HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 3, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

WEST VIRGINIA ISSUES MEDICAID MANAGED CARE REQUEST FOR QUOTES (RFQ)

This week, our *In Focus* section reviews the request for quotes (RFQ) issued by West Virginia's Department of Health and Human Resources, Bureau for Medical Services, for the "Mountain Health Trust" Medicaid managed care program. For the first time, West Virginia is soliciting competitive bids from Medicaid managed care organizations (MCOs) to serve nearly 370,000 current enrollees as well 78,000 Medicaid SSI enrollees who will transition to managed care on July 1, 2016.

The RFQ comes in response to a legal settlement after the state's expansion of the Mountain Health Trust managed care program to newly eligible enrollees under the Medicaid expansion was challenged in court. The lawsuit, brought against the state in April 2015, challenged the state's decision to award no-bid contracts for the Medicaid expansion population, arguing that competitive bids would save state taxpayers. Medicaid managed care enrollment increased by nearly 90 percent in 2015, up from just around 200,000 enrollees at the end of 2014.

Covered Population & Benefits

Mountain Health Trust currently enrolls pregnant women, low-income families and children, the Medicaid expansion population, children with special health care needs and the medically needy who spend down to eligibility. As noted above, approximately 78,000 Medicaid SSI beneficiaries will also be covered under the new contracts awarded from this bid.

West Virginia carved in pharmacy benefits to managed care in 2013 and added behavioral health services as of July 1, 2015. The RFQ indicates that the new contracts will include the personal care benefit as of July 1, 2016. Long-term supports and services (LTSS) remain excluded.

Key RFP, Contract Provisions

MLR Target. Contracted MCOs will be required to meet a minimum medical loss ratio (MLR) of 85 percent. Plans falling below this standard will be required to make rebate payments to the state while MCOs with MLRs above 85 percent will receive additional payments to cover a portion of the difference.

Performance Withhold. Five percent of a MCO's capitation will subject to a performance withhold and must be earned back (either in whole or in part) by meeting benchmark targets across 10 HEDIS measures. The performance withhold will not be applied to the SSI population.

Contract Awards and Term of Contract

The state has not provided evaluation criteria at this time beyond a price component. Bidders must complete a rate cell proposal within specified rate ranges.

West Virginia intends to award up to a maximum of six contracts with contract terms of one year (from July 1, 2016 through June 30, 2017) and two optional renewal years, for a maximum contract term of three years. It does not appear that awarded MCOs will be required to operate statewide as plans may request service area expansions during the life of the contract.

RFQ Timeline

The RFQ has a very aggressive turnaround, with proposals due just one month after the RFQ release. Proposals are due on Thursday, March 3, 2016, with a go-live date for new contracts of July 1, 2016.

RFQ Milestone	Date
RFQ Released	February 2, 2016
Technical Questions Due	February 16, 2016
Proposals Due	March 3, 2016
Implementation	July 1, 2016

Current Managed Care Market

The Mountain Health Trust managed care program has grown significantly in the past year, ending 2015 at nearly 370,000 enrollees. Based on the RFQ data book, we estimate annualized managed care spending of more than $990 million, a figure that will increase significantly with the inclusion of the Medicaid SSI population. At this time, the state has not provided rate setting data on the Medicaid SSI population or on the carve-in of the personal care benefit.

Medicaid MCO	Enrollment (Dec. 2015)	Market Share
Unicare (Anthem)	126,051	34.3%
Carelink (Aetna)	121,085	32.9%
Health Plan of the Upper Ohio Valley	67,492	18.4%
West Virginia Family Health (Highmark)	53,030	14.4%
Total Mountain Health Trust Enrollment	**367,658**	

HMA Medicaid Roundup

Alaska

New Medicaid Reform Subcommittee to Review Case Management Bills. On January 27, 2016, *Alaska Public Media* reported that a new Medicaid reform subcommittee will look at two separate bills regarding the use of case management. Both bills also seek to reduce pharmacy spending by pointing patients toward generic prescriptions. A recommendation to the full Senate Finance Committee is expected by the end of February. Read More

Arkansas

Governor Hutchinson Seeks "GOP-Friendly" Changes to Medicaid Expansion Program as Waiver Set to Expire This Year. On February 1, 2016, *Kaiser Health News* reported that Governor Asa Hutchinson will meet with federal officials to negotiate the Medicaid expansion program. Arkansas was awarded a waiver known as the "private option" in 2013. As a result, the state's uninsured rate fell by more than half to 9.1 percent in 2015. The waiver is set to expire at the end of 2016, so Hutchinson is seeking GOP-friendly changes to the program. Hutchinson's proposed new policy is called "Arkansas Works." Read More

California

HMA Roundup – Don Novo (Email Don)

Governor Brown Struggles to Gain Support for MCO Tax. On February 1, 2016, *Los Angeles Times* reported that Governor Jerry Brown's Administration is struggling to find a replacement for the state's current tax on managed care organizations that can receive support from both insurers and Republican lawmakers. The current tax expires in June and if it is not replaced, the state will lose over $1 billion in federal Medi-Cal funds. The Brown Administration has crafted a package of tiered tax rates and relief from other levies but insurers have not publicly backed details of the plan. Conversations are ongoing. Read More

California Insurance Commissioner Dave Jones Skeptical of Pending Mergers. On January 29, 2016, *California Healthline* reported that California Insurance Commissioner Dave Jones is highly skeptical of three pending mergers: Anthem's proposal to buy Cigna for $52 billion, Aetna's plan to purchase Humana for $37 billion, and Centene's $7 billion bid for Health Net. The Department of Managed Health Care must approve all of the mergers, but the Centene-Health Net deal must also be approved by the California Department of Insurance, headed by Dave Jones. In a January 22nd hearing,

Jones pointed to studies that indicate that consolidations result in higher premiums for consumers and weaken competition. Jones appeared prepared to impose stiff conditions on that deal and his staff entertained the notion of rejecting it outright. Read More

California Residents to Vote on Ballot Proposition to Control Cost of Prescription Drugs. On January 29, 2016, *Kaiser Health News* reported that Californians will get a chance to vote on a ballot proposition that will regulate prescription drug costs by requiring the state to not pay more than the U.S. Department of Veterans Affairs. The proposition is sponsored by the AIDS Healthcare Foundation. Several pharmaceutical companies have already spent nearly $39 million to defeat the initiative. Read More

Senate Proposes Bill to Let Consumers Know if Their Premiums are Deemed "Unreasonable". On January 27, 2016, *California Healthline* reported that a new bill would notify consumers if their health insurer's rate hike was deemed unreasonable. Currently, after state officials review all health insurance premium rate hikes, they ask the insurer to retract it. The insurer can then agree to alter the increase or go ahead it. For consumers to know if their premiums were considered unreasonable by the state, they must find it on the state agency website. Even so, it is not always clear what products are affected. A new bill proposed in the Senate seeks to change this. The bill is expected to be heard by a committee in April. Read More

Childhood Vaccinations Rise in 49 of 58 Counties. On January 21, 2016, *NPR* reported that according to data from the California Department of Public Health, childhood vaccinations rates rose in 49 of 58 counties last fall. For the 2015-2016 school year, 92.9 percent of kindergartners were up-to-date on their shots. Last February, state lawmakers introduced a bill to eliminate the personal belief exemption that will go into effect in July 2016. Read More

California Pays Medi-Cal Health Plans to Cover Hepatitis C Drugs. On January 27, 2016, *KQED* reported that the state is paying private Med-Cal managed care plans supplemental payments to cover Hepatitis C medication costs. The companies are paid a flat rate per member each month to cover all health care needs. According to the Department of Health Care Services, this is the first time the state has paid a plan supplemental money to cover the cost of a drug. Payments to plans are expected to continue in the next fiscal year. The department has budgeted $303.4 million for health plans for 2016–17. Read More

Colorado

70th General Assembly. This week marked the first full week of the second session of the 70th General Assembly of Colorado. The Department of Health Care Policy and Financing (HCPF), the State Medicaid Agency, has three bills on its legislative agenda this session:

- SB16-027: Medicaid Option for Prescribed Drugs by Mail. This bill would allow Medicaid members the option to receive prescribed medications used to treat chronic medical conditions by mail and pay the same copayment applicable to receipt through other methods. HCPF will encourage the use of local retail pharmacies for mail delivery.
- HB16-1097: PUC Permit for Medicaid Transportation Providers. This bill creates a new category of non-emergency transportation (NET) carriers

to serve Medicaid clients that allows NET providers to operate under a limited regulation permit from the public utilities commission rather than a certificate of public convenience and necessity.

- HB16-1081: Obsolete Reporting Department of Health Care Policy and Financing. This bill repeals certain obsolete reporting requirements of the department and other providers.

Enrollment. Between November 1, 2015 and January 15, 2016, over 190,000 Coloradans enrolled in health care coverage, including 142,632 people enrolling in private health and dental coverage through Connect for Health Colorado. Another 45,100 enrolled in Medicaid and 2,771 enrolled in Child Health Plan *Plus*. Read More

Connecticut

Advocates Urge State to Apply for Federal Waivers. On January 25, 2016, *Connecticut Health I-Team* reported that according to advocates, health insurance coverage can be more accessible and affordable if the state applies for an Affordable Care Act Section 1332 waiver and a Medicaid Section 1115 waiver. A policy brief commissioned by the Universal Health Care Foundation of Connecticut and the Connecticut Health Foundation can be found here. Connecticut currently participates in 11 Medicaid waiver programs. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Proposed Legislative Budgets for FY 2016-17: On February 3, 2016, both the Senate and House Appropriations Committees passed the Chairman's budget proposals. The Senate budget of $81 billion ($30.2 billion of General Revenue, or "GR") is approximately $1 billion larger than the House budget of $80 billion ($29.5 billion GR). Next week, both chambers will pass their respective budgets off the floor and Conference Committees will be appointed to resolve differences. The Senate's Medicaid budget of $25.7 billion is approximately $400 million larger than the House's Medicaid budget of $25.3 billion. Both houses fully fund the estimated 4.2 million Medicaid beneficiaries and the 194,000 children in the KidCare program. Below are highlights of the Medicaid budget.

Medicaid issues funded by both the Senate and House:

- **Low Income Pool (LIP) program – $608 million**: Hospital LIP payments are based on a hospital's level of charity care and paid at a percentage of the hospital's charity care cost. The Senate allocates payments to hospitals based on a four-tiered reimbursement methodology and the House uses a three-tiered reimbursement methodology.
- **Disproportionate Share Hospital – $228 million**: The Senate increases payments to stand alone children's hospitals to replace the loss of LIP funds and the House allocates payments to hospitals determined by their levels of inpatient care and graduate medical education.
- **Physician Supplemental Payments - $198 million:** Payments to medical school physician faculty replace the loss of LIP funds.
- **ICF/DD Rate Increase – $10.3 million:** Funds a 4 percent rate increase.

- **Nursing Home Prospective Payment System – $500,000:** Funding to develop a plan to convert Medicaid payments for nursing home services from a cost based reimbursement system to a prospective payment system.
- **FMMIS Procurement – $8.7 million:** Funding for the FMMIS/Decision Support/Fiscal Agent procurement project.
- **Evaluation of Medicaid Waiver Programs – $751,000:** Funding for an independent evaluation of Medicaid waiver programs.
- **Contract Compliance System – $480,000:** Funding to develop a Statewide Medicaid Managed Care (SMMC) contract compliance tracking system.

Additional Senate funded Medicaid issues:

- **DRG Rate Adjusters - $173.5 million:** Increases hospital inpatient DRG rate adjusters for neonates.
- **APD iBudget Waiver - $36.4 million:** Funding to serve 1,350 individuals on the waitlist.
- **Coverage for Lawfully Residing Children - $28.8 million:** Eliminates the five-year wait period for lawfully residing children for Medicaid and KidCare eligibility.
- **Community Primary Care Grants - $14.3 million:** Grants to increase access to primary care services.
- **LTC Waiver - $9.2 million:** Funding to serve 570 individuals on the waitlist with a priority score of four or higher.
- **Homeless Mental Health Transitional Housing - $10.3 million:** Will provide flexible services for persons with severe mental illness or substance abuse disorders, including, but not limited to, temporary housing assistance.
- **Individuals With Phelan-Mcdermid Disease - $5.1 million**: Funding to provide home and community-based services to individuals with Phelan-Mcdermid disease.
- **All-Payer Claims Database (APCD) - $4.5 million**: Funds an APCD.
- **Critical Pediatric NICU/ PICU Rate Increase - $3.8 million:** Funds a rate increase for critical pediatric services.
- **Private Duty Nursing Rate Increase - $3.1 million**: Funds a rate increase for private duty nursing services provided by licensed practical nurses.
- **Rural Inpatient Hospital Reimbursement Adjustment - $2.4 million:** Increases rural hospital reimbursement.

Additional House funded Medicaid issues:

- **APD iBudget Waiver - $15 million:** Funding to serve 700 individuals on the waitlist.
- **LTC Waiver - $10.8 million:** Funding to serve 664 individuals on the waitlist with a priority score of for or higher.

- **Rural Hospital Financial Assistance Program - $4.9 million:** Increases rural hospital reimbursement.
- **Hospital Inflationary Rate Reduction – $69.9 million *reduction*:** Offsets the hospital 2 percent inflationary rate increase.
- **Hospital Outpatient Prospective Payment System (PPS):** Implements, in a budget neutral manner, a hospital outpatient services PPS using Enhanced Ambulatory Patient Groups (EAPGs), effective October 1, 2016.

Sen. Garcia Proposes Hospital Budget Focused on Charity Care Reimbursement. On January 28, 2016, *Tampa Bay Times* reported that Sen. Rene Garcia (R) proposed a hospital budget that would fully reimburse hospitals that see the most charity care patients. A second tier would receive reimbursement of 67 percent, a third tier would receive 7.5 percent, and the bottom tier 1 percent. Additionally, $7.3 million would be set aside for specialty children's hospitals. Read More

Florida Faces Severe Nursing Shortage. On February 1, 2016, *Tampa Bay Times* reported that Florida is facing a nursing shortage, with nearly 12,500 vacant registered nursing positions across the state. Vacancies have increased 30 percent since 2013 and an additional 9,947 nursing positions are expected to be created in 2016. Florida's population growth, which continues to grow faster than almost any other state, has made it difficult to keep up. Furthermore, 17 percent of residents are over 65, making it the "oldest" state in the nation. Registered nurses also have a high turnover rate – 18.3 percent in 2015. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Dental Association Opposes Hygienist Bill. On January 27, 2016, *Georgia Health News* reported that the Georgia Dental Association is refusing to discuss a bill to let dental hygienists practice in safety-net settings without a dentist present. House Health and Human Services Committee Chair, Sharon Cooper, tabled the bill after more than an hour of questions from lawmakers and testimony from proponents of the legislation. Read More

Indiana

Medicaid Expansion Lowers Uncompensated Care for Hospitals. On February 1, 2016, *IndyStar* reported that hospitals are seeing lower rates of uncompensated care as the state enters its second year of Medicaid expansion. The Health and Hospital Corporation of Marion County saw uncompensated care drop from 35 percent to 25 percent at Eskenazi Health, the hospital that has had the largest uncompensated care costs in the state. At Reid Health, the amount of unpaid bills decreased by 40 percent. Preliminary data of a state-commissioned survey found that 55 percent of 270 health-care providers reported a decline in the number of uninsured patients, and almost 40 percent have seen a decline in the request for charity care. Read More

Iowa

WellCare and Meridian Continue Fight to Manage Medicaid. On February 1, 2016, *Iowa Public Radio* reported that WellCare and Meridian are each continuing to fight against the state to manage Medicaid. WellCare was originally chosen to privatize Medicaid but since then had its contract terminated after it violated the rules of the bid process. The insurer argues that there was no violation. Meanwhile, Meridian argues that the Department of Human Services used an arbitrary, capricious, and unfair process to select the winning bidders and wants its application to be reevaluated. Read More

Kansas

Reports of Continued Issues with Medicaid Eligibility System. On February 1, 2016, *Kansas Health Institute* reported that the Medicaid eligibility system continues to experience issues as thousands of residents wait months to receive care. Problems arose after state officials moved Medicaid eligibility processing to the Kansas Eligibility Enforcement System (KEES), causing time-consuming workarounds. Furthermore, on January 1, 2016, Medicaid eligibility determination for the individuals who are elderly and disabled was transferred to the Kansas Department of Health and Environment. Read More

Maine

New Bill Could Raise MaineCare Reimbursement for Methadone Clinics. On January 28, 2016, *Portland Press Herald* reported that Senator David Woodsome proposed a bill to increase the MaineCare reimbursement rate at the state's methadone clinics to deal with ongoing heroin crisis. Weekly reimbursements would increase from $60 to $80 per patient. A public hearing on the bill will be held by the Legislature's Health and Human Services Committee. The reimbursement increase would cost the state an estimated $950,000, in addition to the federal government paying an extra $1.7 million to fund the higher reimbursements, according to a fiscal note attached to the bill. Maine had 71 heroin overdoses through the first nine months of 2015, compared to 57 in all of 2014. Read More

Massachusetts

Governor Baker's Proposed Budget Adds $30 Million to Nursing Homes; Industry Promises to Boost Worker Pay. On January 29, 2016, *Boston Globe* reported that Governor Charlie Baker proposed adding an additional $30 million to the nursing home budget. The industry is promising to use the additional funds to increase the pay of workers. However, advocates are urging for a requirement that the funds go to wages. Read More

Governor Baker's Proposed Budget Increases MassHealth Spending by 5 Percent. On January 28, 2016, *Boston Globe* reported that Governor Charlie Baker's proposed budget increases spending on MassHealth by five percent, compared to double-digit increases in recent years. The program will account for $15.4 billion of the $39.6 billion state budget. Rising costs of the program are

attributed to the rising enrollment, prices of prescription drugs, and prices of medical services. It currently insures nearly 1.9 million residents. Read More

Governor Baker's Proposed Budget Adds $250 Million Hospital Tax. Governor Charlie Baker released his $39.6 billion FY 2017 proposed budget. It includes a new tax of $250 million on acute care hospitals to gather revenue for the MassHealth Delivery System Reform Trust Fund. The fund will leverage federal matching funds to support the MassHealth Accountable Care Organization program.

Gilead Sciences Faces Challenges Regarding Hepatitis C Drug and HIV Drug. On January 27, 2016, *The New York Times* reported that Gilead Sciences is facing opposition from the state attorney general and the AIDS Healthcare Foundation over its drugs. In a letter to the company from Maura Healey, state attorney general, Healy stated that her office was examining whether Gilead violated state consumer protection laws by overcharging for its hepatitis C medication. Additionally, the AIDS Healthcare Foundation filed a lawsuit seeking to invalidate patents covering the new version of Gilead's HIV drug, tenofovir. Read More

Michigan

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

From the *HMA Michigan Update*: Pathway to Integration Section 1115 Waiver. As noted in the December edition of The Michigan Update, the Michigan Department of Health and Human Services (MDHHS) is seeking approval from the federal Centers for Medicare & Medicaid Services of a Section 1115 demonstration waiver - *Pathway to Integration* - to combine under a single waiver authority for all behavioral health services and eligible populations currently served through Section 1915(b), 1915(c) and 1915(i) behavioral health waivers. The proposed waiver would also include services for Healthy Michigan Plan enrollees currently served under a separate Section 1115 demonstration waiver. A press release on December 22, 2015 announced that MDHHS would accept public comments until February 2, 2016 and that two public hearings were scheduled in January, one a webinar on January 13, 2016 and the other a face-to-face meeting on January 28, 2016. The current target for implementation of the new waiver is April 1, 2016, the point at which the extension of the current 1915(b) Specialty Services and Supports Waiver expires. Total estimated costs for the five years of the waiver are just over $15 billion.

The press release on the waiver notes that "a vital component of the demonstration is the alignment of quality and financial incentives between traditional Medicaid Health Plans and Michigan's Specialty Service System. Demonstration incentives would include the joint identification and tracking of high risk and high utilizing populations, the prevention of modifiable risk factors, access to care incentives, pilot demonstrations through accountable systems of care, the enhancement of co-occurring serious mental illness and substance use disorder delivery systems, and the use of specialized complex care managers for individuals considered high utilizers." Current benefits will not be reduced or restricted as a result of the Pathway to Integration waiver. The waiver summary notes that the state is "seeking broad flexibility to develop quality, financing and integrated care (physical and behavioral health care) initiatives for all Specialty Service Populations on a statewide basis." This waiver

is expected to work in conjunction with the Accountable Systems of Care developed under the Blueprint for Health Innovation (Michigan's State Innovation Model) in advancing delivery system reforms.

Minnesota

Audit Finds DHS Medicaid Eligibility Errors Cost Taxpayers Up to $270 Million; Software Glitches Largely to Blame. On January 28, 2016, *Twin Cities Pioneer Press* reported that a nonpartisan audit found that approximately 38 percent of people enrolled in MNsure were not eligible for the program, based on a sample size of 157 people. This translates to between $115 million and $271 million in overpaid benefits over the entire population from January through May 2015. The audit found information was not accurately and fully transferred between the MNsure software and the department's separate payment software, causing the errors. Additionally, the MNsure software had difficulty connecting to the federal government's computers to share information and could not cross-check reported income or family information with available tax records or wage information. Other problems were caused by human errors. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Developmental Disabilities Provider On-line Training System RFP Released. On February 1, 2016 the New Jersey Department of Human Services (DHS), Division of Developmental Disabilities (DDD) released a Request for Proposals (RFP) for entities with experience running on-line training systems for community provider agency direct support staff. The RFP goal is "a better trained, more stable workforce which will thereby support a federal commitment to assure the health and safety of individuals with developmental disabilities residing in the community." There are currently over 28,000 individuals registered with DDD over the age of 21 in the state and an estimated 20,000 direct service providers. DDD will fund one entity up to $500,000 per year for a three year contract with the option of two 1-year extensions. A voluntary technical assistance call is scheduled for interested bidders on February 16, 2016 and proposals are due on March 1, 2016. The award will be announced on April 11, 2016 and the contract will begin on July 1, 2016. Bidders can register for the technical assistance call and submit questions by emailing ddd.rfphelpdesk@dhs.state.nj.us by 4:00 P.M. on February 10, 2016. Read More

Department of Community Affairs 2015-2019 Consolidated Plan for Affordable Housing Posted. Commissioner Charles Richman released a five year plan for affordable housing in New Jersey that includes input from affordable housing developers, mental health providers, shelter providers, homeless assistance and prevention service providers, and local government agencies.

The consensus from stakeholders was that the major housing and community development needs continue to be: 1) Providing decent, safe affordable housing for both families and disabled households; 2) Providing safety nets and services to stabilize the homeless population and eventually move them into permanent housing; 3) Supporting community and economic development projects that will help stabilize neighborhoods; and 4) Continuing to fund initiatives such as Housing First. A copy of the Consolidated Plan can be found here.

New FQHC Opens in East Newark, New Jersey. *NJBiz* reports that St. James Health, a new federally qualified health center (FQHC), has opened in Newark. The FQHC provides services to area residents who have been without easy access to medical care since the closing of the St. James Hospital in 2008. The facility projects that it will serve 4,000 patients in the first year. According to Nicole Fields, the FQHC's CEO, "many residents [in the East Ward] face language and cultural barriers. They may not have proper health insurance. Most critically they are experiencing disproportionately high rates of asthma, diabetes, and hypertension." Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Covering New York's Remaining Uninsured. A recent report by the Community Service Society of New York presents three different options for extending coverage to New York's remaining uninsured. While the Affordable Care Act (ACA) has helped many New Yorkers obtain health insurance, as many as 457,000 unauthorized, uninsured immigrant New Yorkers remain ineligible for coverage. The report outlines three options that the state could adopt to get immigrants covered, along with a policy and financial analysis for each. The three options investigated are:

- A comprehensive "Essential Plan" for undocumented adults with incomes below 200% of the federal poverty level;
- A "Young Adult" plan for undocumented immigrants ages 19–29 that builds on the Child Health Plus program; and
- A high-deductible "Bronze Plan" for undocumented adults already eligible for Emergency Medicaid.

Transition of TBI and NHTD Waiver Program Participants into Managed Care. Last week, stakeholders met with the Department of Health regarding transitioning the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waivers into managed care. DoH has shared its TBI/NHTD draft transition plan with stakeholders. The draft plan is found here: http://www.alliance-nys.org/wp-content/uploads/2016/01/Final-Draft-Transition-Plan-1.25.16.pdf

The topics covered in the 16 page transition plan include background about the waiver programs, a transition narrative that addresses access to services, a transition timeline, a description of the process for enrollment of existing participants into managed care, the enrollment process after the transition, continuity of care provisions, plan readiness assessment (including network capacity, provider qualifications, and training), service planning and delivery (emphasizing person-centered plan of care), appeals and rights, consumer support, and quality assurance. The transition plan notes that now that NY's Community First Choice Option has been approved, many of the services currently provided through the waiver programs will now be Medicaid state plan services, and as such, are excluded from the Home and Community Based waiver services. The plan also notes that the NHTD/TBI waiver programs will continue to provide these services until such time as the CFCO is fully implemented and the waiver services have been successfully transitioned to managed care.

The draft transition plan has been met with some concern by stakeholders, as they feel that the plan does not adequately address transition issues, and does not include all the services provided under the current waivers, specifically service coordination and HCSS oversight and supervision. Other concerns remain about the role of the Service Coordinator, Regional Resource Development Specialist and RRDC DoH has agreed to meet weekly with the TBI/NHTD Transition workgroup to address these concerns.

Tender Loving Care Health Care Services to Buy Bankrupt Home Health Agency. On February 2, 2016, *Crain's New York* reported that Tender Loving Care Health Care Services of Nassau Suffolk, a subsidiary of a Louisiana home health giant, is seeking approval to buy Visiting Nurse Association of Long Island, a bankrupt home health agency. VNALI declared Chapter 11 last June, blaming the transition to Medicaid managed long-term care from fee-for-service. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio's Joint Medicaid Oversight Committee (JMOC) Discusses Medicaid in Schools. John McCarthy, Ohio's Medicaid Director, and Sue Zake, Director of the Department of Education's Office for Exceptional Children, recently presented on Ohio's Medicaid in Schools program. They described changes to reimbursement policies starting in August when program services will have to be authorized by a medical professional who is either a Medicaid billing provider or a Medicaid ordering, referring and prescribing provider. Ohio's program covers services, such as behavioral health, nursing, occupational therapy, targeted case management and specialized transportation for students with certain conditions. Right now, Medicaid can reimburse for services if they are approved by parents and the student's Individualized Education Plan team. According to *Gownger*, Director McCarthy clarified that, "many of these kids, they already have a physician ordering these services, prescribing these services outside of the school environment. Really it's getting that piece of paper, that prescription from the physician." Director Zake explained that this change does not change the IEP process and that IEP teams still make decisions on what is best for a student's special education needs. Read More

Low-Income Seniors Struggle to Afford Dental Care. On January 31, 2016, *The Columbus Dispatch* reported that lower-income seniors, especially those who are disabled or unable to leave their house, struggle to receive dental care. Nearly 37 percent of the state's poorest seniors have had all their teeth removed as a result of tooth decay or gum disease. Medicare rarely pays for dental care so many turn to emergency rooms for care. Ohio's Medicaid program, however, does provide adult dental benefits, but only 30 percent of the state's dentists participate. Advocates are pushing Ohio to allow the licensing of dental therapists to provide basic services in underserved areas. Read More

Oklahoma

Oklahoma Pushes Back ABD Managed Care RFP Timing. This week, the Oklahoma Health Care Authority (OHCA) revised its ABD Care Coordination timeline, pushing back the targeted RFP release date to August 2016 from July 2016, with proposals now due at the end of October. OHCA is targeting announcing contract awards in January 2017 and beginning a multi-year, multi-phased implementation process in late 2017. The ABD Care Coordination program will likely cover more than 177,000 Medicaid ABD beneficiaries.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Agrees to Bolster Support for Individuals with Mental Illness in ACLU Settlement. The Department of Human Services and the ACLU of Pennsylvania announced a settlement to a federal lawsuit that results in the Department agreeing to make changes to improve how mentally ill defendants in the criminal justice system receive treatment. *PennLive* reports the settlement involves the Department creating 170 new treatment slots, spending $1 million in the next three months on supportive housing options as well as developing an agreement in the near future with the ACLU of PA on the maximum number of days a defendant would wait before being transferred to a state hospital. Secretary Ted Dallas said, "Today's agreement will help improve both systems (human service and criminal justice) and make it easier for all of those involved to achieve the best possible result for the individuals they serve." Read More

Trouble Ahead for Critical Access Hospitals in Pennsylvania. Pennsylvania's state budget impasse has resulted in critical access hospitals in the rural areas of the state losing funding but legislation has been introduced to restore those funds. *Bradford Era* indicates that the hospitals struggle financially and the state supplemental payment appropriation helps to offset lack reimbursement from certain government programs. State Representative, Matt Baker, said "…they [critical access hospitals] have a heavy reliance on government reimbursements through Medicare and Medicaid." Read More

PA Department of Health Release Powerful Health Data Analytics Portal. The Department of Health and the Governor's Office of Transformation, Innovation, Management and Efficiency (GO-TIME) announced the launch of a new online tool to access and analyze public health data. The tool called the Enterprise Data Dissemination Informatics Exchange, or EDDIE, includes datasets related to vital records and cancer incidence. Additional features such as environmental health data and county level assessments as well as geographical visualization capabilities will be added in the next couple of weeks. The Department of Health Chief Information Officer, Pat Keating states, "The Department is dedicated to enhancing the profile of public health data by enabling greater data dissemination and decision making. We have increased the value of all the data we collect by preparing and sharing it for everyone to use and learn from." To view the tool click here: http://doh.pa.gov/eddie. Read More

National

Up to 6 Million Americans Eligible for Medicaid, But Do Not Sign-Up. On January 31, 2016, *The Wall Street Journal* reported that as many as six million people are eligible for Medicaid but do not sign up. Federal officials have focused on continuing to expand eligibility for Medicaid and will soon ask Congress for fresh financial incentives for the 20 states that have not expanded at the start of 2016. To reach those who are not enrolling, the administration in enlarging a national campaign aimed at enrolling low-income children to include their parents. Officials will offer $32 million in grants this spring for outreach and enrollment work. Read More

Industry News

LifePoint Health Acquires Providence Hospitals. On February 2, 2016, LifePoint Health announced that the acquisition of Providence Hospitals has been completed, effective February 1, 2016. Read More

Centurion to Provide Correctional Healthcare Services in Florida. On February 1, 2016, Centene announced that Centurion of Florida reached a formal agreement to provide correctional healthcare services in regions 1, 2, and 3 in Florida through January 2018, with optional renewal periods if the state does not finalize a formal procurement. The state terminated its prior vendor early and anticipates to finalize a formal procurement by 2018. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February 5, 2016	Nebraska	Letter of Intent to Contract	239,000
February, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
March 1, 2016	Iowa	Implementation	550,000
March 3, 2016	West Virginia	Proposals Due	450,000
March 15, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
April 29, 2016	Missouri (Statewide)	RFP Released	700,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	RFP Released	177,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Oklahoma ABD	Proposals Due	177,000
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
March 1, 2017	Virginia MLTSS	Implementation	130,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
TBD 2017/2018	Oklahoma ABD	Implementation	177,000
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 17 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	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
California	120,452	117,449	117,307	117,179	116,538	115,743
Illinois	52,170	50,631	49,586	48,779	53,136	54,770
Massachusetts	17,671	17,518	17,179	12,657	12,366	12,285
Michigan	28,171	35,102	42,728	37,072	36,335	34,858
New York	7,122	9,062	8,028	9,942	8,005	6,811
Ohio	61,871	62,418	59,697	61,428	61,333	59,887
South Carolina	1,388	1,380	1,530	1,355	1,359	1,331
Texas	44,931	56,423	45,949	56,737	52,232	48,085
Virginia	29,507	29,200	29,176	27,138	28,644	27,103
Total Duals Demo Enrollment	**363,283**	**379,183**	**371,180**	**372,287**	**369,948**	**360,873**

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 Jan-16
- **Ohio** Medicaid Managed Care Enrollment Is Flat, 2015 Data
- Public documents such as the **West Virginia** Medicaid Managed Care RFQ, **California** Medi-Cal GMC Expansion RFA Responses and Scoring, and the **Oregon** FFS Care Coordination, Integration, and Evaluation Services RFP, Jan-15
- Plus upcoming webinars on *"California Medi-Cal 2020: What the State's 1115 Waiver Renewal Means for Medicaid Providers, Health Plans and Patients," "Value Based End-of-Life Care: Having the Conversation Nobody Wants to Have Benefits Everybody,"* and *"MLTSS Network Adequacy: Meeting the Access Requirements of an Emerging Market"*

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.