HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 9, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

PENNSYLVANIA ISSUES COMMUNITY HEALTHCHOICES RFP FOR MLTSS, DUALS

This week, our *In Focus* section reviews the Community HealthChoices request for proposals (RFP), issued on March 1, 2016 by the Pennsylvania Department of Human Services (DHS). Community HealthChoices is a new statewide managed care program that will provide managed long-term supports and services (MLTSS) to both dual eligible non-dual eligible Medicaid beneficiaries in the state, as well as managed acute care services for dual eligibles without LTSS needs. When fully phased in, Community HealthChoices is anticipated to cover an estimated 420,000 beneficiaries (more than 150,000 in MLTSS), with annual Medicaid expenditures of more than $7 billion.

Covered Populations and Historical Spending

Community HealthChoices managed care organizations (CHC-MCOs) will mandatorily enroll adults age 21 or older who meet a nursing facility level of care, regardless of whether they are in a private or county nursing facility, or reside in the community receiving HCBS.

Additionally, any individual 21 or older who is dually eligible for both Medicaid and Medicare, and is not needing or receiving LTSS, will also be mandatorily enrolled.

Based on historical cost data and member month data provided by DHS, estimated membership by dual eligible and LTSS status is provided below. As mentioned above, there are an estimated 270,000 non-LTSS duals, 150,000 dual and non-dual users of LTSS, for total enrollment of around 420,000. With an estimated total annualized spend of more than $7.1 billion, equating to a statewide average per-member per-month (PMPM) cost of more than $1,400.

	Dual Eligible		Non-Dual		LTSS	Non-LTSS	Total	Estimated
	HCBS	NF	HCBS	NF	Total	Duals	Members	Annual $
Southwest	*9,241*	*18,053*	*2,726*	*1,823*	31,843	67,526	99,369	$1,525,000,000
Southeast	*25,419*	*20,365*	*9,331*	*2,732*	57,847	85,485	143,332	$2,663,000,000
Lehigh/Capital	*5,535*	*17,709*	*1,581*	*1,155*	25,980	53,487	79,467	$1,367,000,000
Northeast	*5,297*	*14,214*	*1,140*	*1,020*	21,671	41,066	62,737	$992,000,000
Northwest	*4,267*	*7,269*	*1,042*	*581*	13,159	22,550	35,709	$624,000,000
Statewide Total	***49,759***	***77,610***	***15,820***	***7,311***	**150,500**	**270,114**	**420,614**	**$7,171,000,000**

Excluded Populations

Dual eligibles and LTSS users will be excluded from CHC-MCO enrollment if they participate in the Act 150 program, receive services through the lottery-funded Options program (unless dual eligible), or reside in a state-operated nursing facility. Additionally, individuals with intellectual or developmental disabilities (ID/DD) eligible for services through DHS' Office of Developmental Programs are ineligible for enrollment.

Finally, individuals may opt to remain in the Living Independence for the Elderly (LIFE) program, Pennsylvania's Program of All-Inclusive Care for the Elderly (PACE) option, rather than participate in CHC.

RFP, Contract Provisions

Bidders on the CHC RFP may bid on any combination of five geographic zones, and must serve the entirety of each zone bid. The CHC zones are the same as the existing Health Choices managed care zones (Southeast, Southwest, Lehigh/Capital, Northeast, Northwest).

All CHC-MCOs must have aligned dual-eligible special needs plan (D-SNP) and current MIPPA agreement with state by the time they being serving a CHC zone.

The CHC RFP indicates that the state may, in future contract years, implement risk adjustment and risk-sharing/stop-loss provisions.

Contract Awards and Term of Contract

Pennsylvania DHS intends to award between two and five contracts per zone, depending on the zone. The initial contract term is dependent on zone, so that all five zones are aligned in their contract end date. As such, the Southwest Zone contract will begin January 1, 2017, with a five year term, and two options years. The Southeast Zone contract will begin January 1, 2018, with a four year term,

and two option years. The Lehigh/Capital Zone, Northeast Zone, and Northwest Zone contract will begin January 1, 2019, with a three year term, and two option years. The option years for all five zones would be 2022 and 2023.

Proposal Evaluation

Proposals will be evaluated on a technical component and a small diverse business participation component. There is no cost component to the RFP evaluation process.

The technical component accounts for 80 percent of points available.

- Soundness of Approach: how the bidder specifically addresses the needs of the LTSS and duals populations, as well as the unique demographic, cultural, economic, geographic, other relevant characteristics of the regions, counties, municipalities covered in the bid.
- Financial Conditions
- Personnel Qualifications
- Prior Experience

The Small Diverse Business Participation component accounts for 20 percent of points available. A "significant commitment" to SDB subcontracting is considered a minimum of five percent of the estimated average administrative PMPM. Under this section, all bids are scored relative to highest scoring SDB proposal.

RFP Timeline

DHS will conduct a Q&A process for potential bidders and hold a preproposal conference on March 16, 2016, with a proposal due date of May 2, 2016. A target date for contract awards has not been formalized at this time. Phase I of implementation is set for January 1, 2017, in the Southwest Zone. Phase II in the Southeast is to follow on January 1, 2018, with Phase III in the remaining three zones set for January 1, 2019.

Calendar of RFP Events	Date
Deadline to Submit Questions	March 16, 2016
Preproposal Conference	March 16, 2016
Q&A Posted	March 31, 2016
Proposals Due	May 2, 2016
Contract Awards	TBD
Implementation of Phase I - Southwest Zone	January 1, 2017
Implementation of Phase II - Southeast Zone	January 1, 2018
Implementation of Phase III - Lehigh/Capital, Northwest, Northeast Zones	January 1, 2019

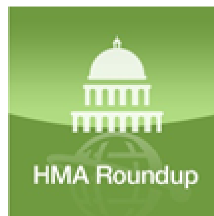
Current Medicaid MCO Market

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 RFP, Supporting Documents

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



HMA MEDICAID ROUNDUP

Arizona

HMA Roundup – Don Novo (Email Don)

Arizona Healthcare Bills Gain Movement. On March 4, 2016, the Arizona Hospital and Healthcare Association discussed four bills on its priority list that gained movement:

- *HB 2502 – Interstate Medical Licensure Compact Bill* passed the House. The bill would help streamline the licensure process for physicians wishing to practice in multiple states.
- *HB 2309 – Children's Health Insurance Program* (KidCare) passed House.
- *SB 1507* passed the Senate. The bill would restore dental coverage for adults with developmental disabilities.
- *HB 2357* passed the House. The bill would add podiatry coverage for adults under the Arizona Health Care Cost Containment System.

Read More

House Passes KidCare Bill. On March 3, 2016, *KJZZ.org* reported that the Arizona House passed House Bill 2309 that would restore KidCare coverage. The bill would allow children in families with incomes from 138 to 200 percent of the federal poverty level to enroll. The bill now moves to the Senate. Read More

Arkansas

Legislative Task Force Supports Hybrid Expansion, Remains Hesitant About Managed Care for Special Needs Populations. On March 7, 2016, *Lexington Herald-Leader* reported that a legislative panel on Monday supported Governor Hutchinson's hybrid Medicaid expansion, but could not agree as to whether services for the individuals with mental illness and intellectual and developmental disabilities should be moved to managed care. While 11 members of the 16 person Health Reform Legislative Task Force voted yes for the hybrid proposal and suggested lawmakers consider the Governor's proposal to rework the "private option" that uses federal funds to purchase private insurance for low-income residents, lawmakers are concerned that ending the hybrid expansion could cost the state $757 million and would jeopardize support for the Medicaid expansion population. However, discussions regarding the managed care proposal for the individuals with severe mental illness and other disabilities are likely to cause more of a debate among lawmakers. Read More

California

HMA Roundup – Don Novo (Email Don)

California to Close Three Institutions for Individuals with Severe Disabilities. On March 8, 2016, *California Healthline* reported that in less than six years, nearly all the residents of three large state-run institutions for individuals with severe disabilities will be transferred to smaller community-based homes. The state will close down facilities in Sonoma and Costa Mesa, and partially close a third site in Porterville, where half of the patients will be moved. California expects to save approximately $250 million a year. The Legislative Analyst's Office released a report raising concern about the potential loss of federal money during the roughly six years it will take to nearly empty the facilities. The state's final proposal will be presented to the legislature Apr. 1. Read More

Providers Hesitant to Join Anthem Blue Cross and Blue Shield of California's Comprehensive Health Information Exchange. On March 2, 2016, *Modern Healthcare* reported that Anthem Blue Cross and Blue Shield of California teamed up in 2014 to build a comprehensive health information exchange, consisting of complete, longitudinal health records for every California resident, called the Cal Index. However, providers are reluctant to share the information. Thus far, only one health system, Dignity Health, agreed to participate in the data exchange, which will go live at the end of March. Cal Index has payer records on 9 million people, covering three years of data claims. The data does not include prices. Read More

Connecticut

Governor Malloy Suspends $140 Million in Payments to Acute-Care Hospitals. On March 3, 2016, *The CT Mirror* reported that due to a significant drop in tax revenues and the state's budget deficit, Governor Dannel P. Malloy's administration suspended $140 million in payments to acute-care hospitals. The move has drawn heavy criticism from the Connecticut Hospital Association. Hospitals are now slated to receive $22 million in tax reimbursement this fiscal year – only 4 percent of what they will pay. Last fiscal year hospitals paid in $349 million and received $80.6 million in reimbursements. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Lawmakers to Reevaluate $1.6 Billion of Hospital Funding. On March 2, 2016, *The Florida Times-Union* reported that the House and Senate are looking to reevaluate a plan to distribute $608 million in LIP funding, and approximately $1 billion in supplemental funding. Safety net hospitals, which rely heavily on this additional money to cover services for the uninsured and under-insured, stand to lose millions of dollars in the upcoming fiscal year. They expected to see some reductions when LIP funding was reduced by $400 million by the federal government, but are concerned by the allocations by the state. Read More

Senate Passed Bill Could Cause Changes To Dental Coverage, Especially For Adults. On March 7, 2016, *Palm Beach Post* reported that a bill passed by the Senate Monday, and on its way to Governor Scott for review, could change the Medicaid dental program. Currently, Florida only requires managed Medicaid plans to cover dental services for children, but many plans also include coverage for adults beyond what the law requires. The new bill would require the state to do a study of dental services by December 1, 2016, which could be used by the legislature to make changes to the program. However, if the legislature does not take action, the state's Medicaid agency would move forward in carving out child dental care into separate dental plans, which would not require the same coverage of adult dental care and likely lead to higher out of pocket cost for adults. Read More

Michigan

Medicaid Coverage Approved for 15,000 Children and Pregnant Women in Flint. On March 3, 2016, *The New York Times* reported that the Obama administration approved a waiver to extend Medicaid coverage to an additional 15,000 children and pregnant women exposed to lead in Flint, Michigan. Children and pregnant woman will now be eligible for Medicaid if their household income does not exceed 400 percent of the poverty level. Additionally, about 30,000 current Medicaid beneficiaries in Flint will be eligible for expanded services under the five-year agreement. Read More

Nebraska

Nebraska Reissues Notice of Intent to Award MCO Contracts after Partial Reevaluation. On March 8, 2016, Nebraska reissued a notice of intent to award Medicaid managed care contracts after a part of the proposals were reevaluated in response to protests. Protests to the initial award announcement concerned the scoring of the corporate overview section of the RFP and initial awards were withdrawn on March 2. Based on the reevaluation, WellCare is now the third overall in terms of scoring, with Aetna in fourth. As a result, Nebraska intends to award contracts to UnitedHealthcare, Nebraska Total Care (Centene), and WellCare. Read More

New Hampshire

Legislation To Renew Medicaid Expansion Could Create Issues Due to Work Requirements. On March 7, 2016, *New Hampshire Public Radio* reported that the House will review legislation this week that could determine whether the state will continue Medicaid expansion for another two years. The biggest hurdle in the proposal will be the work requirement, which requires Medicaid recipients to work or volunteer for 30 hours a week to receive benefits. While other states have pushed for similar requirements, the federal government has rejected them. If the proposal passes in its current form, and is approved, then the program could shut down entirely. However, one lawmaker is pushing for a clause to prevent that. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Democratic Lawmakers Seek Funds to Protect Children from Lead Poisoning after Governor Christie Vetoed Earlier Efforts to Fund Lead Abatement. A-1378 was introduced by Assemblywomen Spencer, Maher Muoio, Pintor Marin and Assemblyman Benson that would make a FY16 supplemental Grants-in-Aid appropriation of $10 million to the Department of Consumer Affairs for Lead Hazard Control Assistance Fund. The bill was voted favorably by the Assembly Appropriations Committee (8 to 2). *NJ Spotlight* reported on the controversy on March 8, 2016 in which the Governor defended his veto, saying that the state spends over $22 million on programs to address lead contamination. Advocates say dedicated dollars from lead paint program revenue sources have been diverted to pay for other state programs. Read More

Proposal to Form a Tiered Health Insurance Network Task Force Passed Assembly Committee. On March 7, 2016 the Assembly Regulatory Oversight and Reform and Federal Relations Committee voted unanimously in favor on A-888, a bill that establishes a New Jersey Task Force on tiered health insurance networks. The Task Force would be charged to: 1) study the recent trend towards tiered health insurance networks, 2) identify the impact of tiered health insurance networks on consumers, hospitals, providers, and the health care delivery system, and 3) make recommendations for legislation and strategies to create more effective and efficient policies regarding tiered health insurance networks in New Jersey. A full assembly vote is necessary to enact the bill. Additional information was reported in *NJBIZ* on March 8, 2016. Read More

New Mexico

New Mexico Facing $147 Million Medicaid Shortfall. On March 5, 2016, the *Albuquerque Journal* reported that the state's budget conditions have left a $147 million shortfall in Medicaid funding over the next 16 months. The budget shortfall could pressure lawmakers to cut reimbursement rates at a time when Medicaid enrollment is climbing. The shortfall is due, at least in part, to declining state oil and gas revenues. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Enrollment in FIDA-IDD Beginning. Enrollment in the Fully Integrated Duals Advantage (FIDA-IDD) care coordination program will begin in March with services beginning as early as April 1, 2016. Voluntary enrollment is available to dual-eligibles over the age of 21 who receive long-term care and developmental disability services. The program is limited to individuals living in NYC, Long Island, Westchester, or Rockland Counties. The FIDA-IDD program offers greater opportunity to be involved in care planning and for greater self-direction through a care plan team designed to address all medical, behavioral, long-term supports and services, and social needs. Partners Health Plan (PHP) is the only plan selected by CMS to offer the FIDA-IDD program. PHP is a not-for-profit managed care organization dedicated solely to providing supports and services for those with intellectual and other developmental disabilities, with over six

decades of experience supporting the needs of individuals with intellectual and other developmental disabilities. Enrollment is coordinated through New York Medicaid Choice, the New York State enrollment broker. Individuals can enroll or disenroll at any time. A presentation about FIDA-IDD can be found on the OPWDD web site.

New York Attorney General Investigates Insurers on Hepatitis C Drug Restrictions. On March 2, 2016, *The Wall Street Journal* reported that New York Attorney General Eric Schneiderman issued subpoenas to 16 health insurers requesting documents on the companies' processes for authorizing drugs used to treat hepatitis C and documentation on patients who have been denied coverage. The allegations against the health plans claim that the firms have been engaging in misleading and deceptive practices by inappropriately rationing care and denying patients the costly hepatitis C medication. According to the attorney general's office, between 50 percent and 90 percent of patients whose doctors prescribed Gilead's Harvoni medicine were denied coverage. Read More

New York Releases 2016-17 Executive Budget Scorecard. New York released its FY 2017 Health Care Savings Proposals – Executive Budge State Investments scorecard. It is available for download here.

Five Percent Drop In New York Medicaid Managed Care Enrollment Causes Insurer Concern. On March 9, 2016 *Crain's* reported that New York City Medicaid managed care plans saw enrollment drop five percent between December 2015 and February 2016, leaving insurers wondering why. MetroPlus, Healthfirst, and Fidelis Care have all seen more than four percent of members lose eligibility in the last two months. While some attribute the decrease to the way that Medicaid members must renew their eligibility, others note that such movement of people in and out of Medicaid eligibility is nothing new. A statement issued by the Department of Health did not address the recertification issue, but instead highlighted that New York Medicaid managed care enrollment is down less than one percent this year and that the shift could be attributed to increased enrollment in the Essential Plan, a coverage option with low premiums. Read More

Capital Grants Announced. Governor Cuomo made the long-awaited announcement about awards for the Capital Restructuring Financing Program and Essential Health Care Provider Support Program. The Governor announced a total of $1.5 Billion to fund 162 projects statewide, part of the state's commitment to help health care providers fund critical capital and infrastructure improvements, as well as integrate and further develop health systems. The two funding streams were created to support the goals of the Delivery System Reform Incentive Payment (DSRIP) Program. New York State had wanted to use DSRIP funds for capital investments in the health care system, but that plan was rejected by CMS. Awards were originally expected in October 2015, but the announcement has been repeatedly delayed without explanation. Of the $1.5 billion awarded, $673 million was awarded to projects in New York City; the rest of the funding was spread across the state. The single largest award went to the NYC Health + Hospitals, which received a grant of $109 million to develop a digital health network. NYC H+H, New York City's public hospital system, received 5 grants totaling over $300 million. A list of awardees and award amounts can be found on the Governor's website here.

Oscar Losing Money in New York. A new health insurance start-up in New York, Oscar Health Insurance Corporation, reported a loss of $92.4 million in NYS in 2015, and is struggling in the New York State of Health marketplace. Bloomberg News reports that with 52,800 members, their medical loss ratio was over 100 percent. Oscar indicates that its losses stem from the cost of starting a new health insurance plan, as well as costlier than anticipated enrollees, and a shortfall in anticipated revenue from the Affordable Care Act risk corridor program. Oscar is narrowing its network in NY as a way to limit costs. Nonetheless, the company, valued at $2.7 billion, recently raised an additional $400 million.

NYC Health + Hospitals Under Increased Financial Strain. NYS Comptroller Thomas DeNapoli released a Review of the Financial Plan of the City of New York, which includes a financial assessment of NYC Health + Hospitals, New York City's public hospital system. NYC H+H operates 11 acute and community hospitals, 5 rehab and residential nursing facilities, a home health agency, and an extensive network of ambulatory care facilities. NYC H+H serves 1.4 million patients annually, 80 percent of whom are uninsured or covered by Medicaid. The report indicated that H+H projects a closing cash balance of $104 million for the fiscal year ending June 30, enough to meet obligations for six days.

According to an assessment by Bloomberg News, H+H is straining under the weight of the costs of treating undocumented immigrants and competition from non-profit hospitals for Medicaid patients. The Comptroller's report also notes that H+H has high overhead. Simultaneously, as part of the Affordable Care Act, the federal government is cutting payments to hospitals that care for a disproportionate number of poor patients, including those in the H+H system. According to the state comptroller, cuts in federal Disproportionate Share Hospital funding to H+H will grow from $180 million in fiscal year 2017 to more than $508 million in 2018 and the system's projected losses will grow from the currently projected $1.1 billion to $2 billion in 2019. In response, part of NYC Mayor Bill DeBlasio's current budget proposal would increase NYC aid to H+H by $337 million in the next fiscal year while working with H+H on a restructuring plan to bring greater fiscal stability to the system.

North Carolina

Provider-Led Group Partners with Presbyterian Health Plan to Manage Medicaid. On March 3, 2016, *Triad Business Journal* reported that Provider-Led, Patient-Centered Care LLC (PLPCC), a group of 11 North Carolina health systems, is partnering with Presbyterian Health Plan of New Mexico to managed Medicaid under a new platform being crafted by state officials. The new Medicaid system must still gain federal approval before being implemented. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

A Bigger Role for Caretakers and Putting Early Intervention Services for Young Children in a Single Agency: This year the administration's Mid-Biennium Review legislation is focusing department-by-department with separate agency-specific bills instead of the mega-bill approach used in the past. The Department of Developmental Disabilities bill, HB 483 introduced by House Speaker Pro Tem Representative Ron Amstutz increases the types of medication and health care activities that a direct caretaker can administer, including inhalers, some forms of insulin, epinephrine, etc. Also included is a change that would put early intervention services solely under the Department, instead of shared with the Department of Health. There will be more discussion with interested parties before the bill moves through the legislature. For a fact sheet on the changes proposed, see here. Read More

Oklahoma

House Passes Bill Cutting 110,000 Medicaid Enrollees. On March 2, 2016, *The AP/Chicago Tribune* reported that the Oklahoma House passed a bill cutting 110,000 residents from Medicaid to help fill the $1.3 billion budget hole. The bill would exclude adults younger than 65 who are not pregnant, deaf, blind or disabled from the program and is expected to save $130 million in state funds. The bill now goes to the Senate for debate. If passed, CMS would need to approve a waiver to exclude these individuals. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Takes Next Step in Modernization of Program Integrity Efforts. The Department of Human Services (DHS) released a request for proposal (RFP) for the implementation of verification services for use when processing benefit applications. This system will help modernize the department's handling of program integrity functions by blocking improper and fraudulent recipients. This identify proofing system will electronically check personal information provided by applicants when applying for or renewing benefits. The system will also automate the department's identity validation process. The update will allow increased security of the client's identity, as well as an expedited verification process, making access to benefits faster and more secure for people across the commonwealth. The RFP is broken into five lots, allowing vendors to bid on components that best fit their offerings. The following criteria are including:

- **Identity Verification** – consisting of services that verify an individual's identify whether the individual applies online, via paper, or by telephone
- **Asset Verification and Identification** – verify assets included and not included on an individual's application
- **Income Verification and Identification** – verify income and to identify other sources of income not indicated on an application

- **Predictive Analysis** – quantitatively assesses the likelihood of eligibility for DHS administered benefits
- **Income Identification in support of Child Support** – verify income sources in support of child support enforcement

The RFP can be found here, and the department is requesting all responses be submitted by May 23, 2016. Read More

Vermont

State Puts Halt on Planned Medicaid Rate Cuts to Hospitals. On March 8, 2016, VT Digger reported that the Department of Vermont Health Access will "pause" planned rate adjustments that would have reduced Medicaid reimbursement rates to the state's seven largest hospitals from around 87 percent of Medicare rates to 75 percent. Critical access hospitals, on the other hand, would have received a 19 percent rate increase, from 93 percent to 112 percent of Medicare rates. The Vermont Association of Hospitals and Health Systems praised the decision. Read More

Washington

HMA Roundup – Ian Randall (Email Ian)

Washington Legislature acts on key health care bills as session concludes. As the legislative session draws to a close on Thursday, March 10, several health care-related bills were passed by the Legislature, while others went into joint committees and remained active. These bills include:

- *SB 6519--Telemedicine*: This bill would create a working committee to make recommendations on telemedicine best practices, and by 2018 would allow for reimbursement for telemedicine services delivered to patients in their homes for commercial plans, Medicaid and public employees.
- *HB 2340--High risk pool*: This legislation would extend the expiration date for the Washington State High Risk Pool, a non-profit entity that provides health insurance coverage to individuals unable to obtain comprehensive health coverage or Medicare supplemental coverage.
- *HB 2730—Prescription drug monitoring program*: This bill would give prescribers better access to information about their patients' current opioid prescriptions, with the intent of reducing opioid abuse and addiction.
- *SB 6445--Mental health/physician assistants*: This bill would enable physician assistants to deliver mental health services through the Involuntary Treatment Act. Physician Assistants' scope of practice would expand consistent with their education, training experience, and their delegation agreement with a supervising physician.

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Washington Health Care Authority (HCA) sued to remove restrictions on Hepatitis C drugs for Medicaid members. A class action lawsuit filed on behalf of two Apple Health clients—along with nearly 28,000 Apple Health Members suffering from liver disease—in the Washington Medicaid program seeks to

require that HCA cover the Hepatitis C drug Harvoni. Harvoni is one of the new class of Hepatitis C drugs that can cure the Hepatitis C virus, but is currently denied by the HCA because of its high costs. Read More

Washington notifies 91,000 Medicaid members of data breach. The Washington Health Care Authority announced that personal data of 91,000 members was breached by an employee. The data included members' Social Security numbers, dates of birth, client ID numbers and private health information. The breach occurred when two employees transmitted the data on an unsecure platform in the course of seeking technical assistance. Read More

Washington ballot initiative would increase state minimum wage to $13.50, take paid sick leave. Ballot Initiative 1433, supported by a group of unions and community organizations, would raise the state minimum wage to $13.50 from 2017 to 2020. The state would increase the minimum wage to $11 in 2017, $11.50 by 2018, $12 by 2019 and $13.50 by 2020, and would require employers to provide paid sick leave to employees. Read More

National

State Medicaid Agencies Push to Repeal ACA Insurance Tax. On March 2, 2016, *Modern Healthcare* reported that state Medicaid agencies are pushing to permanently repeal the Affordable Care Act insurance tax. A total of 38 states and DC, which contract with Medicaid managed care organizations, are responsible to pay the premium tax to ensure plans receive actuarially sound rates. In February, six Republican states filed a lawsuit against the Obama administration, seeking an injunction against the federal rules and a refund for what was already paid. Congress suspended the tax for one year in the year-end omnibus budget bill, along with two-year delays of the ACA's medical-device tax and "Cadillac" tax on high-cost employer plans. It will cost the federal government approximately $13.9 billion. Read More

Exchange Plans to be Rated on Network Size under New Rules. On March 6, 2016, *The New York Times* reported that President Obama's administration is working to implement a rating for network breadth for qualified health plans sold on the HealthCare.gov platform. The new rules, published this week in the Federal Register, will not prohibit the offering of narrow networks on the Exchange, but will provide a rating of network size to consumers for each plan offered. Read More

Predictive Analytics Tools for Home Health Care Workers Is On The Rise. On March 9, 2016, *Kaiser Health News* reported that the number of companies providing predictive data solutions for home health workers to manage patients' conditions at home is growing. One Maryland-based non-profit, the Coordinating Center, helps organize medical and social needs for patients who live in medically underserved areas by visiting patients in their homes and using tablets and predictive analytics tools that generate patient-specific questions. The software was developed by Care at Hand, one of a small but growing number of companies creating products to help identify medical problems prior to hospitalization. It is meant to be user-friendly for non-medical health coaches such as those at the Coordinating Center as well as medical home health aides who care for millions of elderly, sick, or disabled people in their homes. Other companies in the space include eCaring, Honor, and Hometeam. Read More

Industry News

Compassus to Acquire Majority of Genesis Healthcare's Home Health, Hospice Business. On March 9, 2016, *Home Health Care News* reported that Genesis Healthcare has agreed to sell the majority of its home health and hospice operations to Nashville, Tennessee-based Compassus for $84 million. Genesis acquired its home health and hospice division in combination with Skilled Healthcare in February 2015. The deal is expected to close in the second quarter of 2016. Read More

Community Health Systems Announces Acquisition of Two Indiana Hospitals. On March 1, 2016, Community Health Systems announced the acquisition of an 80 percent ownership stake in a JV with Indiana University Health that includes the acquisition of IU Health La Porte Hospital and IU Health Starke Hospital, as well as affiliated outpatient centers and physician practices. The acquisition brings the number of Community Health Systems-affiliated hospitals in Indiana up to eleven. Read More

LifeCare Holdings to Acquire Haven Home Health. On March 1, 2016, LifeCare Holdings LLC announced it plans to acquire Haven Home Health, based in the Dallas-Fort Worth, Texas area. LifeCare Holdings operates LifeCare Hospitals and a press release on the acquisition indicated the deal is consistent with LifeCare's ongoing expansion in the post-acute care landscape. The deal is expected to close in the second quarter of 2016. Read More

Ascension Finalizes Wheaton Franciscan Acquisition. On March 2, 2016, the *St. Louis Business Journal* reported that Ascension has finalized its acquisition of Wheaton Franciscan Healthcare, one of the largest health systems in Southeast Wisconsin. The acquisition includes Wheaton's eight hospitals, 330 physicians, outpatient centers, transitional and long-term care facilities, as well as home health and hospice operations. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
March 29, 2016	Minnesota SNBC	Proposals Due	45,600
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Iowa	Implementation	550,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
April 22, 2016	Minnesota SNBC	Contract Awards	45,600
April 29, 2016	Missouri (Statewide)	RFP Released	700,000
May 1, 2016	Massachusetts MassHealth ACO - Pilot	RFA Released	TBD
May 2, 2016	Pennsylvania MLTSS/Duals	Proposals Due	420,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
May, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
June 1, 2016	Massachusetts MassHealth ACO - Full-Scale	RFA Released	TBD
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
November 1, 2016	Arizona ALTCS (E/PD)	RFP Released	30,000
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)	100,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 1, 2017	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
March 1, 2017	Virginia MLTSS	Implementation	130,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
June 1, 2017	Massachusetts MassHealth ACO - Full-Scale	RFA Released	TBD
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
TBD 2017/2018	Oklahoma ABD	Implementation	177,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Feb. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	127,084	29.5%	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)
Illinois	Capitated	4/1/2014	6/1/2014	148,000	49,294	33.3%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	94,000	12,787	13.6%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	34,833	33.2%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	6,029	4.9%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,246	64.5%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island*	Capitated	12/1/2015	2/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	1,364	2.5%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,296	29.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,298	38.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**370,231**	**28.1%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA NEWS

New this week on the HMA Information Services website:

- Updated Medicaid managed care enrollment data for **Michigan**, **New York**, **Indiana**, and more
- Updated Medicaid managed care plan financials for **Nebraska**, **Illinois**, and more
- Public documents such as the **Nebraska** Medicaid Integrated Managed Care RFP Re-issued Notice of Intent to Award and the **North Carolina** 1115 waiver application
- Plus an upcoming webinar, *"Transgender Care and Transitioning: Implications of New Health Insurance Coverage Guidelines and Research Findings on the Experiences of Transgender Individuals in the Health Care System"*

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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