HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

NEBRASKA ISSUES MEDICAID MANAGED CARE REQUEST FOR PROPOSALS (RFP)

This week, our *In Focus* section reviews the request for proposal (RFP) issued by the State of Nebraska on October 21, 2015, for the statewide rebid of their Medicaid managed care programs, integrating physical and behavioral health for nearly all Medicaid beneficiaries. The integrated statewide program, to be known as Heritage Health, will cover around 240,000 members with more than $1 billion in annual Medicaid spending when fully implemented. A long-planned separate RFP for managed long-term supports and services (MLTSS) is still expected to be released in the coming year, as MLTSS services are not included in this RFP.

Covered Populations, Estimated Spending

Heritage Health will cover nearly all categories of Medicaid assistance, including children, families, individuals who are aged, blind, or disabled (ABD), CHIP, foster care populations, individuals covered under home and community based services (HCBS) waivers (including individuals with

intellectual/developmental disabilities and those with traumatic brain injuries), and enrollees in the breast and cervical cancer program (BCCP).

Based on preliminary data for covered populations provided by the state, the blended per-member per-month (PMPM) rate for Heritage Health is anticipated to be roughly $400, with estimated annual spending of more than $1.1 billion.

Covered Population	Avg. Monthly Members (FY 2015)	Estimated PMPM Rate	Estimated Total Spending
ABD	15,054	$1,539.57	$278,127,093
CHIP	35,441	$184.59	$78,503,489
Children/Families	131,137	$260.38	$409,737,479
Foster Care	8,702	$506.44	$52,885,936
Katie Beckett	69	$13,069.41	$10,769,194
Maternity	738	$8,133.74	$72,064,928
LTSS Institutional	7,595	$477.51	$43,519,420
LTSS HCBS	8,930	$745.05	$79,837,472
Dual Eligible (Non-LTSS)	21,553	$314.78	$81,413,333
Total (Blended)	**229,219**	**$402.40**	**$1,106,858,344**

The only populations excluded from mandatory Heritage Health enrollment are Program of All-Inclusive Care for the Elderly (PACE) enrollees, Medicare enrollees with Medicaid coinsurance/deductibles only, and non-citizens only eligible for Medicaid for emergency reasons.

Covered, Excluded Services

As noted above, this RFP integrates behavioral health and physical health services together under a single contract. Currently, behavioral health services are managed by a separate behavioral health Prepaid Inpatient Health Plan (PIHP). The new contracts will also carve-in pharmacy benefits, previously excluded from physical health managed care.

All LTSS services are excluded from Heritage Health, as are dental services.

Value-Added Service Priorities

More than 5 percent of total RFP response points are dedicated to value-added services, for which the state has outlined the following priorities:

- Reduction in non-emergent use of the emergency department (ED) through increased access to after-hours care, urgent care, same-day appointments, data sharing with physicians and hospitals, member education, and/or other interventions identified by the managed care organization (MCO).
- Improved birth outcomes through prenatal, postnatal, and inter-pregnancy care, reduction in early elective deliveries and Cesarean sections, promotion of vaginal birth after Cesarean section, and other interventions identified by the proposer.
- Improved outcomes through coordination and integration of prevention-focused physical and behavioral health services delivered in community-based settings.

Provisions for MLR, Quality Withhold, and Risk Corridors

Awarded Heritage Health MCOs will be required to meet a minimum medical loss ratio (MLR) of 85 percent.

A 1.5 percent withhold will be applied under the Quality Performance Program, which can be earned back by achieving quality standards outlined in the RFP library.

A risk corridor will be applied to MCO rates, limiting annual profits/losses to 3 percent.

Contract Awards and RFP Timeline

The state intends to award two or three statewide contracts for Heritage Health, with an initial contract term of five years and two optional one-year extensions, for a total potential contract term of seven years.

Proposals are due to the state on December 22, 2015, with a plan to announce intent to award on January 29, 2016, and final contract awards on March 1, 2016. The new contracts will go live on January 1, 2017.

Milestone	Date
First Round of Q&A Posted	November 16, 2015
Second Round Questions Due	November 23, 2015
Second Round of Q&A Posted	December 7, 2015
Proposals Due	December 22, 2015
Letter of Intent to Contract Posted	January 29, 2016
Contract Award Finalized	March 1, 2016
Implementation	January 1, 2017

Evaluation Criteria

Proposals will be evaluated on the criteria in the table below, with a total of 2,400 points available (2,250 if oral interviews are not held). Care management, quality management, and utilization management make up more than 25 percent of total points available.

Evaluation Criteria	Points	% of Total
Corporate Overview	130	5.4%
Technical Approach		
Eligibility and Enrollment	65	2.7%
Business Requirements	70	2.9%
Staffing Requirements	105	4.4%
Covered Services/Benefits	95	4.0%
Value-added Services	130	5.4%
Member Services and Education	100	4.2%
Grievances and Appeals	20	0.8%
Provider Network Requirements	150	6.3%
Provider Services	105	4.4%
Subcontracting Requirements	25	1.0%
Care Management	235	9.8%
Quality Management	200	8.3%
Utilization Management	175	7.3%
Program Integrity	60	2.5%
Provider Reimbursement	65	2.7%
System and Technical Requirements	145	6.0%
Claims Management	120	5.0%
Reporting and Deliverables	40	1.7%
Transition and Implementation	120	5.0%
FFS Claims Management	95	4.0%
Oral Interviews, (if required)	150	6.3%
Total Points Possible	**2,400**	

Current Medicaid Managed Care Market

As of June 2015, there were a little over 167,000 enrollees in one of three physical health MCOs, with Aetna claiming just over half the total market. Magellan holds the current behavioral health contract for the entire state.

Medicaid Physical Health MCO	Enrollment June 2015	% Mkt Share
Aetna	84,765	50.7%
UnitedHealthcare	58,406	34.9%
AmeriHealth Caritas	24,110	14.4%
Total Enrollment	**167,281**	

Source: HMA Investment Services (SNL Financial, NAIC, HMA)

Link to RFP Documents

http://das.nebraska.gov/materiel/purchasing/5151/5151.html

HMA Medicaid Roundup

Alabama

Governor Hints at Rural Health Care Programs in Upcoming State of the State. On November 2, 2015, *AL.com* reported that Governor Robert Bentley has hinted that details on a program or programs concerning rural health care will be unveiled in his State of the State address in February. The Governor's comments came in response to a question about the potential for expanding Medicaid, and he indicated that the program or programs will address more than just health care. Read More

Arkansas

Governor Hutchinson to Remove Two out of Seven Points from Medicaid Proposal. On October 29, 2015, *Arkansas Democrat-Gazette* reported that Governor Asa Hutchinson will follow The Stephen Group's recommendations to remove two of the seven points in his private-option Medicaid proposal. He will no longer eliminate a nonemergency medical-transportation benefit for private-option enrollees nor require that the poorest enrollees be served by traditional fee-for-service Medicaid program instead of the private option. Additionally, he supports the consultant's recommendation to hire managed-care companies to provide Medicaid benefits for high cost populations with oversight by the state. Read More

California

HMA Roundup – Don Novo (Email Don)

DHCS, CMS Announce Conceptual Agreement of Major Components of 1115 Waiver Renewal. In a Stakeholder update issued on October 31, 2105, the California Department of Health Care Services (DHCS) outlined the core elements of the conceptual agreement reached with CMS for renewal of the California Bridge to Reform Demonstration. The core elements include:

- Global Payment Program (GPP) for services to the uninsured in designated public hospital (DPH) systems. The GPP converts existing Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding – which is hospital-focused and cost-based-- to a system focused on value and improved care delivery. The funding of the GPP will include five years of the DSH funding that otherwise would have been allocated to DPHs along with $236M in initial federal funding for one year of the SNCP component. SNCP component funding for years two through five would be subject to an independent assessment of uncompensated care.

- Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals (DMPH), known as PRIME (Public Hospital Redesign and Incentives in Medi-Cal). The federal funding of PRIME for the DPHs is a total of $3.2655 billion over the five years of the Waiver, which includes $700 million for each of the first three years, $630 million in year four, and $535.5 million in year five. The federal funding for the DMPHs is a total of $466.5 million over the five years of the Waiver, which includes $100 million for each of the first three years, $90 million in year four, and $76.5 million in year five.
- Dental transformation incentive program. The funding of this program is $750M in total funding over five years.
- Whole Person Care Pilot (WPC) program that would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations. The funding of this program would be up to $1.5B in federal funds over five years.
- Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries.
- Independent studies of uncompensated care and hospital financing.

Read More

Diverse Enrollment Leads to Stabilized Risk Scores in Covered California Plans. On October 27, 2015, *California Healthline* reported on *Health Affairs* blog post looking at risk scores for Covered California enrollees. The *Health Affairs* writers found that risk scores in California have stabilized, and contends this is a key to stability of premiums and the overall Marketplace. According to the blog post, other states could follow California's lead and use the state's efforts as a model. Read More

Signatures Gathered for Statewide Ballot Initiative on Drug Pricing. On November 3, 2015, the *San Jose Mercury News* reported that advocates have gathered well over the required number of signatures to move ahead a potential ballot measure on drug pricing. The initiative, which could be on the ballot next fall, would require state programs, such as Medi-Cal, to pay rates for prescription drugs no higher than those negotiated by the U.S. Department of Veteran Affairs. The measure, known as the "California Drug Price Relief Act," would apply to any program where the state ultimately pays for a drug, even if the state does not purchase the drug directly. Read More

San Francisco to Implement Law for Compulsory Mental Health Treatment. On October 26, 2015, *KQED News* reported that as of November 1, San Francisco County will be the fifth in the state to implement Laura's Law, a measure allowing judges to mandate treatment for individuals with severe mental illness. The measure is targeted toward people who are resisting care and have a history of hospitalization, incarceration or violence. Family members, mental health providers or police officers can petition the court to compel patients into outpatient treatment, though patients cannot be forced to take medication. Read More

Inspector Deems Care at North Kern State Prison Inadequate. On October 23, 2015, *The Sacramento Bee* reported that state inspectors have deemed that medical care at North Kern State Prison remains below acceptable levels. As the state works to retake control of prison health care from under years of federally

mandated receivership, this is now the second prison found to be inadequate, while four other prisons have been deemed adequate. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Hospital Price Gouging Complaints Cite Costs, Unexpected Bills, Insurance, and Gov. Scott. On November 2, 2015, *Politico Florida* reported that in response to Gov. Rick Scott's request for hospital price gouging stories, 85 complaints were submitted. Most of the submissions came from those who said they were insured. The complaints cite numerous issues, including costs of care, unexpected ER bills, costs of health insurance, and comment on Gov. Scott. The submissions are posted on the Commission for Health Care and Hospital Funding's website. Read More

Florida Children's Medical Services Panel Holds First Meeting. On October 30, 2015, *Sayfie Review* reported that the first meeting of the Children's Medical Services Managed Care Plan Technical Advisory Panel discussed the difficult transition and challenges. The panel consists of experts to aid in the continued transition of the Children's Medical Services plan from a direct service provider network to a managed care plan. It was created by the State Department of Health after a storm of criticism when thousands of children lost their eligibility in the transition process. In September, an administrative law judge ruled against the department's eligibility-screening tool. The screening process has been suspended, while a rule-making process to approve a new screening tool is underway. Read More

Kansas

Lawmakers Urged to Look at Indiana Model for Expansion. On November 3, 2015, the *Kansas Health Institute* reported that Medicaid expansion supporters are pushing for lawmakers to follow Indiana's example to expand Medicaid, inviting a delegation of Indiana hospital officials to speak to a panel that included a number of state legislators. Despite a Republican Governor and Legislature, both opposing the ACA, a deal was reached with CMS to expand coverage in Indiana through high-deductible health plans, personal spending accounts, and requiring individuals to pay a portion of premiums. The Kansas Hospital Association is reportedly preparing a plan to bring to the legislature. Read More

Maryland

Maryland Healthy Smiles Contract Awarded to Scion Dental. On November 3, 2015, Scion Dental, a SKYGEN USA benefit management company, announced that it has been awarded a contract by the Maryland Department of Health and Mental Hygiene to manage dental benefits for roughly 650,000 Medicaid beneficiaries through the Maryland Healthy Smiles program. Scion's contract goes live on January 1, 2016. Read More

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Six Medicaid Plans Appeal State's Contract Rebid Decisions. On October 30, 2015, *Crain's Detroit Business* reported that HAP Midwest, Sparrow PHP, Meridian, Molina, Fidelis SecureCare, and Total Health Care appealed the state's contract rebid decisions worth $42 billion. The appeal decision will be made mid-November. Michigan bid out the contracts based on a 10-region approach, rather than by each county. Read More

Minnesota

State Begins Process of Transitioning UCare Members. On November 3, 2015, the *Minneapolis Star Tribune* reported that the state has begun the process of shifting more than 350,000 Medicaid beneficiaries who were enrolled with UCare to other managed care plans. UCare lost its contract with the State in all but one county under a competitive bid of the state's Medical Assistance programs, which is estimated to generate $450 million in savings. Read More

Missouri

Local Health Care Providers Concerned About Medicaid Overhaul. On October 31, 2015, *Springfield News-Leader* reported that some local health care providers say that the state's plan to privatize Medicaid may limit access and possibly reduce reimbursements. Lawmakers predict the state' plan will cut state costs. The switch will affect most Medicaid families in Greene County. Privatization is expected to be completed by next summer. Read More

Montana

CMS Approves Montana Medicaid Expansion Proposal. On November 2, 2015, CMS officials approved Montana's Medicaid expansion waiver proposal, paving the way for 70,000 Montanans to become eligible on January 1, 2016. Montana will become the 30th state to adopt the Medicaid expansion provisions under the ACA, though its waiver includes provisions requiring beneficiaries to pay premiums that amount to 2 percent of their income. The state has named Blue Cross and Blue Shield of Montana, the state's largest insurer, as the administrator of the expansion program. Read More

Nebraska

Gov. Ricketts Opposes Medicaid Expansion. On October 29, 2015, *JournalStar.com* reported that Gov. Pete Ricketts stated that he does not trust the government to honor its commitment to pay at least 90 percent of costs of the proposed Medicaid expansion. He said it will cost the state $158 million over six years. Read More

Nevada

Advocates Concerned Over Proposed Medicaid Privatization. On October 30, 2015, *Las Vegas Sun* reported that advocates are concerned over a proposed change to privatize Medicaid for patients who are elderly, blind, or, disabled. It is unclear if the change will affect that entire population or a subset that receives nonmedical services through waiver programs. Advocates fear how privatization will affect access to services, potential gaps in service, and the quality of service. The move to managed care may result in stricter eligibility requirements and reduced services for those who are already vulnerable. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Statewide Integrated Population Health Database Proposed. On October 19, 2015, Senators Stephen Sweeney, Kevin O'Toole, and Joseph Vitale introduced a bill (S3220) to establish a statewide, integrated population health data system ("iPHD"). The system would aggregate de-identified social services data received by individuals who are served by, for example, the state's Medicaid program, Supplemental Nutrition Assistance Program, Low Income Home Energy Assistance Program and Social Services for the Homeless program. It aims to remove existing barriers to accessing data and to find holistic solutions to the state's health and social service challenges. Read More

Marketplace Premiums for State's Benchmark Plan Increase by 5 Percent – Less Than the Average Increase of 7.5 Percent Across 37 States. On October 26, 2015 *NorthJersey.com* reported that New Jersey residents will experience lower increases in their health coverage through the Affordable Care Act compared to residents in other states. Nineteen states will experience double digit increases in the premiums of their benchmark plans. Open enrollment season began on November 1, 2015 and will continue through January 31, 2015. More than 250,000 New Jersey residents received Marketplace coverage in 2015. Read More

State Releases Self-Help Clearing House RFP. On November 2, 2015 the Department of Human Services, Division of Mental Health and Addiction Services issued a Request for Proposals for an entity to operate and manage the statewide New Jersey Self-Help Clearinghouse. Annual funds of $89,000 would be available to run this service. The contractor would be responsible for assisting the public and professionals in finding and establishing self-help groups with a toll-free helpline, online database, group resource handouts, training, and more. A mandatory bidders' conference will be held on November 13, 2015 and proposals are due on December 10, 2015. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Cleveland Clinic Takes Over Akron General Health System. The Cleveland Clinic announced November 2, 2015 that they have both state and federal approval to move forward on their acquisition of Akron General Health System. Last year's $100 million deal for minority ownership of the health system gave the Clinic the option to fully acquire Akron General after a year. According to

Ohio.com, with the deal Cleveland Clinic assumes responsibility for all of Akron General's debt and will make nearly $30 million in capital improvements in the first year. Akron General facilities are keeping the Akron General name under the deal. Also under the deal, a new emergency department will be built with construction beginning in the first quarter of 2016. A new outpatient physician's office facility in Portage County will also open. Read More

Ohio Department of Health Partners with CDC on Heroin Fight. The Centers for Disease Control and Prevention are onsite to help Ohio in its fight against heroin. Specifically, the six person team will be looking at deaths when heroin has been laced with fentanyl. According to the *Washington Times*, Ohio experienced 502 fentanyl related deaths last year, up from 84 the year before. Fentanyl is 30 to 50 times more powerful than heroin, and addicts often don't know their heroin has been laced with fentanyl. Ohio is working with the CDC to analyze Ohio's fentanyl related drug overdose data. The CDC will compare victims of this type of overdose with people who died from painkillers and heroin in an attempt to determine what puts people at risk for overdose and how to prevent it. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Updates in Pennsylvania's MLTSS procurement process. In advance of the January 2017 transition to Community HealthChoices and its upcoming procurement, Pennsylvania's Department of Human Services (DHS) has adjusted the timeline to incorporate more stakeholder feedback. DHS will release for public comment a draft RFP and draft program requirements on November 16, 2015. Comments will be due on December 11. DHS also plans to release additional draft materials and information relative to the enrollment/eligibility process for public comment on December 14. Comments will be due January 8. Once comments have been reviewed, DHS will officially release the RFP for a 60 day response period.

Updates from Medical Assistance Advisory Committee MLTSS Subcommittee.

Office of Long Term Living (OLTL) Update. Jen Burnett, Deputy Secretary for OLTL, informed the subcommittee that the state budget was on day 125 of the impasse and had no other budget news. OLTL received over 1200 Comments in response to the Managed Long Term Services and Supports (MLTSS) Concept Paper. As Pennsylvania prepares to switch to managed long term care, the department will expand education efforts and outreach to hospitals to inform them of Home and Community Based Services (HCBS) resources so they are aware of Nursing Facility alternatives. The MLTSS initiative will provide parity between nursing facility and HCBS eligibility requirements.

CMS Authority Next Steps. Virginia Brown, Director of the Bureau of Policy and Regulatory Management informed the subcommittee that DHS has decided to pursue a concurrent 1915b and 1915c waiver to implement managed care with HCBS. A 1915b waiver allows the state to implement mandatory managed care. A 1915c waiver addresses eligibility and providing LTSS in the community. Currently there are five Pennsylvania Medicaid waivers under 1915c. These will be combined into one 1915c

waiver for Community HealthChoices and DHS will develop a 1915b waiver. Both waivers will be released for Public Comment before they are submitted.

Aetna Signs ACO Agreements. Aetna recently announced accountable care organization (ACO) arrangements with Mercy Accountable Care and Quality Health Alliance in Blue Bell, offering southeastern Pennsylvania commercial customers a way to improve care quality, efficiency and patient experience. The plans' respective parent organizations, Mercy Health System and St. Mary Medical Center, both affiliated with Trinity Health, aim to deliver a value-based, patient-centric and preventative model of healthcare delivery. The two hospitals were classified as Tier 1 providers under Aetna's Savings Plus network earlier this year. Read More

Court Rules Medicaid Managed Care Rates Are Public Information. On October 28, 2015, *Law 360* reported that the Pennsylvania Supreme Court reversed a ruling protecting Medicaid managed care organizations from disclosing rates paid to subcontractors. The court stated that the rates are financial records that should be publicly accessible since they use public funds and are subject to agency approval. Read More

Governor Wolf Announces Naloxone Standing Order to Combat Heroin Epidemic. Governor Wolf stood with Physician General Dr. Rachel Levine at the Pennsylvania Medical Society as Dr. Levine signed a statewide standing order for naloxone, a medication that can reverse an overdose that is caused by an opioid drug. The governor was also joined by Secretaries of the Department of Human Services, the Department of Health and the Department of Drug and Alcohol Programs. Through the signing of this standing order, Dr. Levine has signed a prescription for naloxone to all Pennsylvanians. For more information about naloxone and how to administer it, please visit the Department of Drug and Alcohol Program's page on overdose reversal. Read More

Rhode Island

Rhode Island Names Anya Rader Wallack New Medicaid Director. On October 29, 2015, *Providence Journal* reported that the Office of Health and Human Services named Anya Rader Wallack as the new Medicaid Director, as of November 1. Wallack was previously appointed by Governor Raimondo to head the state-based health insurance market, HealthSource RI, eleven months ago. Read More

Texas

Texas Names Gary Jessee New Medicaid Director. On November 2, 2015, *The Courier* reported that the Health and Human Services Commission named Gary Jessee as the new Medicaid Director. Jessee served as the Medicaid/CHIP Division's chief deputy director for program operations. Former Medicaid Director Kay Ghahremani is retiring. Read More

Texas Asks Court to Implement Children's Therapy Cuts. On October 28, 2015, *The Texas Tribune* reported that Texas is seeking an override to a court order that stopped funding cuts to therapy for children with disabilities. Lawyers for the state claim that the District Judge had no "statutory- or rule-based right" to keep the state from cutting payments. State health officials are hoping the 3rd Court of

Appeals will overturn the decision to stop $100 million in cuts in payments to speech, physical, and occupational therapists through Medicaid. Read More

Washington

Health Officials Request to Expand Medicaid Access to Hepatitis C Drug. On October 31, 2015, *The News Tribune* reported that state health officials want to begin covering Hepatitis C medication to a wider range of patients. The state had estimated it would treat 3,600 Medicaid patients, but only treated 1,200. With the $44 million left, state officials hope to expand access to those with moderate liver scarring, F2 fibrosis, not just stages F3 and F4. Additionally, the Health Care Authority is asking the Legislature to approve an additional $33.3 million to expand treatment to those patients. Read More

United States

Texas, Kansas, Louisiana Challenge ACA Insurance Fee in Federal Court. On October 28, 2015, *Bloomberg BNA* reported that Texas, Kansas, and Louisiana filed a complaint that the health insurance provider fee that Medicaid managed care organizations must pay is not permitted by the Supreme Court. The fee is estimated to raise between $8 billion and $14.3 billion a year from 2014 through 2018 to help cover the costs of the ACA. However, states must reimburse Medicaid MCOs for their portion of the fee. The states said the fee is devastating their Medicaid and CHIP budgets. Read More

State Medicaid Programs to Pay Home Health Workers Minimum Wage and Overtime Next Month. On October 31, 2015, *Modern Healthcare* reported state Medicaid programs are bracing for a new U.S. Labor Department law to pay home health services workers minimum wage, overtime, and traveling expenses starting next month. The industry has strongly opposed the rule, claiming home healthcare would become unaffordable to patients. The National Association of Medicaid Directors, as well as federal officials, said states are not prepared. Managed care plans may also not be aware that they are responsible for additional costs. Some fear that without additional funding, many home health agencies are likely to react to the ruling by cutting workers' hours to avoid incurring overtime expenses. Read More

Challenges Expected Signing Up Uninsured on Exchanges. On October 30, 2015, *Kaiser Health News* reported that the third open enrollment for the Affordable care Act exchanges will see challenges signing-up the remaining 29 million people who are uninsured. The Obama administration predicts enrollment will increase by only 900,000. Studies have showed that many don't see the need for coverage, believe it's too expensive, or are unaware of financial assistance available. Advocates, health industry groups, and consumer organizations have revised strategies to attract more people to sign up or renew coverage. Read More

National Advertising Campaign to Highlight HealthCare.gov Subsidies. On October 29, 2015, *The New York Times* reported that the Obama administration will begin a national campaign to inform people they can qualify for financial help when signing up for health insurance through the exchanges. Research shows that many consumers are not aware subsidies are offered and as a result believe that insurance under the ACA is not affordable. Read More

Industry News

WellCare Reports Third Quarter Earnings, Anticipates Losses Related to Iowa Contract. WellCare reported adjusted third quarter net income of $44.6 million, or $1.00 per diluted share. Medicaid membership grew to approximately 2.4 million members at September 30, 2015, an increase of 147,000 members from September 30, 2014, and 5,000 members from June 30, 2015. The company disclosed that it expects to record a pretax premium deficiency reserve in the range of $85.0 million to $95.0 million, or approximately $1.20 to $1.35 per diluted share, in the fourth quarter of 2015. The premium deficiency reserve is related to start-up and operating costs on its recently awarded Iowa contract that exceed its expected revenue. Read More.

Pamplona Capital Management to Acquire MedAssets for $2.7 Billion. On November 2, 2015, MedAssets announced that they have entered into a definitive agreement to be acquired by Pamplona Capital Management. The deal is valued at $2.7 billion and is expected to close in the first quarter of 2016. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
December 22, 2015	Nebraska	Proposals Due	239,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
March 1, 2016	Nebraska	Contract Awards	239,000
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	Nebraska	Implementation	239,000

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 capitated model 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:

- **Illinois** Medicaid reimbursements by provider, hospital, and more
- **Pennsylvania** Medicaid MCO enrollment rises 23.7%, Sep-15 data
- Public documents such as **Michigan** Comprehensive Health Care Program (CHCP) award protests and tentative agreement for the extension of **California** "Bridge to Health Reform" 1115 Waiver
- Plus upcoming webinars on "*The Residency Program of the Future: How Healthcare Reform is Impacting Medical Training and Graduate Medical Education*" and "*The Future of Community Behavioral Health: Leveraging the Transformation to Value-Based Healthcare*"

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's Vern Smith Part of NAMD Panel Reviewing Medicaid at 50

HMA Managing Principal Vern Smith was one of four experts who took part in the plenary panel discussion "Medicaid at 50: Past, Present and Future" at the National Association of Medicaid Directors (NAMD) fall conference Tuesday. He was joined by:

- Thomas Betlach, NAMD President, Arizona Medicaid Director, AHCCCS
- Deborah Bachrach, Partner, Manatt, Phelps & Phillips LLP
- Charles Milligan, Jr., CEO, UnitedHealthcare Community & State – New Mexico

They discussed how Medicaid has fundamentally transformed from its origins in 1965, and what the future of the program holds. Judith Moore, co-author of *Medicaid Politics and Policy*, and a health policy consultant, moderated the panel which followed the keynote address of Secretary Sylvia Mathews Burwell of the U.S. Department of Health and Human Services. Click here to see the discussion as it appears in the video archive of C-Span3.