HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 18, 2015

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THIS WEEK

The HMA Weekly Roundup will not publish next Wednesday, November 25th. We will resume publication the following Wednesday, December 2nd.

IN FOCUS

PENNSYLVANIA ISSUES DRAFT MLTSS RFP

This week, our *In Focus* section reviews the draft request for proposals (RFP) for the Pennsylvania Community HealthChoices (CHC) program, which will coordinate physical health services and long term services and supports (LTSS) under a new statewide managed care program. The state is requesting comments on the draft RFP, program requirements, and forthcoming eligibility and enrollment documents through the beginning of next year, in anticipation of a final RFP release in January 2016. The CHC program, scheduled to implement over three years beginning in 2017, will serve an estimated 450,000 individuals, including 130,000 with LTSS needs.

Covered Populations

CHC will cover an estimated 450,000 dual eligibles and individuals receiving LTSS, both in the community and in a nursing facility. This includes:

- Adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC);
- Current participants of Office of Long-Term Living (OLTL) waiver programs who are 18 to 21 years old; and
- Dual eligibles age 21 or older whether or not they need or receive LTSS.

As noted earlier, approximately 130,000 of the 450,000 projected enrollees are adults with LTSS needs, while the remaining 320,000 are dual eligible adults without LTSS needs.

Enrollment will be mandatory, although select individuals may have the option to instead enroll in the Living Independence for the Elderly (LIFE) program, which is a separate managed care program option that is available in certain areas of the state.

Covered and Excluded Services

CHC health plans will provide all physical health benefits, mirroring what is currently provided in the Pennsylvania HealthChoices program. LTSS benefits will include those currently delivered by OLTL programs, including nursing facility services and home and community-based services (HCBS). As in the HealthChoices program, behavioral health services are carved-out and managed by a behavioral health managed care organization (BH-MCO). CHC MCOs will be required to coordinate with BH-MCOs around behavioral health needs.

Contract Awards and RFP Timeline

Pennsylvania intends to award a minimum of two and up to five CHC-MCOs per zone (bidders may bid on any combination of zones). Although the draft RFP indicates that the state may enter into additional agreements with other qualified CHC-MCOs in future years. Contract terms will vary based on zone, as follows.

- Southwest (SW) Zone contracts are scheduled to run for five years, beginning January 1, 2017, with two optional extension years.
- Southeast (SE) Zone contracts are scheduled to run for four years, beginning January 1, 2018, with two optional extension years.
- Lehigh-Capital (LC), Northwest (NW), and Northeast (NE) Zone contracts are scheduled to run for three years, beginning January 1, 2019, with two optional extension years.

Per the timeline below, a final RFP is set to be released sometime in January, with only a 60-day turnaround on responses.

RFP Timeline	Date
DRAFT RFP Released	November 16, 2015
DRAFT RFP Comments Due	December 11, 2015
RFP Release	January, 2016
Proposals Due	TBD (60 Days After RFP Release)
Implementation (SW Region)	January 01, 2017
Implementation (SE Region)	January 01, 2018
Implementation (LC, NW, NE Regions)	January 01, 2019

Evaluation Criteria

The technical sections of the RFP will be worth 80 percent of total points available, and will be evaluated on soundness of approach, financial condition, personnel qualifications, and prior experience. The remaining 20 percent of points available pertain to small diverse business (SDB) subcontracting commitments. The RFP will not require a cost proposal.

To receive credit for SDB subcontracting commitment, the SDB subcontractor must perform at least fifty percent of the work subcontracted to it. There are additional requirements around percentage commitments of the administration portion of the per-member-per-month (PMPM) rates.

SDB commitments are scored in relation to the bidder with the highest SDB commitment. The state has provided an example of SDB scoring on their website, available here.

Current Medicaid MCO Market

Pennsylvania's physical health managed care program (HealthChoices) is served by seven MCOs, which cover around 2.1 million beneficiaries as of September 2015, up more than 30 percent from March 2015 enrollment of 1.6 million. AmeriHealth Caritas is the largest of these MCO providers, with just over 30 percent market share (see the table below). However, the state is currently in the process of rebidding HealthChoices contracts. As a note, this procurement includes a renaming of the New West and New East zones as Northwest and Northeast, respectively.

Current HealthChoices MCOs	Regions Currently Served	Sept. 2015 Enrollment	% Market Share
AmeriHealth Caritas	Southeast; Lehigh/Capital; New West; New East	633,805	30.5%
UPMC	Southeast; Lehigh/Capital; New West	354,850	17.1%
Gateway	Southeast; Lehigh/Capital; New West	311,474	15.0%
Health Partners	Southeast	222,131	10.7%
United Healthcare	Southeast; Southwest; Lehigh/Capital	206,140	9.9%
Aetna Better Health	Statewide	182,414	8.8%
Geisinger	New East	165,547	8.0%
Total All MCOs		**2,076,361**	

Link to Draft RFP, Supporting Documents

The draft RFP, draft Program Requirements, and other supporting materials, including past and upcoming webinars, are available here:

http://www.dhs.pa.gov/citizens/communityhealthchoices/#.Vky3_HarRpj

HMA Medicaid Roundup

Alabama

Governor Bentley Exploring Medicaid Expansion. On November 12, 2015, *The New York Times* reported that Governor Robert Bentley said he is exploring Medicaid expansion, but that state funding could be a major challenge. He stated that he is looking at the possibility, but no decision has been made on how it would work. Earlier this year, Governor Bentley said he could support a program that would require recipients to work and pay premiums. Read More

California

HMA Roundup – Don Novo (Email Don)

California to Pay Overtime to Home-Care Workers Beginning February 2016. On November 6, 2015, *The Sacramento Bee* reported that California will begin paying home-care workers overtime starting February 1. 2016. The state has nearly 400,000 home-care service providers. Read More

Attorney General's Decision on Daughters of Charity Deal Expected. On November 18, 2015, the *San Jose Mercury News* reported that Attorney General Kamala Harris' approval decision on the deal between Daughters of Charity Health System and New York-based BlueMountain Capital Management is expected Thursday, November 19, 2015. The potential deal is worrying many industry experts, who have stated that allowing the hospital system to remain a nonprofit for up to 15 years, allowing BlueMountain to take advantage of laws exempting nonprofit systems from taxes. Read More

Covered California Concludes Bus Tour; Outreach to Continue Through End of Enrollment Period. On November 13, 2015, *California Healthline* reported that Covered California concluded its bus tour advertising campaign that traveled 2,000 miles and stopped in 38 locations. The Exchange will continue to outreach efforts through January. 31, 2016. Read More

CANHR Files Lawsuit Against DHHS Over Alleged Nursing Home Resident Dumping. On November 10, 2015, *California Healthline* reported that California Advocates for Nursing Home Reform (CANHR) filed a lawsuit against the state Department of Health and Human Services for alleged failure of nursing homes to readmit Medi-Cal patients after they had been hospitalized. The lawsuit seeks injunction against the state's lack of readmission order enforcement. Read More

Medi-Cal Patients with Cancer Less Likely to Get Recommended Treatment; Have Lower Survival Rates. On November 6, 2015, *Kaiser Health News* reported that according to a new study by University of California-Davis, Medi-Cal patients with cancer are less likely to get recommended treatment and have

lower survival rates than those with other types of insurance. Medi-Cal currently covers 12 million people. Read More

Connecticut

Nursing Home Workers Reach Agreement for $15 Wage. On November 13, 2015, *McKnight's* reported that the New England branch of the Service Employees International Union, SEIU 1199NE, reached a tentative agreement to raise the minimum wage for nursing home workers to $15 per hour. Once finalized, the agreement will cover 2,600 certified nursing agreements at 20 Connecticut nursing homes owned by iCare and Genesis. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Department of Community Health Board Meeting Summary. The Georgia Department of Community Health (DCH) held its monthly board meeting on November 12, 2015. During the meeting, Georgia Medicaid chief Linda Wiant presented an update on Georgia's Medicaid program, including enrollment and spending trends. She stated that the protest period is still in effect for the care management organization (CMO) procurement. Three managed care plans have protested the award of the Medicaid contracts, which were announced in September. Wiant also discussed several ongoing and upcoming initiatives, including a re-bidding of the non-emergency travel contract currently under development, and the implementation of a centralized and simplified credentialing verification organization (CVO) process.

Commissioner Clyde Reese announced the agency's decision to table a proposal by the Cancer Treatment Centers of America to reclassify as a general acute-care hospital – which would have eliminated the hospital's cap on in-state patients – due to "overwhelmingly negative" public response during a recent hearing. Commissioner Reese also indicated that the agency has decided not to move forward with a Section 1115 waiver request to CMS to provide coverage for uninsured patients at several pilot sites using federal matching Medicaid dollars, but he stated that he is currently reviewing an updated proposal by Atlanta-based Grady Hospital to provide coverage under the waiver for the aged, blind, and disabled (ABD) population. Additionally, Commissioner Reese noted the Georgia Chamber of Commerce is examining alternatives to traditional Medicaid expansion that would meet Governor Nathan Deal's requirements of being fiscally sound for the state and financially solvent for DCH.

Chief Information Officer Matt Jarrard provided an overview of the Office of Information Technology, during which he noted that the Health Information and Analytics (HIA) division is currently working on an RFP procurement to re-procure a new system, with an expected go-live date of January 2018.

The Board also voted in favor of initial adoption of two policies to update the inpatient DRG version to reflect ICD-10 changes and to update home care licensing requirements for independent contractors.

Iowa

Senate President Meets with CMS on Iowa Managed Care Concerns. On November 18, 2015, the *Dubuque Telegraph Herald* reported that Iowa Senate President Pam Jochum reported "feeling somewhat positive" after meeting with officials at the Centers for Medicare & Medicaid Services (CMS) around concerns with the state's planned transition to Medicaid managed care. Senator Jochum said that she and two other senators communicated their concerns to CMS around adequacy of provider networks and managed care organization staffing and systems. Read More

Kansas

KanCare Reimbursement Change Leaves Adult Care Facilities Wary. On November 17, 2015, *KHI News* reported that representatives of the adult care facility industry are wary of a change in reimbursement calculations under KanCare, but will accept the changes in hopes of streamlining the rate-setting process. Under the new structure, Medicaid rates for adult care facilities will be calculated twice annually, instead of every quarter. Industry representatives hope the change will lead to fewer billing issues, but worry about the negative financial impact of caring for costlier members between rate adjustments. Read More

Michigan

HMA Roundup – Eileen Ellis (Email Eileen) & Esther Reagan (Email Esther)

Update on Michigan Medicaid Rebid. In early May of this year, the State of Michigan released a Request for Proposals (RFP) to re-procure the state's Medicaid managed care contracts. Effective January 1, 2016, the new contracts will be for a term of five years with three additional option years. The RFP included a new regional configuration and required bidders to be able to serve all counties within a particular region. This new requirement caused some of the existing managed care plans to expand their service areas and bid on new regions; it also caused others to elect to give up counties in regions where they only had a small "footprint". Proposals were due in early August; 13 health plans submitted proposals. Initial announcements of recommended awards were made by the Department of Health and Human Services (DHHS) in early October (See the October 14, 2015 HMA Weekly Roundup for additional information including a map of the regional configuration.)

Some of the bidders that proposed to serve new regions were successful but others were not. Aetna Better Health and Priority Health Choice proposed service area expansions but were only approved for some of the new regions. Centene's MI Complete Health (Fidelis SecureCare), not a current Medicaid managed care plan but a contractor in the state's demonstration program for Medicaid beneficiaries dually eligible for Medicare ("duals") proposed to serve two regions in southeast Michigan but was not selected. Sparrow PHP, a long-time health plan serving primarily the region in and around the state's capital city of Lansing, was not selected either. HAP Midwest Health Plan, also a long-time Medicaid health plan and a contractor in the state's demonstration program for duals, was only recommended for a contract in one of the three regions where it currently serves Medicaid members; that region does not include the

area served for the duals demonstration. Six bidders submitted protests, and the results of the state's review of the protests were announced by DHHS on Friday, November 13, 2015. Although there were minor adjustments in scores and rankings among bidders as a result of scoring errors identified and corrected, only one award changed following the protest period; in Region 7 a change in score allowed Molina Healthcare of Michigan to unseat UnitedHealthcare Community Plan. The earlier decisions affecting MI Complete Health, Sparrow PHP and HAP Midwest Health Plan were upheld. (Aetna and Priority were not recommended for awards in some of the regions for which they submitted a bid, but they did not protest the decision.)

On November 17, 2015 the state's Administrative Board (preceded by the Finance and Claims Committee) met to authorize the new contracts. The Committee and Board heard comments from two of the unsuccessful bidders – HAP Midwest Health Plan and Sparrow PHP – who asked for an exception to the scoring and contract awards. Their testimony did not affect the outcome; the Board approved contracts for only the recommended health plans. Following the Board meeting, representatives from the two health plans were reported as saying they are still weighing options for further appeal of the contract award decisions.

The table below indicates the regions for which each bidder was and was not successful. If a health plan is a current contractor for all counties in a region, their result is shaded green. If the health plan is a current contractor for some but not all counties in a region, their result is shaded yellow. If the health plan does not currently serve Medicaid members in a region, their result is shaded blue.

	Region1	Region 2	Region 3	Region 4	Region5	Region 6	Region 7	Region 8	Region 9	Region 10
Aetna Better Health (CoventryCares)					No			Yes	Yes	Yes
Blue Cross Complete				Yes		Yes	Yes		Yes	Yes
HAP Midwest Health Plan						Yes			No	No
Harbor Health Plan										Yes
McLaren Health Plan		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Meridian Health Plan of MI		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MI Complete Health (Centene/Fidelis)									No	No
Molina Healthcare of MI		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Priority Health Choice		No	No	Yes				Yes	No	
Sparrow PHP							No			
Total Health Care										Yes
UnitedHealthcare Comm. Plan		Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Upper Peninsula Health Plan	Yes									

Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Health Co-op Shuts Down. Health Republic of New York, the health insurance co-operative operating on the NY health marketplace, New York State of Health, will cease operation on November 30, one month earlier than originally announced. Amid investigations by the NY Department of Financial Services, the state has announced a series of steps meant to reduce the widespread confusion and chaos that resulted from Health Republic's shut-down. The state has extended the enrollment deadline for individual consumers wishing to enroll in another health plan, and developed an auto-enrollment option for those that do not select a new plan prior to the deadline. Individual Health Republic members have until November 30, 2015 to select a new health insurance plan for December coverage through the NYSOH. After that date, in order to ensure continuous coverage, the State will auto-enroll individual Health Republic consumers in new health insurance plans. Three plans - Fidelis Care, MVP and Excellus, were selected for automatic enrollment of individuals who don't opt out or pick another option on the exchange.

The Department of Financial Services (DFS) has opened an official investigation specifically focused on Health Republic's inaccurate financial reporting. DFS investigators are collecting and reviewing evidence relating to Health Republic's substantial underreporting of its financial obligations. Among other issues, the investigation will examine the causes of the inaccurate representations to DFS regarding the company's financial condition.

Providers across the state have begun to express concerns about getting paid for services provided to Health Republic members. Crain's cites the Health Care Association of NYS that over $160 million is owed in claims; of the nearly 800 physicians who responded to a survey by the Medical Society of the State of New York, 43% have outstanding claims with Health Republic. DFS is reminding providers of NYS's prohibition against balance billing, taking actions that will apply the state law that prohibits providers from collecting or attempting to collect from Health Republic consumers, payments that are owed by Health Republic.

Community First Choice State Plan Amendment Approved. NYS has received CMS approval for its State Plan Amendment implementing the Community First Choice option (CFCO), available here. The CFCO was established by the Affordable Care Act that allows states to provide consumer-controlled personal attendant services and supports in their state plan. CFCO provides additional Federal Medicaid Assistance Percentage (FMAP) of six percent to states to expand and enhance home and community-based services and supports. New York plans to use the funds to support its Olmstead agenda. New York's CFCO addresses a range of services including personal care, consumer-directed personal care, home health care, home and community support services, community habilitation, home maintenance (chore service), community transportation, and congregate/home delivered meals. Now that the SPA has been approved the state is planning a webinar to describe its approach to the program.

Caring Neighborhoods to Enhance Primary Care. NYC announced a new initiative to enhance the availability of primary care in underserved neighborhoods. The project, Caring Neighborhoods, is a collaborative effort to

improve access to primary care by two city entities: the NYC Health and Hospitals Corporation and the New York City Economic Development Corp. Caring Neighborhoods aims to expand a nonprofit health center model that offers people who are uninsured or on Medicaid access to a wide range of services, from pediatrics to dental care, under one roof. Over the next two years, HHC will spend $12 million to create five health centers and expand services at six existing centers in its affiliated network of primary care sites. An additional $8 million in grants will be made available to other organizations to create new health centers in high-need areas.

Essential Health Care Provider Support Program Funds Available. The New York State Department of Health (NYSDOH), Office of Primary Care and Health Systems Management (OPCHSM) announced the availability of funds under the Essential Health Care Provider Support Program. Funds are available under two separate Requests for Applications (RFA) to essential health care, for the purpose of facilitating health care transformation through mergers, consolidation and restructuring activities intended to create financially sustainable systems of care. The first pool of funds, totaling $300 million, is available to essential health care providers to support preservation of essential health care services. The second pool, totaling $55 million, is available to providers that have demonstrated a commitment to establishing innovative models of health care delivery in order to preserve and further expand innovative models of care.

The Requests for Applications (RFA) can be accessed through the New York State Department of Health website at http://www.health.ny.gov/funding/. The deadline for applications has been extended to December 9, 2015. Questions and Answers related to the funding opportunity can be accessed through the NYSDOH website at http://www.health.ny.gov/funding/.

NYS Medicaid Director Honored. NYS's Medicaid Director, Jason Helgerson, has been honored by Governing magazine as one of its Public Officials of the Year. Every year Governing honors individual state and local government officials for outstanding accomplishment. Helgerson was one of 9 officials receiving recognition this year.

NYC Health Goals for 2020. New York City's Department of Health and Mental Hygiene announced the launch of Take Care New York 2020, its updated blueprint for improving the city's health over the next five years. This year's plan includes four broad goals: promoting healthy childhoods and neighborhoods, supporting healthy living and making quality care more accessible. The initiative is also aimed at decreasing health disparities among neighborhoods.

Primary Care Planning for DSRIP. The Department of Health has released a draft of the Performing Provider System Primary Care Plan. The Primary Care Plan will consist of a narrative section provided by the PPSs to describe their overall approach to Primary Care development, and include details on their work with PCPs at the practice level, resources and support for PCMH/APC activities, and Primary Care representation in PPS governance. The Primary Care Plan narrative is supplemented by data and other information aggregated by the State, both from existing DOH databases and the PPSs' Implementation Plans and Quarterly Reports. The draft plan is available upon request.

New York City Health and Hospitals Corporation Rebranding. New York City Health and Hospitals Corporation is rebranding, changing its name to NYC

Health + Hospital. The new brand strategy unifies the organization's more than 70 patient care locations. The change is designed to help redefine the public health care system as it embarks on an aggressive campaign to attract new patients, expand primary care services in underserved communities, increase membership in its health insurance plan MetroPlus, and grow revenue to preserve its mission.

FIDA Benefits. As part of its on-going effort to attract interest in its duals demonstration program, Fully Integrated Duals Advantage, the Department of Health has posted a detailed benefit comparison chart. The chart includes information about four managed long term care plans available to Medicaid beneficiaries in NYS – FIDA, partial capitation managed long term care, PACE and Medicaid Advantage Plus. One intent of the benefit comparison is to highlight the more generous benefit package available through the FIDA program. The chart is available in English and Spanish on the Medicaid Redesign Team website.

Medicare Advantage Plan Shuts. Touchstone Health HMO, a Medicare Advantage plan, will wind down operations at the end of the year, ending coverage for more than 10,000 members. In a public notice posted on its website the HMO indicated that it will no longer offer coverage of Medicare Advantage benefits to Medicare members in the Bronx, Queens, Kings, Richmond, New York, Westchester and Orange counties. According to a report in Crain's, Touchstone has struggled to maintain the funding reserves required by government regulators, and its membership decreased by more than 30 percent during the past five years. Crain's notes that by the end of 2014, Touchstone was $8.5 million below its minimum net worth requirements, with assets exceeding liabilities by $9.6 million, and a profit margin under 1 percent.

DSRIP Performing Provider System Presentations. The DSRIP Project Approval and Oversight Panel met in October to hear presentations from the 12 non-NYC Performing Provider Systems. Each PPS was given 15 minutes to provide an update on the status of DSRIP implementation, and an additional 15 minutes to respond to questions. Milestones that had to be met during the first six months of DSRIP tended to be process measures, with an emphasis on establishing governance and fund flow procedures. A recording of the 2-day meeting is posted on the DSRIP website along with copies of each PPS's presentation.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Revamping Graduate Medical Education Reimbursement. Ohio's General Assembly recently created the Graduate Medical Education (GME) Study Committee. In its October meeting, the GME Study Committee reviewed why Ohio's current GME formula yields dramatically different results for hospitals that provide similar medical training opportunities. At the November 30th meeting, the Committee will hear testimony for improving the program. Specifically, the Committee is looking for recommendations to (1) update the GME formula (e.g., recognize changes since the program was created in 1987) and achieve fairness in training program support, and (2) promote state health policy priorities (e.g., recruit and retain more physicians into primary care and specialties with shortages, and strengthen and improve minority training

programs). The Study Committee's scope is limited to Ohio Medicaid's GME reimbursement, but stakeholders are welcome to identify additional recommendations to (3) create a comprehensive approach to medical education (e.g., repurpose medical school earmarks, loan forgiveness programs). The opportunity to provide testimony and some helpful resources for preparing testimony can be found here.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Firm Under Federal Probe Owns 4 of 5 Most Profitable Pennsylvania Mental Hospitals. Four of the five most profitable mental-health hospitals in Pennsylvania are owned by Universal Health Services Inc. (UHS), according to a report being published November 17, 2015, by the Pennsylvania Health Care Cost Containment Council. The King of Prussia company, which is under federal investigation for its Medicare and Medicaid billing practices at about 20 facilities in nine states, owns eight psychiatric hospitals in Pennsylvania, including three that are under investigation. Two of those under investigation, Roxbury Treatment Center in Shippensburg and the Meadows in Centre Hall, are among the most profitable. The third is Friends Hospital in Philadelphia. The report showed that psychiatric hospitals in the aggregate have been profitable for 10 straight years, after a decade of losses. In UHS's case, the most recent data are from 2013, when UHS accounted for 47 percent of the net patient revenue in the state's free-standing inpatient psychiatric facilities. Read More

UPMC, Highmark Resolve Dispute Over Patients' In-Network Care. In the latest arbitration over unresolved issues between UPMC and Highmark, the two Pittsburgh health giants have agreed that the ability of a Highmark member to continue receiving in-network care by UPMC physicians and hospitals will be decided by the patient and the treating physician. The agreement released Thursday applies only to those patients who have a chronic or persistent medical condition, such as diabetes or cancer. Also, any Highmark member with a confirmed pregnancy by December 31 may continue to use UPMC on an in-network basis for the maternity care, delivery and postpartum care. The long-standing contract between Highmark and UPMC that gave Highmark members in-network access to UPMC expired January 1, although some members have retained access under provisions of state-brokered consent decree agreements signed by both parties last year. The new agreement released Thursday applies for the duration of the consent decrees, which expire June 30, 2019. While reaching an accord on this issue, other issues remain between the two, including a dispute now before the state Supreme Court on whether UPMC can exclude Highmark's Medicare Advantage members. Read More

Geisinger to Test Giving Refunds for Patients Treated Unkindly. Geisinger Health System said Wednesday it wants to know whether patients were treated with kindness and compassion, and will allow patients who fee1 they weren't to claim a refund. Additionally, Geisinger says it will allow the unhappy patients to decide the size of the refund. The program has been launched as a pilot at Geisinger's main hospital in Danville. It involves surgery patients enrolled in the pilot using a mobile app developed by Geisinger to name the size of their refund. The refund will consist of all or part of the patient's co-pay. The pilot is called "ProvenExperience" and is an

offshoot of Geisinger's "ProvenCare" approach to certain surgeries which brought national attention to Geisinger in 2006. Read More

Puerto Rico

Impending Health Care Cuts Continue to Drive Concerns. On November 16, 2015, the *New York Times* reported on the continued voicing of concerns from residents and advocates in Puerto Rico, as the territory faces looming health care cuts. Medicaid and Medicare programs serve nearly 70 percent of the population, around 2.37 million people. Puerto Rico's Medicare Advantage program, which serves around 560,000 residents, is facing an 11 percent cut in January 2016, with cuts projected in Medicaid over the next two years. The cuts could lead to higher copays and loss of benefits in the short term, but longer term concerns about how the cuts will impact doctors' willingness to serve patients are present as well. New York Governor Andrew Cuomo and New York City Mayor Bill de Blasio have pledged to pressure Congress to help Puerto Rico obtain equal funding, while President Barack Obama's administration has urged Congress to approve reforms to Puerto Rico's Medicaid program that would improve access to health care and expanded benefits. Read More

Texas

Texas Cancels Medicaid Contract with TAPS Public Transit. On November 12, 2015, *The Dallas Morning News* reported that Texas officials canceled the contract with TAPS Public Transit to provide non-emergency medical trips to Medicaid recipients in 16 counties and launched an investigation into the possibility of fraud in handling subcontracts. The Texas Health and Human Services Commission said that the magnitude and severity of the contract deficiencies could not be fixed. TAPS has also been struggling financially in recent months due to mismanagement and overspending of its budget. Trips for recipients will be rerouted to other providers with no interruptions in service. Read More

Virginia

Medicaid Forecasters Predict $1 Billion Cost Increase in Next Two Years. On November 17, 2015, the *Washington Post* reported that a new state forecast is projecting Virginia's Medicaid costs to increase by $956 million through the next two-year budget period. The increased forecast is reportedly due largely to a surge in previously eligible, but newly enrolled Medicaid beneficiaries, who are not eligible for the enhanced matching funds under the Affordable Care Act. The report comes as Governor Terry McAuliffe plans to renew a push to expand Medicaid in the state. Read More

National

Federal Officials and Lawmakers Target Pharmaceutical Companies Over High Drug Prices. On November 15, 2015, *The Wall Street Journal* reported that lawmakers and federal officials are increasing efforts to target pharmaceutical companies for high drug prices. HHS is considering new steps to protect

consumers and will hold a day-long forum on the issue with employers, insurers, consumers and drug makers. Read More

Consumers Face Sticker Shock from High Deductibles. On November 14, 2015, *The New York Times* reported that consumers are facing sticker shock when learning about their plan's high deductible under the ACA. Some say they feel just as vulnerable as they did without coverage. In many states, over half the plans offered through HealthCare.gov have a deductible of $3,000 or more. Read More

543,000 Sign Up for Health Coverage During Start of Open Enrollment. On November 12, 2015, *The New York Times* reported that over 543,000 people signed up for health coverage as the 2016 open enrollment got underway. Approximately two-thirds were returning customers. The goal of the administration is to sign up 10 million. Read More

NAMD Survey Shows Payment and Delivery System Reform Top the List of Medicaid Agency Innovations. On November 11, 2015, *FierceHealthPayer* reported that according to a new survey by the National Association of Medicaid Directors, Medicaid is evolving and innovating at a rapid pace. Payment and delivery system reform is at the top of Medicaid agency innovations, with nearly 60 percent of Medicaid directors spending half or more of their time on such reforms. MLTSS and managed behavioral health programs are top line issues for four-firths of all agencies. Additionally, agencies are moving to performance-based reimbursement models within both traditional fee-for-service care delivery and managed care. Despite limited staff and tight resources, Medicaid agencies are building new capabilities to improve program accountability, transparency, performance, and integrity. Read More

Industry News

Molina to Acquire Columbia United Provider's Medicaid Business. On November 12, 2015, Molina Healthcare and Columbia United Providers (CUP) announced that Molina Healthcare of Washington will acquire CUP's Medicaid business. The transaction is expected to close in the first quarter of 2016. CUP serves over 55,000 Medicaid members. Read More

Addus HomeCare Acquires BestCare HomeCare. On November 12, 2015, Addus HomeCare Corporation announced that it acquired the assets of Five Points Healthcare of Virginia's personal care business, d/b/a BestCare HomeCare, effective November 9, 2015. BestCare has annualized revenues of $5.7 million for the first nine months of 2015. Read More

Apollo Global Management to Acquire RegionalCare Hospital Partners. On November 13, 2015, RegionalCare Hospital Partners announced that Apollo Global Management agreed to acquire the eight non-urban hospitals from Warburg Pincus. No financial terms were disclosed. Read More

WellCare Health Plans Sees Revenue Grow 133 Percent in Last Give Years. On November 15, 2015, *Tampa Bay Times* reported that WellCare Health Plans saw revenues grow from $6 billion to a projected $14 billion in the last five years. WellCare currently serves over 2.4 million Medicaid members and 1.4 million Medicare members in 15 states. CEO Ken Burdick stated that the largest areas for continued growth are states that have yet to adopt managed Medicaid, states yet to expand Medicaid, and existing geographies with only one or two programs in managed Medicaid. Read More

AlohaCare CEO to Retire in 2016. The president and CEO of AlohaCare, John McComas, has announced his intention to retire in the second quarter of 2016. McComas led AlohaCare since 1996. A successor has not been named at this time.

RFP Calendar

Date	State/Program	Event	Beneficiaries
November, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
December 11, 2015	Pennsylvania MLTSS/Duals	DRAFT RFP Comments Due	450,000
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
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
March 1, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	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	Nebraska	Implementation	239,000
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 capitated model demonstration enrollment.

State	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	49,038
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657
Michigan		9,216	14,867	28,171	35,102	42,728	37,072
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,546**

HMA NEWS

New this week on the HMA Information Services website:

- **Missouri** to Rebid Medicaid Managed Care Contracts, Nov-15 Opportunity Assessment
- Market Share for **New York** Medicaid MCOs, Sep-15 Data
- Public documents such as the **Pennsylvania** Community HealthChoices Draft RFP and the 2013 **Texas** STAR+PLUS Medicaid Rural Service Area Proposals
- Plus upcoming webinars on *"Outreach and Enrollment: Maximizing Medicaid and Marketplace Penetration"* and *"Medicaid Enrollment and Spending Trends: An Inside Look at Findings from the 15th Annual Kaiser 50-State Medicaid Budget Survey"*

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 Webinar Replays Available

- *"Oregon and the Future of Medicaid Managed Care"*
- *"The Future of Community Behavioral Health"*
- *"The Age Wave in Social Programs"*