HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 10, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MINNESOTA ISSUES SPECIAL NEEDS BASICCARE (SNBC) REQUEST FOR PROPOSALS

This week, our *In Focus* section reviews the request for proposals (RFP) issued by Minnesota's Department of Human Services for the Special Needs BasicCare (SNBC) Program, which provides voluntary managed care services to Medicaid adults with disabilities. This procurement covers more than 45,000 enrollees in 62 of Minnesota's 87 counties, more than 90 percent of the statewide SNBC program. A primary goal of the RFP is the integration of Medicaid and Medicare benefits through the encouragement of dual eligible special needs plan (D-SNP)

participation. Currently, less than 800 dual eligible enrollees are in an integrated SNBC plan, out of more than 27,000 duals in SNBC overall.

Covered Population and Benefits

The SNBC program voluntarily enrolls individuals ages 18 to 64 who have a disability and are eligible for medical assistance. Enrollees who turn 65 may choose to stay in the program, and any enrollee may opt out of the program at any time. As noted above, approximately 45,600 enrollees are enrolled in SNBC and reside in counties covered by this procurement. Based on a PMPM rate of roughly $1,200, we estimate the annual spending associated with these contracts at $660 million.

In addition to preventive and acute care, SNBC program services include behavioral health, pharmacy, dental, vision, home care, and up to 100 days of nursing facility care and support services. The program does not include home care nursing, personal care services, or home and community-based waiver services, which are delivered on a fee-for-service basis to those who qualify.

Key RFP, Contract Provisions

Plans must be non-profit entities in order to be eligible for a SNBC contract. The state is encouraging responders to offer a Dual Eligible Special Needs Plan (D-SNP) and to meet CMS requirements as a low income benchmark plan for Part D benefits. Proposals that include a dual eligible integrated SNBC product in 2017 will receive additional points during the evaluation process.

The state is also encouraging respondents to maintain their currently contracted SNBC service areas and to propose providing services in the northern Minnesota counties from which Medica health plan is withdrawing in July 2016. Proposals including these components will also receive additional points during the evaluation process.

Contract Term and Awards

The RFP does not explicitly state an initial contract term; however, based on the current SNBC contract, it is assumed that the initial contract will be for one year, with the state retaining the option to renew the contract for up to five years. The RFP does not specify the number of contract awards DHS intends to make.

RFP Timeline

The RFP includes a quick turnaround, targeting an implementation date of July 1, 2016, in the northern counties of the state, to compensate for Medica's planned July 2016 withdrawal from the SNBC program in many of these counties. The RFP questions for the responders' conference has a quick turnaround, with questions due on February 15, only one week after the release of the RFP. Proposals are due on March 29, with contract start dates of July 1, 2016, for counties in the northern part of the state and January 1, 2017, in the remaining counties, as detailed below.

RFP Milestone	Date
RFP Released	February 8, 2016
Questions for Responders' Conference Due	February 15, 2016
Deadline to Register to attend Responders Conference	February 16, 2016
Responders Conference	February 18, 2016
DHS responses to written questions published	February 25, 2016
Proposals due to DHS 4:00 pm CST	March 29, 2016

Anticipated Selection of Successful Responder(s)	April 21, 2016
Notice of Intent to Contract	April 22, 2016
Contract start date for Aitkin, Becker, Benton, Carlton, Cass, Chisago, Clay, Cook, Crow Wing, Isanti, Itasca, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, Marshall, Mille Lakes, Norman, Ottertail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Sherburne, Stearns, Wilkin, and Wright counties.	July 1, 2016
Contract start date for Anoka, Blue Earth, Carver, Chippewa, Cottonwood, Dakota, Faribault, Fillmore, Hennepin, Houston, Jackson, Kandiyohi, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Ramsey, Redwood, Rice, Rock, Scott, Swift, Washington, Watonwan, Winona, and Yellow Medicine counties.	January 1, 2017

Evaluation Process

The evaluation process consists of three phases. The first phase consists of the submission of required documents and will be evaluated on a pass/fail basis. Phase II is a mix of pass/fail and scored components, which are listed below. If a responder fails one of the components marked as pass/fail, they will not move on to Phase II. In Phase III, evaluators may require oral presentations or further detail in written form. As noted above, proposals that include a dual eligible integrated SNBC product in 2017, maintain services in a county it already serves, or provide services in one of the northern counties from which Medica is withdrawing, will receive additional points.

There does not appear to be an explicit cost component; however, proposals will be evaluated on "best value."

Current SNBC Market

As of this month's enrollment figures, UCare and Medica split more than 86 percent of the SNBC market. Medica's exit from many northern counties provides an opportunity for smaller SNBC plans, or new market entries, to pick up significant market share. Furthermore, it is worth noting that UCare lost its traditional Medicaid managed care and MinnesotaCare contracts in a rebid this past summer because of high-cost proposals.

SNBC Plan	Statewide Enrollment (Feb. 2016)	Statewide Market Share
UCare	21,831	43.1%
Medica	21,817	43.1%
Metropolitan Health Plan	2,591	5.1%
South Country Health Alliance	2,258	4.5%
PrimeWest Health	2,106	4.2%
Total (All SNBC Plans)	**50,603**	

Link to RFP

http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs-285504.docx

HMA Medicaid Roundup

Alabama

Alabama Receives Federal Approval For a New Medicaid Delivery System Using Regional Care Organizations. On February 9, 2016, *Alabama Today* reported that Alabama received federal approval to transition from a fee-for-service model to one closer to managed care through entities called regional care organizations, or RCOs. Under the new structure, Alabama's Medicaid system will enter into contracts with RCOs to provide certain covered services for Medicaid patients at an established cost. Although the state could receive up to $750 million from the federal government to help pay for the move to the new delivery system, year-to-year funding for the Medicaid program continues to be a concern. Read More

Governor Bentley Does Not Propose Medicaid Expansion, Despite Task Force Recommendations. On February 6, 2016, *Montgomery Advertiser* reported that Governor Robert Bentley did not propose Medicaid expansion during his State of the State Address. Bentley stated that he will focus on completing the implementation of Regional Care Organizations in hopes of encouraging more preventive care and less hospital use. He also stated that the legislature would not approve expansion. The Alabama Health Care Improvement Task Force, created by Bentley, recommended expansion in November 2015. Read More

Arkansas

Cindy Gillespie Named Director of Arkansas DHS. On February 3, 2016, *KATV* reported that Cindy Gillespie was named the new director of the Arkansas Department of Human Services, effective March 1. Gillespie was previously senior health care advisor to former Massachusetts Governor Mitt Romney. Read More

California

HMA Roundup – Don Novo (Email Don)

Legislature Introduces Health Plan Tax Bill. On February 8, 2016, *KCRA News* reported that the California legislature has unveiled a proposed health plan tax aimed at filling a $1.1 billion gap in the state budget due to the impending expiration of the previous Medicaid-only health plan tax. The plan would redesign the health plan tax structure to apply to all health insurers in the state, as required by the federal government. At this time, the California Association of Health Plans has yet to weigh in on the bill and it remains unclear if Governor

Jerry Brown will have the necessary votes in the legislature to pass the bill. Read More

Experts Predict Medi-Cal Cost for Undocumented Children Can Rise. On February 9, 2016, *California Healthline* reported that experts predict that state officials may have underestimated the number of children in the United States illegally who will be eligible for Medi-Cal. As a result, the cost of providing full benefits will be significantly higher than projected. The Department of Health Care Services said about 170,000 such children will be eligible for full Medi-Cal beginning in May, when the expansion takes effect, and that covering them will cost the state $142.8 million in fiscal year 2016-2017. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House Committee Approves Bill to Transition Dental Benefits to Standalone Dental Plans. On February 10, 2016, *Health News Florida* reported that the Florida House Health & Human Services Committee approved a bill that could lead to carving dental benefits out of managed care and into separate dental plans. The bill would require that a report be submitted to the governor and legislative leaders by December 1, 2017. If the legislature does not take action on the report's findings by July 1, 2017, the bill would require continued provision of dental services through the Medicaid managed care program; the state would move forward in transitioning services to separate dental plans. The bill now moves to the full House for review. Read More

FBI and State Investigating Corruption Claims at Broward Health After CEO's Suicide. On February 3, 2016, *Modern Healthcare* reported that Broward Health is under federal and state investigations following the suicide of CEO Dr. Nabil El Sanadi. The FBI is looking into corruption claims based on evidence gathered by a private investigator hired by El Sanadi. Additionally, Florida's Chief Inspector General sent a letter to the company outlining plans to conduct a review of all contracts the system has entered into since July 1, 2012. Read More

Iowa

Iowa Senate Fails to Repeal Medicaid Privatization. On February 4, 2016, *The Des Moines Register* reported that Iowa Senate Democrats proposed a new bill, known as the Health Care Protection Act, to repeal Medicaid privatization. The bill would terminate the contracts with the three managed care companies and direct the Department of Human Services to continue previous efforts to improve patient outcomes, increase access to care, and continue to make the public management of Medicaid more efficient. House Republicans have stated that the bill will be dead upon arrival. Read More On February 5, 2016, *Sioux City Journal* reported that a legislative rule-making panel defeated the bill. Read More

Kansas

Medicaid Expansion Bills Introduced in House, Senate. On February 8, 2016, *The Wichita Eagle* reported that "The Bridge to a Healthy Kansas," a plan to expand Medicaid in the state has been introduced in both the House (HB 2633)

and Senate (SB 371). The plan, authored by the Kansas Hospital Association, would include residency requirements, employment incentives, as well as deductibles and premiums for members, and would be budget positive to the state's general fund. However, the prospects for passage are unclear, with many leading lawmakers opposed to expansion and Governor Sam Brownback's administration yet to weigh in on the bill. Read More

Kentucky

Former Kansas Hospital Association Executive named Medicaid Commissioner. On February 9, 2016, Governor Matt Bevin announced the appointment of Stephen P. Miller, formerly an executive with the Kansas Hospital Association, as the state's new Medicaid commissioner. Prior to working at the Kansas Hospital Association, Miller held positions with two different Kentucky hospitals. Read More

Massachusetts

Proposed Bill to Lower Nursing Home Costs for Middle Class. On February 5, 2016, *The Milford Daily News* reported that State Representative John Fernandes (D) proposed a bill (H.529) to make nursing homes more affordable for middle class families. The bill would change the formula for calculating allowances to a lower and fairer investment interest. Read More

Attorney General to Investigate 12 Home Health Agencies for Medicaid Fraud. On February 3, 2016, *The Boston Globe* reported that Governor Charlie Baker's Executive Office has asked Attorney General Maura Healey to investigate 12 home health care providers for fraudulent billing. The Medicaid Fraud Division will review internal data and consumer complaints that may be representative of fraud. The investigation comes as the state is hit with a surge in spending on home health care services, up by 82 percent from two years earlier. Read More

Montana

Medicaid Expansion Job Training Program Launches. On February 9, 2016, the *Great Fall Tribune* reported that Montana's Medicaid expansion program, known as HELP, has launched its job training program, known as HELP-Link. The HELP-Link program is designed to provide job training to Medicaid expansion enrollees. Although not required, participation in HELP-Link will prevent participants from being disenrolled for failure to pay their monthly premium. Read More

Nebraska

Nebraska Announces Medicaid Managed Care RFP Contract Awards. On February 5, 2016, Nebraska announced the contract awards for the full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. The winners were UnitedHealthcare, Nebraska Total Care (Centene), and Aetna Better Health. AmeriHealth Caritas, Meridian Health Plan, and WellCare also submitted bids. Read More

Nebraska Medicaid Director Opposes Costly Expansion Bill. On February 10, 2016, *Lincoln Journal Star* reported that Medicaid Director Calder Lynch will testify in opposition to LB1032, a proposal that would expand health care coverage for more than 100,000 Nebraskans and cost an estimated $978 million over a 10-year period. The bill would also provide the state with access to an additional $13 billion in federal matching dollars. Lynch cited concerns about the cost of the expansion, the potential impact on the ability of current Medicaid members to access services, and the implications if the federal government reneged on its pledge to provide funding. While sponsors of the bill point to the bill's potential to ease the burden on the state's health care providers, Lynch remains skeptical. Read More

New Hampshire

Jeffrey Meyers Named Commissioner of Health and Human Services. On February 1, 2016, *New Hampshire Public Radio* reported that Jeffrey Meyers was named as the new Commissioner of Health and Human Services. He will be serving a four-year term. Meyers is urging lawmakers to extend Medicaid expansion past 2016. Read More

Addiction Treatment Programs Face Staffing Shortages. On February 1, 2016, *New Hampshire Public Radio* reported that the state is facing staffing shortages at addiction treatment programs, as it tries to address an opiate abuse epidemic. Fewer counselors are taking jobs because of poor funding and poor coordination from the state. For instance, the state requires a certain number of beds to be available for court-ordered clients, state subsidized clients, and privately insured clients. As a result, clients are put on waiting lists while beds remain empty. In 2015, 39 people became licensed addiction treatment counselors, while 35 counselors let their licenses expire. The state netted a total of only 4 new licensees. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Human Services appoints a new Medicaid Director. On February 8, 2016 the Division of Medical Assistance and Health Services (DMAHS) notified staff that Medicaid Director, Valerie Harr, had accepted a new position at the Department of Human Services as Deputy Commissioner. In that capacity Ms. Harr will oversee the Divisions of Disability Services, Medical Assistance and Health Services and Aging Services. Meghan Davey, the current Chief of Operations at DMAHS was selected to replace Ms. Harr and will serve as the new Medicaid Director. Ms. Davey has been with DMAHS since 1999.

Developmental Disabilities Division update on the Supports Program. The Supports Program, which launched in July 2015, has been monitoring the first group of individuals (Cohort 1) who enrolled. The Supports Program is a state initiative included in the Comprehensive Medicaid Waiver to provide supports and services for adult individuals, 21 and older, with developmental disabilities and living with their families or in other unlicensed settings. It provides employment/day services and individual/family support services based on an individual's assessed level of need.

The Division determined that Cohort 1 has been able to continue accessing their services and that their providers successfully received Medicaid reimbursement for services. As a result they will begin to enroll Cohort 2 into the Supports Program beginning in February 2016. This second group represents 275-300 individuals are currently receiving a wider variety of services from a larger number of providers. About 30 Support Coordination Agencies, and 25 to 30 providers are serving Cohort 2. A third cohort that will consist of the 2016 graduates (students who are eligible for and in need of DDD services because they are ending their educational entitlement at 21 years of age) will begin enrolling in the Supports Program this spring.

NJ Study finds that hospital readmissions are reduced through home health care. The New Jersey Home Care and Hospice Association released a report of a study on hospital readmissions that found that home health care leads to lower rates of readmissions. Quality Insights studied Medicare data to compare the readmission rates of patients who received home health care post-discharge, and those who did not. Association president, Chrissy Buteas attributes the findings to RNs and therapists who are "trained to recognize the subtle differences in a patient's condition to make a medically sound assessment of which symptoms require a trip to the hospital and which do not." Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

DSRIP Extension Discussed. The United Hospital Fund and the NYS Health Foundation hosted a conference on the future of health care in NYS. Health Care 2021: A Vision for New York included panels on consumers and patients; technology and information-sharing, and providers and plans. In the latter session several panelists shared their opinions about NY's DSRIP program. The sense was that the current five-year program will not be sufficient to achieve the health system transformation that is envisioned. Panel members agreed that successful payment reform and health system transformation will require a longer time frame as well as additional resources; probably another five years on top of the current five-year program.

FIDA Trends and Opportunities. The Department of Health has created a new page on its website specifically about the duals demonstration initiative, Fully Integrated Duals Advantage. The web page provides current enrollment information by county and by plan. It also provides information on the number of potentially eligible FIDA participants and the number of opt-outs. As of January 2016, the state estimates that 109,000 individuals are FIDA-eligible; 6,290 have enrolled in the program; and 61,362 have opted out. Among the 17 plans participating in FIDA VNS has the largest share of enrollment with 2,264 enrollees; HealthFirst is second with 1,237. No other plan has more than 400 enrollees.

Rate of Uninsured Decreases. A recent report by the National Center for Health Statistics found that NY is one of eight states that saw a significant decline in its uninsured numbers in 2015. The report provides state-specific health insurance estimates for the first 9 months of 2015. The data show that New York had a statistically significant lower percentage uninsured than in 2014. Kentucky and Arizona had the biggest percent reductions; New York followed, with a reduction of 5.6 percentage points.

Public Health and Health Planning Council 2015 Annual Report. The Public Health and Health Planning Council released its 2015 Annual Report. The PHHPC is responsible for adopting and amending the Sanitary Code and health care facility, home care agency, and hospice operating regulations. The PHHPC also makes decisions concerning the establishment and transfer of ownership of health care facilities, home care agencies and hospice programs. It makes recommendations to the Commissioner of Health concerning major construction projects, service changes, and equipment acquisitions in health care facilities and home care agencies. It also advises the Commissioner on issues related to the preservation and improvement of public health. The Annual Report highlights the activities of each of the PHHPC's committees: Codes, Regulations and Legislation; Establishment and Project Review; Health Planning; and Public Health. It also lists all the health facilities that requested changes that require approval by PHHPC. The Annual Report is available on the Department of Health website.

Medicaid Billing Information for Alcohol and Substance Abuse Services. The Office of Alcoholism and Substance abuse Services has reorganized information about fee for service rates on its web page. Effective Jan. 1, 2016, the most up-to-date Medicaid Fee for Service information can be found on the NYS OASAS Managed Care webpages, specifically the APG Medicaid fee for service page. With the transition to Medicaid Managed Care (MMC), OASAS providers will be reimbursed at the current APG rate for two years once MMC is implemented in their region. By moving the current fee for service information, including the APG rates, Revenue Calculator, etc., to the Managed Care webpage providers will be able to find the information they need all in one location.

Eastern Niagara Health System Closing Emergency Department Site. Eastern Niagara Health System has announced it will transition the emergency department at the system's Newfane site into an urgent care service. According to Buffalo Business First, the unit is slated to transition on March 15, after which ambulances and patients with emergency symptoms will be referred to the system's Lockport hospital emergency department. They report that the ED is serving on average only 11 patient per day, while incurring annual losses of about $1.5 million. Eastern Niagara is one of the state remaining independent, rural hospitals.

North Carolina

North Carolina Medicaid Program Under Budget for the Third Year in a Row. On February 10, 2016, *Winston-Salem Journal* reported that the North Carolina Medicaid program is projected to be under budget for the third straight fiscal year. Medicaid Finance Director Trey Sutten reports that the program is $181 million, or 9.3 percent, under budget through December 31, 2015, because of lower utilization of services, flat enrollment levels, and lower costs. Additionally, the state is on track to submit Medicaid reforms to CMS by March 1 that would better coordinate care and ensure budget predictability. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Prior Authorization Could Be Quicker, Might Use a Web-based System. *Gongwer* is reporting that work continues on a bill in the House that establishes a timeline for companies to respond to prior authorization requests and creates a web-based system for communication between insurers and physicians. The bill (SB 129) has been under development for months and was unanimously cleared by the Senate in December. More than 70 medical organizations have reportedly signed on so far, including the Ohio State Medical Association, which is reported to have submitted written testimony in support of the bill. Some basic provisions are still being worked out, like the timeline for initial responses to a prior authorization request, which has been shortened to five days rather than the federal guideline of 15 days. Also, Ohio's Legislative Service Commission anticipates the bill would increase administrative costs for the Department of Insurance, the Department of Medicaid, and Medicaid-managed care organizations. A fiscal note filed by the Commission describes the increased administrative cost to the Department of Medicaid and to Medicaid managed care plans as "unknown." Read More

30,000 Ohioans May be Impacted by Ohio's Move to End Medicaid Spend-down Eligibility. The Center for Community Solutions (Jon Honeck, Edward D. and Dorothy E. Lynde Fellow) has posted to the CCS blog, information describing changes that may impact the eligibility of 30,000 people on Ohio Medicaid. The blog posting is titled: Over 30,000 Ohioans Affected by the End of Medicaid "Spend-down" Eligibility. It describes those areas of Medicaid eligibility that are expected to be impacted by moving Ohio Medicaid to a unified disability determination system. This is being done so that individuals who qualify for SSI will automatically qualify for Medicaid. There are many moving parts associated with these change. Read More

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Moda's Financial Problems, State Oversight. On January 27, the Oregon Department of Consumer and Business Services (DCBS), Division of Financial Regulation issued an order of supervision for Moda Health Plan, Inc., based on its determination that the carrier was experiencing significant financial difficulties, including significant operating losses and inadequate capital and surplus. The order allowed the Division to place an employee on site and to take control of the company's financial decisions. Under the order, Moda was barred from issuing new policies or renewing existing ones. The order also requires the company to get sufficient capital and present DCBS with a business plan that demonstrates the company can operate in sound financial condition.

On February 8, the Division replaced the order of supervision with a consent order, which outlines a plan for the carrier to continue to serve customers without interruption. The consent order removes the ban on new policies, allowing the carrier to sell and renew policies in the individual and group markets. Moda, which has over 62,000 lives in the state's individual market and is a key player in the state Exchange, is required to raise $179 million, which DCBS Director Patrick Allen and Administrator of the Division of Financial

Regulation/Insurance Commissioner Laura Cali testified to the House Committee on Health Care will cover ongoing plan operations and allow for a margin for adverse events.

Although Moda also sells policies in Alaska, the carrier is domiciled in Oregon, making DCBS the one state agency with the authority to issue the consent order. In addition to requiring the carrier to file a plan of action (including a confidential plan for raising capital and at least monthly reporting on cash flow, cost management and other financial issues), DCBS has approval over any changes in executive compensation. The Department also required Moda to set aside $15 million to play claims for its Alaska members.

Oregon Health Authority Delays Launch of Eligibility and Enrollment Website. The Oregon Health Authority (OHA) has delayed the launch of a new public website (Oregon Eligibility, also known as ONE) that would allow Medicaid applicants to apply for and enroll in coverage. The website, which was supposed to launch to the public on February 6, has been used by state workers since December. There is a backlog of applications to be processed, including approximately 24,000 applications that have been waiting for a determination for more than the federally allowed 45 days. An estimated 49,000 applications have been submitted because Oregonians have been accessing healthcare.gov and have been assessed as having Medicaid-level income. The OHA, the state's Medicaid agency, noted that the backlog is due to a federal change in data format that has kept the ONE system from accepting electronic account transfers from healthcare.gov. All new and renewing applications must have data entered manually rather than being sent electronically from old systems.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf Announces New Efficiency Measures. Governor Tom Wolf announced the administration's proposal to consolidate the Pennsylvania eHealth Partnership Authority into the Department of Human Services as part of the 2016-2017 proposed budget. The 2016-2017 Budget proposes to move the eHealth Partnership Authority to DHS to realize administrative savings and maximize federal dollars. Moving current personnel to the department would save approximately $1 million annually, in addition to improving operations and timeliness. Authority leadership learned of this last week. Over the coming weeks, the Authority Board and staff leadership will be working to understand the Governor's plan and the "logistics—legislative, administrative, and more—of a transition to DHS. A statement issued by current Executive Director Alix Goss, says "regardless of the ultimate structure of our agency, the Board, staff, and agency partners remain committed to the mission of the Authority to establish statewide health information exchange. Our current HIO-to-P3N onboarding schedule—establishing statewide connectivity this spring—is unchanged." Read More

Rhode Island

Health Advocates Support Governor Raimondo's Budget Plan. On February 4, 2016, *Providence Journal* reported that health advocates largely support the Reinventing Medicaid program going forward in Governor Raimondo's budget.

Medicaid director, Anya Rader Wallack, said the plans make significant changes to cut costs but do not cut eligibility and benefits while expanding the number of residents who are covered. Advocates remain cautious about how some issues will resolve once spending plans are finalized. Read More

Vermont

Officials Delay Major Technology Updates for the Agency of Human Services; to Release Revised RFPs. On February 4, 2016, *VPR* reported that state officials are delaying major technology updates for the Agency of Human services and starting the process anew using solutions developed in other states. Contracts negotiations for work on Integrated Eligibility and work on the Medicaid Information System (MMIS) Core are being halted while the state prepares to release revised RFPs. Read More

Virginia

Virginia Seeks 1115 Waiver to Privatize Medicaid for the Elderly, Blind, and Disabled; Pursue Delivery-System Reforms. On February 4, 2016, *Modern Healthcare* reported that Virginia is seeking approval from CMS for a 1115 waiver to move Medicaid to managed care. The waiver would first transition the blind, elderly, and disabled, which includes dual eligibles, into capitated plans. As a result, the state's dual demonstration, Commonwealth Coordinated Care, would end at the end of 2017. Additionally, the waiver requests a Delivery System Reform Incentive Payment program to allow the state to use federal Medicaid funding to create financial incentives for providers to pursue delivery-system reforms. Read More

National

Top Insurers Stop Paying Brokers Sales Commissions for High-Cost Coverage. On February 4, 2016, *Kaiser Health News* reported that Anthem, Aetna, and Cigna will cease to pay brokers a commission on coverage sold outside the normal enrollment period. Currently, the health law allows people in certain circumstances (e.g., losing other coverage, new children) to buy insurance after enrollment season ends. However, the enrollees were much more expensive than expected. Cigna and Humana have stopped paying brokers to sell gold marketplace plans, but continue to pay for lower-benefit plans. Gold plans typically enroll sicker members. Last year, United suspended almost any commissions for such business. Critics say that encouraging brokers to avoid high-cost members limits access and discriminates against people with greater medical needs. Read More

Eight States Saw Significant Drops in Uninsured. On February 9, 2016, *The New York Times* reported that according to the Nation Health Interview Survey, eight states saw significant drops in the number of uninsured last year: Arizona, California, Colorado, Florida, Illinois, Kentucky, Michigan, and New York. Five of the states currently have GOP governors. Furthermore, 10 states saw notable reductions in the percentage of uninsured residents. Nationally, the uninsured rate was 9.1 percent during the first nine months of 2015. Read More

Lawsuits Raise Questions About Necessity and Feasibility of States Providing Hepatitis C Drugs. On February 9, 2016, *The Pew Charitable Trusts* reported that class actions law suits in federal courts in Indiana, Massachusetts, Minnesota and Pennsylvania argue that by denying drugs to hepatitis C patients, states are violating the law. Under federal law, states can exclude a drug from Medicaid coverage only if its prescribed use "is not for medically accepted indication" as determined by the FDA. However, one study published last summer showed that at least 34 states restricted treatment to patients with advanced liver disease, with some states limiting approval to prescribers specializing in gastroenterology, infectious diseases, or liver transplantation, restrictive practices that are not applied to treatments for other diseases. While several medical societies recommend early treatment for hepatitis C, paying for treatment for everyone is difficult for states, which are required to balance their budgets every year. Read More

Department Of Health And Human Services Budget Increases To $1 Trillion. On February 9, 2016, *The Washington Post* reported that spending for the Department of Health and Human Services would increase to $1 trillion under a proposal that would add mandatory expenditures for cancer research and combatting drug addictions. The budget would modify the Cadillac tax, allow the government to compel pharmaceutical manufacturers to disclose research and development costs, further efforts towards new payment methods in Medicare, and allow states to receive federal funding for Medicaid expansion for three years regardless of when they begin expansion. Read More

Industry News

Addus HomeCare Acquires South Shore Home Health. On February 8, 2016, Addus HomeCare announced that it has completed the acquisition of South Shore Home Health Services, a New York-based home care services agency primarily providing personal care services. Read More

PSA Healthcare Acquires Care Unlimited. On February 8, 2016, PSA Healthcare announced that it has acquired Care Unlimited, a Pennsylvania-based provider of home care services to fragile children. The transaction closed on January 31, 2016. Financial terms were not disclosed. Read More

Civitas Solutions Announces Acquisition of Three Massachusetts ADH Centers. On February 9, 2016, Civitas Solutions, Inc. announced the acquisition of three adult day health (ADH) centers in Massachusetts as of February 1. The three centers, two in Boston and one in Worcester, have total capacity to serve approximately 410 individuals and generated approximately $8.7 million in revenue in the year prior to acquisition. The acquisitions mean Civitas now operates 11 ADH centers in the state, serving around 1,900 individuals, with the anticipation of opening two additional centers in the fourth quarter of 2016. Read More

Nautic Partners Completes Sale Of All Metro Health Care Services To One Equity Partners. On February 10, 2016, *PE Hub* reported that Nautic Partners LLC completed the sale of All Metro Health Care Services, a home care services company located in New York, New Jersey, and Florida, to private equity firm One Equity Partners. Financial terms were not disclosed. Read More

Blue Wolf Capital Wins Auction for Jordan Health. On February 4, 2016, *PE HUB* reported that Blue Wolf Capital Partners won an auction for Jordan Health Services. Palladium Equity put Jordan Health up for sale in fall. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
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
March 29, 2016	Minnesota SNBC	Proposals Due	45,600
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
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 22, 2016	Minnesota SNBC	Contract Awards	45,600
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 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
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
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
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:

- **Nebraska** Awards Managed Care Contracts, Feb-16
- **Florida** Medicaid FFS Rate Trends, 2012-2015
- Public documents such as **Arizona's** Medicaid managed care financial reports by plan and the **Minnesota** Special Needs BasicCareRFP, 2016
- Plus upcoming webinars on "*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.

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