HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 28, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

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IN FOCUS

HMA/RWJF REPORT ON MAKING ACA COVERAGE A REALITY – EXAMINATION OF PROVIDER NETWORK MONITORING PRACTICES

This week, our *In Focus* section reviews key findings and recommendations from a report released this month by Health Management Associates (HMA), with funding from the Robert Wood Johnson Foundation (RWJF). The report, *"Making Affordable Care Act Coverage a Reality: A National Examination of Provider Network Monitoring Practices by States and Health Plans,"* was prepared by HMA's Karen Brodsky, Diana Rodin, and Barbara Smith, with support from the State Health Reform Assistance Network, a RWJF program.

HMA would like to thank RWJF for its strong support and guidance in enabling this research and final report. We also express our deep appreciation to the state agencies and health plans that recognized the importance of the issues addressed in the project and, through their participation in surveys and interviews, provided essential information to assist the authors in

understanding the challenges involved in building and sustaining provider networks that ensure access to care. We are grateful for the ongoing interest and assistance in health plan outreach from Medicaid Health Plans of American (MHPA) and the Association of Community Affiliated Plans (ACAP). Finally, we would like to acknowledge our colleagues Jessica Foster, Diana Rodin, Melissa Sanchez, Danielle Lundstrom, and Andy Griggs for their invaluable work in gathering and analyzing data and making the surveys and interviews possible.

Summary of Key Findings and Recommendations

This qualitative study examines the standards and practices that state agencies and health plans use to ensure access to care in the period following the implementation of the Affordable Care Act (ACA). Based on evidence gathered through surveys of and interviews with key informants in state agencies and plans, the study explores the standards applied by commercial insurance regulators and Medicaid agencies and the practices actually employed by Medicaid managed care organizations (MMCOs) and Qualified Health Plans (QHPs) in Marketplaces to form provider networks and monitor performance. While the response sample is small, the information provided paints a picture of the range of standards and practices used and the challenges faced, which provides a basis for identifying gaps in current understanding and strategies and opportunities for developing best practices. The key findings and recommendations are set forth below.

Key Findings

1. **Network standards differ significantly between state insurance regulators and Medicaid agencies.** Consistent with their differing roles, state insurance regulators (referred to also as Departments of Insurance or DOIs) and Medicaid agencies differ significantly in the detail and number of standards for network adequacy. The relationship between Medicaid agencies and MMCOs is contractual – MMCOs are vendors of the Medicaid agency. Therefore, contractual provisions on network adequacy tend to be highly prescriptive. By contrast, DOIs serve as regulators to create the basic floors for market entry, primarily to avoid market disruptions. Their standards overall tend to be more general, with more permissive thresholds, and they are less directed to achieving optimal performance.

2. **Health plans report that they are exceeding state network standards.** Notwithstanding their different regulatory frameworks, both MMCOs and QHPs report that they exceed state standards, although the degree to which state standards are exceeded is reported to be much greater among QHPs. They report that they need to maintain these high levels of performance to be effective in competing for market share. It is unclear what role required accreditation for QHPs by independent quality review organizations plays in network formation, although the requirement does provide external standards and scrutiny beyond that provided by the DOIs.

3. **Primary Care Practitioners (PCPs) are defined broadly by states and health plans.** In defining what types of practitioners can be designated as PCPs, both DOIs and Medicaid agencies include a broad range of providers. Allied professionals such as nurse practitioners and physician assistants tend to be recognized as PCPs. MMCOs and QHPs mirror this inclusiveness.

4. **Provider-to-enrollee ratios and maximum travel time and distance (geo-access) standards vary widely.** Requirements regarding provider-to-enrollee ratios and geo-access standards vary widely, with geo-access standards having the widest variation. Regulators do not appear to have used a consistent methodology or approach to developing standards for measuring network adequacy – either in terms of geo-access or provider-to-enrollee ratios. The standards themselves reflect little consensus regarding optimal provider distribution based on geography or population. No effort appears underway to develop algorithms or formulas that apply local variables in a consistent way to arrive at standards that reflect a reliable indication of access. Similar variation exists among QHPs and MMCOs in the standards adopted. Most surveyed QHPs report having more providers for their enrolled population than required by DOIs and using geo-access standards. Reporting MMCOs appear on average to have fewer providers to enrollees than the standards reported on average by Medicaid agencies. However, it is not clear that those plans with fewer providers to enrollees deviate from the actual contractual standards in their particular states. Some key informants question the degree to which these metrics provide insight into the "nitty gritty" of the actual availability of care when it is needed.
5. **Few states track provider network overlap across plans.** It is rare for regulators to take into account the multiplicity of plans with which providers contract (plan overlap) to evaluate actual provider capacity. Providers who serve patients in a large number of plans may have less capacity to serve patients in any one plan than is suggested by plan-specific provider to enrollee ratios. Only a small number of Medicaid agencies, MMCOs, and QHPs monitor total provider patient load and its consequent effects on patient wait-time, out-of-network utilization, and access by new patients. Most regulators limit the evaluation of provider capacity to an individual plan's provider network. DOIs universally fail to monitor plan overlap effects on provider networks.
6. **Essential Community Providers (ECPs) are an increasing option.** Some states have integrated into their general commercial market and Medicaid program Marketplace requirements to include ECPs in provider networks.
7. **After-hours appointment availability is still rare.** While 24/7 telephone availability to a provider is almost universally reported by plans and Medicaid agencies as a standard for network performance, after-hours in-person appointment availability remains on the sidelines of network planning for state agencies and plans. No DOIs and few Medicaid agencies require it.
8. **Many plans report covering out-of-network care provided by clinicians working at in-network facilities to protect consumers from having to pay for unintended out-of-network care.** While a majority of MMCOs and QHPs report addressing this issue, most Medicaid agencies and state insurance regulators do not. Some state insurance regulators report emerging legislative activity to protect consumers from out-of-network costs for in-network facility care.
9. **Member complaints are the most frequent but not the most reliable indicator of systemic network deficiencies.** In monitoring network structure and availability, DOIs, Medicaid agencies, QHPs, and MMCOs rely extensively on consumer complaints and surveys to flag problems. State

insurance regulators report that while they rely on complaints, they find them to be poor indicators of problems, either because they represent only "the tip of the iceberg" or are distorted by provider efforts to encourage their patients to complain about proposed networks that do not include those providers. While not completely absent, little analysis of claims data such as emergency room, out-of-network, or specialist utilization occurs that might be early-indicators of difficulties in gaining access to in-network care.

10. **Many regulators are hampered by insufficient information technology (IT) to monitor networks.** Many state insurance regulators and Medicaid agencies report that they do not have the IT resources necessary to automate monitoring activities and perform data analytics, a situation that impedes timely and accurate evaluation. This presents more of a challenge to state agencies than achieving adequate staffing levels. Some states are moving to increase their IT capabilities and are engaging partners in data collection efforts so as to have an independent source of information on providers and locations against which to compare plan network files.

11. **State insurance regulators report substantially increased oversight activity since the passage of the Affordable Care Act.** Some report the change as "dramatic" with "frenetic" levels of activity around the new plan designs and submissions required under the ACA. This increased activity responds to new levels of regulation regarding network adequacy and increased public scrutiny in an environment where having insurance is mandatory.

Key Recommendations

While the variety of practices and perceptions suggests there are many avenues to achieving more consistency in network standards and ensuring better access to care, the recommendations set forth below reflect the synthesis of experiences that provide evidence for approaches that are both useful and feasible.

1. **Monitor program-wide provider capacity.** Monitoring of provider total patient capacity and plan overlap should be implemented as a way to assess actual provider availability. If the monitoring process is to be effective, it must be based on program-wide standards (e.g., Medicaid managed care in one state) and cross-program standards (e.g., Medicaid managed care, the Marketplace and other insurance programs in one state) on provider capacity and a re-examination of the basis for determining provider-to-enrollee standards. On the other hand, this standard also must account for the benefits to consumers of continuity-of-care when providers participate in multiple networks so that consumers can move between plans while maintaining the same providers.

2. **Invest in network standards.** More investment is needed to develop network standards based on data to ensure that application of the standards will result in care being available when it is needed. This requires consensus on how to develop the data and build algorithms. More forums for collaboration among states and across coverage programs should be convened. This effort will provide useful information to state agencies that are struggling to develop appropriate metrics. It will also promote standardization of measures and practice, which will be useful to plans operating in multiple markets.

3. **Increase after-hours access.** Standards for after-hour appointments in primary care settings need to move from the frontier to the mainstream. This

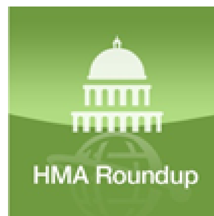
will require close collaboration with providers to develop the infrastructure and staffing organization to make complying with such standards feasible. Approaches used to establish Patient-Centered Medical Homes (PCMH) and access to telemedicine and urgent care centers could be used as models.

4. **Deploy data analytics.** More data analytics need to be employed to create "early-warning" flags for network availability problems, particularly the analysis of claims data to signal whether enrollees are resorting to emergency room and out-of-network care to deal with network access problems and to determine if specialty care is occurring in appropriate ratios to overall utilization. Enhanced data analytics need to be employed to determine the accuracy of provider network information and enable mapping of providers to evaluate access. This may entail developing more centralized data bases on providers across a state.

5. **Increase the state insurance regulator's role in network oversight.** Given the large number of newly insured people and the importance of ensuring the integrity of insurance products when people are mandated to purchase insurance, state insurance regulators may need to reevaluate their role to encompass more oversight of ongoing performance by plans.

Link to Study

https://www.healthmanagement.com/assets/Publications/HMA-Final-Report-RWJF-Project-Provider-Network-Monitoring-Compliance-Survey-Oct-2015.pdf



HMA MEDICAID ROUNDUP

California

HMA Roundup – Don Novo (Email Don)

Field Poll Survey Reveals Low-Income Elderly Opted Out of Cal MediConnect Out of Fear of Change and Losing Personal Doctor. On October 27, 2015, *Kaiser Health News* reported that survey data released by the Field Poll showed that many of the low-income elderly have opted out of Cal MediConnect, the state's duals managed care experiment, because they feared losing their doctors and were reluctant to make any changes to their health care. Nearly 30 percent of those enrolled in the new managed care program ended up with a different personal doctor. However, once enrolled, less than 10 percent decided to leave the program. Read More

CMS Releases Risk Corridor Results; Covered California Sees Improving Health Risk. On October 26, 2015, *Health Affairs* reported that the Centers for Medicare and Medicaid Services released its risk corridor results, which showed that some insurers were not projecting premiums at a sufficient level to account for risk. Unlike most of the country, California has been enrolling a diverse population through its Covered California exchange. As a result, health risk scores for enrollees in individual plans have stabilized in the second year, with risk more evenly distributed across the plans. Additionally, overall risk score for enrollees with chronic conditions has decreased. This all allowed California's premium growth for 2016 to be lower than 2015. Covered California's premiums in 2016 are only increasing by a weighted average of 4.0 percent. Read More

Survey Shows 36 Percent of Uninsured Unaware of Premium Subsidies; State to Make Changes to Exchange Site. On October 23, 2015, *Los Angeles Times* reported that Covered California survey data shows that 36 percent of uninsured Californians are unaware of premium subsidies available under the health law. Officials say this is a problem since consumers often cite high costs as the reason they do not sign up. Peter Lee, executive director of Covered California, stated that the exchange will make changes to the website to better show the potential savings. Officials found that consumers stop shopping after seeing the total premium, without looking farther down where it shows the discounted amount. Read More

California Leads on Prescription Drug Cost Controls. On October 24, 2015, *San Jose Mercury News* reported that California has among the most aggressive effort to tackle prescription drug profits. The Covered California exchange became the first in the nation to apply a cap on out-of-pocket costs for drugs treating life-threatening conditions. The cap limits co-payments to $250 per drug per month for outpatient prescriptions. Inpatient medication, such as lifesaving intravenous

medication administered at hospitals, will not benefit from the cap. However, some critics say price caps will increase premiums for everyone else. Read More

Two Reports: California Palliative Care Improving; More Services needed to Meet Patient Demand. On October 22, 2015, *San Jose Mercury News* reported that California's palliative care is improving, with 74 percent of hospitals in the state offering some type of palliative care program. The national average is 66 percent. However, more services are needed to meet patient demand. Most care was centered at large and nonprofit facilities in urban parts of the state. Specifically, the state needs more specialists and certification programs, as well as reliable funding and better standardization of care. Read More

California to Receive $982,373 for Community Mental Health Clinic Program Trial. On October 22, 2015, *California Healthline* reported that 24 states will be granted $22.9 million for community mental health clinics. States will use the grant money to prepare applications for a two-year trial program for clinics. In 2017, eight states will be awarded funding. Read More

CMS Grants California Waiver to Change Medicaid Hospital Admission Process. On October 19, 2015, *Modern Healthcare* reported that a newly approved waiver will launch a two-year process for hospitals to voluntarily transition to a more streamlined process for admitting Medicaid patients. Hospitals will be able to forgo the pre-authorization process and instead follow established national clinical guidelines. Eleven hospitals will receive education and training starting early 2016. By 2018, the state intends to have all hospitals using the new process. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Healthy Kids Dental Benefits Coverage. On October 26, 2015, the Florida Healthy Kids Corporation (FHKC) released the ITN to secure comprehensive dental services for enrollees in the Healthy Kids component of the Florida KidCare program. Current Dental Benefit Contracts in Florida's 67 counties will reach their termination date on June 30, 2016. The proposed effective date for implementation of awards under this ITN is July 1, 2016. All existing dental plan contracts have then reached their final renewal period and cannot be extended. Separate health plan contracts are not affected by this ITN. Total enrollment in the program is 159,468 children as of October 2015. The ITN materials can be viewed here.

FHKC Dental Benefits Timeline	
Activity	**Date**
Final ITN Released	10/26/2015
Letters of Intent Due	11/2/2015
Bidders' Conference	11/6/2015
Proposal Deadline	11/20/2015
Personal Interview	TBD
Anticipated Award	1/27/2016
Implementation Date	7/1/2016

Iowa

Court Finds Issue with Medicaid Director Communications during RFP Review Period. On October 27, 2015, *The Des Moines Register* reported that the state acknowledged improper communications between the Medicaid Director, an insurance company consultant, and a former lawmaker during the review period to choose the state's Medicaid managed care companies. The Iowa Department of Human Services insists that the communications had no bearing on Iowa's selection of insurers. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

MLTSS Update. On October 19, 2015, Nancy Day, Director of the Division of Aging Services provided the Medical Assistance Advisory Council (MAAC) with an update on the MLTSS enrollment figures by service setting. The state has 42,247 individuals receiving long term care. Of those, 43.6 percent are enrolled in a managed care organization, and the remainder are under Medicaid fee-for-service (FFS). The majority of individuals under FFS were in nursing facilities at the time of MLTSS implementation and were grandfathered to remain carved out of managed care. Twenty-four percent of the individuals receiving MLTSS under managed care reside in a nursing facility. The state's overall nursing facility population has decreased since the MLTSS implementation by more than 2,800, while the number of individuals receiving home and community based services has increased by more than 2,700. The majority of New Jersey residents on Medicaid who are receiving long term care are age 65 or over (over 76 percent) and dually eligible for Medicare and Medicaid (90 percent). Only a fraction of the 42,247 Medicaid enrollees receiving long term care are children (or .006 percent).

Large Numbers of Medicaid Expansion Enrollees are Failing to Renew Medicaid Eligibility. On October 19, 2015 at a meeting of New Jersey's Medical Assistance Advisory Council (MAAC), Medicaid Director Valerie Harr, notified MAAC members that a significant number of individuals who became eligible for Medicaid through the expansion have not responded to mailings and telephone calls to remind them to renew their eligibility. NJ Spotlight reported on this on October 22, 2015 and noted that this puts many New Jersey residents at risk for losing Medicaid coverage and for incurring tax penalties if they do not have other health insurance coverage in 2016. Read More

Nurse Licensure Compact Bill Would Allow Nurses to Practice Across State Lines, Advance Telemedicine in New Jersey. On October 22, 2015 NJ Spotlight reported on S3167, sponsored by Senators Jim Whelan and Joseph Vitale and co-sponsored by Senator Madden, which would enact a Nurse Licensure Compact (NLC), enabling nurses to hold a multistate license issued by their home state. The NLC would address the increasing use of advanced communication technologies and expanded mobility of nurses, calling for greater coordination across states. Nurses would be permitted to practice nursing in any other state that has joined the compact. It would further establish an Interstate Commission of Nurse Licensure Compact Administrators to join the party states. To date 25 other states have joined the compact, which becomes effective when a majority of the states join it. The next state that signs on would make the compact effective. Read more.

RLI Released to Launch Behavioral Health Homes in Atlantic, Cape May and Monmouth Counties. The state's Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) has issued a Request for Letters of Interest (RLI) to provide start-up funding for capacity building of behavioral health homes (BHH) in Atlantic, Cape May and Monmouth counties. According to the RFI, awards of up to $50,000 each are available to cover "costs associated with an applicant's preparation to deliver BHH services including, but not limited to: purchasing or leasing of equipment; purchasing or making necessary changes to existing Electronic Health Records (EHR); participating in a Health Information Exchange (HIE); costs to recruit, orient and train staff; and the cost of renovations or refurbishing of existing buildings to co-locate or partially co-locate primary medical care services." Proposals in response to the RLI must be received by 4:00 pm on November 12, 2015. A copy of the RLI can be found here.

Opioid Overdose Recovery Program Grant Funds Available. The Department of Human Services, DMHAS issued notice of a two year funding opportunity for an Opioid Overdose Recovery Program. According to the notice, this program would "use Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment." DMHAS expects to make one award in either Atlantic or Passaic county. An RFP has been posted to the Department's website and may be found here. Proposals are due by 4:00 pm on November 24, 2015.

New Mexico

Officials Request Additional $85.2 Million Funding for Rising Medicaid Costs. On October 28, 2015, *Albuquerque Journal* reported that Human Services Department officials requested an additional $85.2 million in funding for rising Medicaid costs. Medicaid funding for the current fiscal year budget is $891.7 million. The proposal for additional money would raise funding to $976.9 million. Human Services Secretary Brent Earnest stated that Medicaid enrollment is rapidly increasing. By mid-2017, enrollment is expected to be over 919,000. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

CMS to Attract Providers in Effort to Turn Around Struggling Duals Demonstration. On October 21, 2015, *Modern Healthcare* reported that CMS will try to attract providers for New York's struggling Fully Integrated Duals Advantage demonstration to try to draw patients and other beneficiaries. As of Sept. 1, New York has 7,280 people enrolled in the duals demonstration and 57,375 who have opted out. During the launch this year, 124,000 were eligible. A white paper released this month by the New York State (NYS) Department of Health wrote that providers were not encouraging patients to enroll and patients were opting out in fear of losing their current providers. Read More

Children's Health Home Implementation Timeline Updated. The NYS Department of Health has announced that Children's Health Home implementation will be delayed Statewide for another nine months. Until yesterday, the planned implementation was January 1, 2016. They have now

announced that all Children's Health Home Services will be delayed until September, 2016. The conversion for NYS Adult Health Home providers to new rate structures and billing procedures is also delayed until September, 2016. Legacy mental health, substance use and HIV case management providers will continue to bill Medicaid directly for Adult Health Home services using legacy rates for service dates up to and including **August 2016**. The NYS Medicaid Analytics Performance Portal (MAPP), the State's performance management system that was scheduled to go live this month has also been delayed. Phase I implementation of the portal is now scheduled for March, 2016. New dates and detailed information about the MAPP are available here. For additional information, contact Meggan Schilkie: mschilkie@healthmanagement.com

North Carolina

Dee Jones Named Operations Director for North Carolina's New Medicaid Division. On October 22, 2015, *WRAL.com* reported that Dee Jones, current operations director for the state's Medicaid program, was named to be operations director of the new Division of Health Benefits created under House Bill 372, which shifts Medicaid to managed care from fee-for-service. The division will operate on separate personnel rules from the majority of state government. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Upgrades a Tool in the Drug War. Governor Kasich announced this week that Ohio will invest up to $1.5 million to upgrade OARRS, the Ohio Automated Rx Reporting System used by pharmacists and prescribers to quickly check patient electronic medical records and opiate prescription histories. Pharmacies and prescribers are required by law to report data about controlled substances. In 2014 the number of prescriber and pharmacist's queries of OARRS increased from 778,000 in 2010 to 9.4 million. According the Ohio Department of Health, last year the number of prescription opiates dispensed to Ohio patients decreased by more than 40 million doses. At the Governor's announcement about the upgrade Monday, he also said that opioid abuse and heroin addiction remain problems that the state will continue to battle aggressively. "I think the message to Ohioans, despite the fact that we still see a tsunami of drugs, is that we're not going to give up in this state until we win more and more battles and maybe ultimately the war." Read More

Medicaid Cuts to Nursing Services Worries Families. On October 26, 2015, *The Columbus Dispatch* reported that medically fragile Ohioans and their families who rely on nursing services through the Medicaid program are concerned over recent Medicaid cuts and are trying to appeal the state. It's unclear how many people might be affected statewide, but state officials insist there's been no policy change when it comes to private-duty nursing care. At least seven individuals in Delaware County have been affected by a proposed reduction or elimination of their nursing services in recent months, with the potential of 40 families to be affected countywide. The Ohio Association of County Boards of Developmental Disabilities is looking to see if this is a statewide trend. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Advisory Committee October 22, 2015 Meeting – Office of Medical Assistance Programs Update. Despite Pennsylvania's budget impasse, providers who are participating in the Medical Assistance program and receiving payments through DHS are receiving payments, according to Leesa Allen, Deputy Secretary, Office of Medical Assistance Programs (OMAP). Awards for the Physical Health HealthChoices RFP will be made in mid-January. The Department of Human Services also issued a Request for Information related to the Medical Assistance Transportation Program. Responses to the RFI are due November 20.

Medical Assistance Advisory Committee October 22, 2015 Meeting – Office of Mental Health and Substance Abuse Services Update. The Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with CMS has selected Pennsylvania to receive a grant for the planning of Certified Community Behavioral Health Clinics. CMS envisions integrated services, this process will be impacted by Shared Space policy statement issued by the Department. For more details, please see the article below.

Medical Assistance Advisory Committee October 22, 2015 Meeting – Office of Long Term Living Update. A procurement for Managed Long Term Services and Supports, called Community Health Choices, will occur in November. An RFP and Draft Agreement will be issued November 16, 2015. There will be a comment period for Draft Agreement that will not be impacted by the RFP "blackout period". OLTL will set up meetings between provider groups and MCOs in early November, as well as issuing an open invitation to MCOs "LTSS 101".

PA Receives $886K Award in CCBHC Behavioral Disorder Funding. The Substance Abuse and Mental Health Services Administration (SAMHSA) – in collaboration with both the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE) – recently awarded an $886,200 grant to the Pennsylvania Department of Human Services (DHS) for the planning of Certified Community Behavioral Health Clinics (CCBHCs). Pennsylvania's award, the first of a two-phase process, is made possible via the Protecting Access to Medicare Act of 2014 which actively promotes a "comprehensive effort to integrate behavioral health with physical health care." The planning grant will be used by DHS to certify CCBHCs, solicit input from stakeholders, establish prospective payment systems for demonstration reimbursable services, and prepare an application to participate in the demonstration program." Read More

Pennsylvania's DHS issues Procurement for MRT Services. On October 22, 2015, Pennsylvania's Department of Human Services Office of Income Maintenance (OIM), which administers a Disability Advocacy Program (DAP) that provides assistance to public assistance recipients who potentially may be eligible for Social Security disability, issued a solicitation. As part of DAP, OIM uses a Medical Review Team to review public assistance recipients' medical, social, and vocational histories to determine if they can be certified as disabled under Social Security Administration rules. DHS seeks an entity that is able to provide these MRT services. Proposals are due December 4, 2015. Read More

Puerto Rico

Obama Urges Congress to Grant Puerto Rico Bankruptcy Protection and Broaden Medicaid Access. On October 21, 2015, *The Washington Post* reported that the Obama administration is urging Congress to grant bankruptcy protection available only to territories. Puerto Rico is $73 billion in debt and is expected to run out of money by the end of the year. In a fact sheet released by the administration, it states that Puerto Rico will need to choose between repaying its debts and maintaining vital public services. The administration is also recommending Congress broaden access to Medicaid, adding money to the health care system. Read More

Virginia

Justice Department Seeks Major Changes to State Care of the Severely Disabled; Judge Postpones Decision. On October 22, 2015, *The Washington Post* reported that the Justice Department is increasing pressure on the state to boost construction of privately run group homes, increase funding for more Medicaid vouchers paying for care outside of institutional settings, and overhaul the system of care for children with intellectual and developmental disabilities. The Justice Department claims that the state is not trying hard enough to make the reforms outlined in a 2012 federal settlement. It will seek a contempt-of-court order if the state does not speed up its efforts. With seven years left to achieve the goals, the state has moved approximately half of the disabled residents who were institutionalized but has been slow in its financing efforts to build smaller group homes for those left behind. Read More In a court hearing to increase pressure, a U.S. District Court Judge postponed the decision on whether to force Virginia so speed its efforts in overhauling system until December. Read More

National

HHS Analysis Finds Silver Plan Premiums to Rise 7.5 Percent Next Year. On October 27, 2015, *Kaiser Health News* reported that according to an analysis by the U.S. Department of Health and Human Services, premiums will rise 7.5 percent for the second-lowest-cost silver insurance plan to be offered in 2016 in 37 federally-run marketplaces. The largest premium increase will be in Oklahoma – 36 percent. Alaska, Montana, and New Mexico will see premiums rise above 25 percent. The largest drop will be in Indiana, where premiums will decrease by 13 percent. A separate Kaiser Family Foundation analysis found that premiums for benchmark plans in major cities in 48 states and the District of Columbia would rise an average of 10.4 percent next year before accounting for the tax credits. Read More

Increased CMS Oversight Slows Medicaid Managed Care Rate Setting; Process Less Predictable. On October 26, 2015, *Modern Healthcare* reported that, after CMS decided to take a more direct role in approving rates, health insurers say the rate-setting process for Medicaid managed care plans have become less predictable and more expensive. The new oversight means higher costs for state Medicaid agencies because CMS sends detailed queries to actuaries as it reviews the rates, back and forth, adding billable hours. However, increased CMS involvement has added more uniformity to the process from state to state. Read More

Medicare Study Finds Costs of Care for Dementia Exceeds Other Diseases. On October 26, 2015, *The New York Times* reported that a study found that the disease with the greatest health care costs in the last five years was dementia. The average total cost of care for a person with dementia over the five years was $287,038 and the average out-of-pocket cost was $61,522. Dr. Amy S. Kelley, a geriatrician at Icahn School of Medicine at Mt. Sinai in New York, conducted the study using data from the Health and Retirement Survey, which links to the Medicare database and the National Death Index. Read More

CMS Issues Proposed Methodology for Determining Funding for Basic Health Program. The Centers for Medicare & Medicaid Services (CMS) issued a proposed notice establishing the methodology for determining federal funding for the Basic Health Program (BHP) in program years 2017 and 2018. The BHP provides states with the option to establish a health benefits coverage program for low-income individuals as an alternative to Health Insurance Marketplace coverage under the Affordable Care Act. This proposed notice is substantially the same as the final notice for the program year 2016. This proposed BHP payment notice for 2017 and 2018 is on display here.

INDUSTRY NEWS

Walgreens to Buy Rite Aid for $17.2 Billion. On October 27, 2015, *Bloomberg Business* reported that Walgreens Boot Alliance Inc. agreed to acquire Rite Aid Corp. for $9.4 billion, or approximately $17.2 billion including debt. The acquisition, which combines the second- and third-largest drugstore chain would put Walgreens ahead of current market leader CVS Health Corp. The deal is expected to close in the second half of next year. Read More

Anthem Net Income Up 3.8 Percent. On October 28, 2016, Anthem released its 2015 third quarter earnings. Net income was $654.8 million, or $2.43 per share, up from $630.9 million, or $2.22 per share, in the third quarter of 2014. Enrollment grew 0.5 percent to 38.7 million. Read More

Universal Health Services Net Income Up 81.5 Percent. On October 27, 2015, Universal Health Services released its 2015 third quarter earnings. Net income was $150.3 million, or $1.48 per share, up from $82.8 million, or $0.82 per share, in the third quarter of 2014. Read More

Centene Revenue Increases 31 Percent Year Over Year. On October 27, 2015, Centene released its 2015 third quarter earnings. The company had diluted earnings per share of $0.75. Premiums and service revenues were $5.46 billion and total cash from operations was $62 million. Read More

Magellan Health Reports Net Loss of $7.8 Million, Adjusted Net Income of $18.9 Million. On October 27, 2015, Magellan Health released its 2015 third quarter earnings. The company reported net revenue of $1.2 billion, segment profit of $55.3 million, and a net loss of $7.8 million, or a loss of $0.31 per diluted share. However, the company reported adjusted net income of $18.9 million and adjusted earnings per share of $0.76. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 16, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January 15, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	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	Aug-15	Sep-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452	116,470	117,307
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170	51,631	49,663
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671	17,518	17,337
Michigan					9,216	14,867	28,171	35,102	42,728
New York	17	406	539	6,660	7,215	5,031	7,122	9,062	8,028
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871	62,418	59,697
South Carolina		83	1,205	1,398	1,366	1,317	1,388	1,380	1,530
Texas			58	15,335	27,589	37,805	44,931	56,423	45,949
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507	29,200	29,176
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**	**379,204**	**371,415**

HMA NEWS

New this week on the HMA Information Services website:

- Medicaid Managed Care Enrollment for 300+ Plans in 36 States, Plus Ownership and For-Profit vs. Not-for-Profit Status, Updated Oct-15
- **North Carolina** Lawmakers Agree to Shift to Medicaid Managed Care, Sep-15
- Public documents such as the **Montana** HELP Program TPA Proposals and RFP, Jul-15 and the **Ohio** HCBS Revised Transition Plan Draft, Oct-15
- Plus upcoming webinars *"Rethinking SBIRT: Lessons from the Past 10 Years, Strategies for the Next 10"* and *"New Models for FQHC Partnerships with Hospitals"*

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.

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