with 19 other states over allegations it did not return overpayments made by Medicaid, said Attorney General Kathleen Kane on Monday. The pediatric health center was accused of rounding up service delivery time to the nearest whole hour in submitted claims and overcharging for some nursing services, in addition to the claims of non-repayment, Kane said. The $2.4 million in the settlement will be refunded to each state's Medicaid programs. Pennsylvania will receive about $81,000 in restitution and other recoveries as part of the settlement. Read More

National

Audit Finds Most Health Co-ops Losing Money. On August 14, 2015, *The New York Times* reported that a federal audit of 23 health insurance co-ops found that 22 lost money last year and most enrolled fewer people than predicted. Six co-ops are currently on an informal watch list. CMS has also increased the data and financial reporting requirements for the co-ops. Earlier this year, Iowa-based CoOportunity Health was shut down by the Iowa insurance commissioner, and a state court found it insolvent. The insurer used $145 million in federal loans. Co-ops, in total, received $2.4 billion in federal loans. Read More

Study Finds Non-Expansion States Hinder Ability to Care for Individuals with Mental Illnesses. A Psychiatric Services in Advance report found that the 19 states that have not expanded Medicaid may be hindering their ability to care for individuals with mental illnesses. The report found that nationwide expansion would provide an estimated $11.3 million for mental health services, $1.6 million for substance abuse services, and $230 million in additional revenue for health centers.

Industry News

No Industry News to report this week

RFP Calendar

Date	State/Program	Event	Beneficiaries
October 1, 2015	Montana Expansion (TPA)	Proposals Due	70,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 30, 2015	Washington (SW - Fully Integrated)	Proposals Due	100,000
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
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
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	4/1/2016	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	Jul-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671
Michigan					9,216	14,867	28,171
New York	17	406	539	6,660	7,215	5,031	7,122
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871
South Carolina		83	1,205	1,398	1,366	1,317	1,388
Texas			58	15,335	27,589	37,805	44,931
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**

HMA NEWS

New this week on the HMA Information Services website:

- **Iowa** Awards Medicaid Managed Care Contracts to Serve 570,000 Members
- **Ohio** Medicaid Managed Care Enrollment is Down 1%, Jul-15 Data
- **California** Duals Demo Enrollment Nears 123,000, Jun-15 Data
- Plus public documents including the **Washington** Apple Health Southwest Region RFP, **Iowa** High Quality Healthcare Initiative Waiver Proposal, and **New Jersey** Fiscal Intermediary RFP

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 WELCOMES…

Sean Kolmer, Principal – Portland, Oregon

Sean Kolmer comes to HMA most recently from the State of Oregon where he served as a Senior Policy Advisor to the Office of Governor Kate Brown and the Office of Governor John Kitzhaber. In this role Sean was a senior leader and strategic advisor for all issues related to health and health care, including commercial health insurance, Medicaid, mental health, and public health. Some of his key accomplishments include the successful development, negotiation, and transition of Cover Oregon to the Department of Consumer and Business Services to ensure Oregon's state-based marketplace; successful development and negotiation of the Oregon Medicaid budget including renewal of a hospital provider tax; recruitment and confirmation of Oregon Health Authority Director; and leading implementation for achievement of 95 percent health insurance coverage in Oregon.

Prior to his work with the Governor's office, Sean served on the Public Employees Benefit Board as both a Board Member and as the Chair. Here he led the strategic planning efforts and transformation of purchasing to contract for care models that started in 2015 that would provide better care and save over $2B through 2020.

Additional roles that Sean has served in include Deputy/Acting Chief of Policy and Programs with the Oregon Health Authority; Senior Policy Advisor with Office of Governor John Kitzhaber; Deputy Administrator with the Oregon Health Authority; Research Manager with the Office for Oregon Health Policy and Research; and several roles with the Oregon Health & Science University to include Research Associate, Manager of Distribution and Partnerships, Senior Research Assistant, Distribution Manager, and Research Assistant 2.

Sean received his Masters of Public Health degree from Portland State University and his Bachelor of Science degree in Exercise Science from Linfield College.

Lori Raney, M.D., Principal – Denver, Colorado

Lori comes to HMA most recently from Axis Health System where she served as the Medical Director for the last 15 years. While there, Lori also served as a contracted Psychiatrist for the Albuquerque Area Indian and Health Service; she has served patients in her own private practice and has done consulting through her company – Collaborative Care Consulting.

As the Medical Director of Axis Health System in Durango, Colorado, Lori worked in the design and development of collaborative care models in diverse locations including Federally Qualified Health Centers, Rural Health Centers and School-based Health Centers in rural Colorado. She participated in the design of a fully integrated healthcare facility that combines both primary care and traditional behavioral health services and which opened in December 2011; Cortez Integrated Healthcare brings together primary care services for the patients with mental illness and provides integrated services to the larger community seeking this form of care. One of her sites received status as a FQHC. She has served as a consultant psychiatrist to these varying locations.

Through working with national leaders in integrated care, Lori helped design a curriculum to teach these models to psychiatrists and primary care providers and has been active in presenting this across the country. She was asked to chair the American Psychiatric Association's Workgroup on Integrated Care in January 2011 and continues to hold this position. Lori speaks nationally on the topic of collaboration with primary care and works with organizations to design and implement these evidence- based care teams.

Additional roles that Lori has served in include Consulting Psychiatrist with Telluride Medical Center; in-patient Staff Psychiatrist with Colorado West Stabilization Unit; and Clinical Director and Director, Counseling Services Department with Kayenta Service Unit/Navajo Area Indian Health Service.

Lori received her medical degree from the University of North Carolina and her Bachelor of Arts degree in Biology from UNC. She completed her psychiatric residency at Sheppard-Enoch Pratt Hospital in Maryland. Lori is board certified by the American Board of Psychiatry and Neurology and is a licensed physician in Colorado.

Rich VandenHeuvel, Principal – Lansing, Michigan

Rich comes to HMA most recently from Lakeshore Regional Partners, where he served as the Chief Executive Officer over the last few years. In this role Rich provided leadership of this newly formed public Behavioral Health Managed Care Organization that was created by five Community Mental Health Boards. Rich was responsible for managing the $250 million-plus annual budget for the provision of specialty behavioral health services across a diverse, seven-county region in Western Michigan via contract with the State of Michigan. Additionally, he was charged with the integration and management of substance abuse services; integration and management of Health Michigan funds and benefits; collaboration and coordination with Medicaid managed health care plans; governing board development; and population-based data analytics pilot development and procurement.

Prior to his role with Lakeshore, Rich served in several different roles during his 22-year tenure with West Michigan Community Mental Health System. The most recent role he held with them was as Executive Director for the last nine years. In this role, Rich was responsible for strategic planning; public relations;

comprehensive organizational restructuring; management of federal, state, and local funding streams and requirements; budget planning and implementation; and affiliation management and decision-making. Other roles Rich served in at WMCMHS include Clinical Director, Access and Utilization Management Director, Vice President for Performance and Service Improvement, and Wraparound Resource Coordinator.

Additional roles that Rich has served in include Temporary Mental Health Clinician with Lake County Community Mental Health; Case Manager for Huron Services for Youth; and Residential Technician for Clinton-Eaton-Ingham Community Mental Health.

Rich received his Master's degree in Social Work from Grand Valley State University and his Bachelor of Arts degree in Psychology from Michigan State University.