HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 7, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

INDIANA ISSUES MANAGED CARE RFP FOR HOOSIER HEALTHWISE, HIP

This week, our *In Focus* section reviews the request for proposals (RFP) released this week by the Indiana Family and Social Services Administration (FSSA) to rebid the Hoosier Healthwise and Healthy Indiana Plan (HIP) Medicaid managed care programs. Combined, the two programs serve around 900,000 Indiana Medicaid beneficiaries. Below, we review the two programs and provide an overview of the RFP and the existing Hoosier Healthwise/HIP market.

Program Overview

Hoosier Healthwise is a health care program for low-income parents and caretakers, pregnant women, and children. The program covers acute care, pharmacy, behavioral, and dental services. Indiana offers Hoosier Healthwise members three benefit packages (Package A – Medicaid, Package C – CHIP, or Package P – Presumptive Eligibility) depending on the member's category of aid. The Hoosier Healthwise program currently serves over 600,000 members.

Healthy Indiana Plan 2.0 (HIP 2.0), replaced the original HIP waiver program and extended Medicaid coverage to an estimated 350,000 adults with incomes

between the previous Medicaid income limit – about 24 percent of the federal poverty level (FPL) – and 138 percent of the FPL. Certain adults previously covered under the Hoosier Healthwise managed care program and all adults previously enrolled in HIP were also transitioned to HIP 2.0. Each HIP 2.0 member is required to contribute to a Personal Wellness and Responsibility (POWER) account, similar to a health savings account. Monthly POWER account contributions are income-based; individuals may be disenrolled or transitioned to a more limited benefit package, depending on income, in the event of non-payment. Approximately 350,000 members are currently enrolled in HIP 2.0.

RFP Overview

Interested health plans are expected to bid on both the Hoosier Healthwise and HIP programs, with the intention to award three or four plans to serve both programs statewide. This RFP has no impact on the Hoosier Care Connect (managed Medicaid ABD) program, which was implemented earlier this year.

The RFP requests that interested bidders complete an Intent to Respond Form by October 22, 2015, although it is unclear if this is mandatory prior to bidding.

The RFP will be conducted in two phases – an initial technical and business phase will be completed and evaluated first. After this initial evaluation, the state will release capitation rate information to the remaining short-listed bidders who will then submit the cost portion of the proposal for evaluation.

As in past Indiana procurements, a portion of overall points are awarded if the bidder qualifies as an Indiana company under the Buy Indiana definitions. However, it is worth noting that the Buy Indiana points available for this RFP are half of what they were under last year's Hoosier Care Connect RFP (5 percent instead of 10 percent of overall score).

Evaluation Criteria

As noted above, the Buy Indiana requirement accounts for 5 percent of total available points (excluding bonus points). The Indiana Economic Impact section is also worth 5 percent, as are sections on minority, women, and veteran-owned subcontractor commitments, with each of these three offering an opportunity for bonus points.

The cost proposal, worth 20 percent of available points, will be conducted under the second phase of proposal evaluation. According to the RFP, the cost proposal will be measured against the actuarially sound capitation rate ranges, with points awarded based on a graduated scale relative to other bidders. Respondents who propose rates at the top of the rate range receive fewer points, while those proposing rates at the bottom of the rate range receive more points.

Table 1 – RFP Evaluation Criteria

Evaluation Criteria	Points
Adherence to Mandatory Requirements	Pass/Fail
Management Assessment/Quality (Business, Technical Proposals)	55
Cost Proposal	20
Indiana Economic Impact	5
Buy Indiana (bidder qualifies as Indiana company)	5
Minority Subcontractor Commitment	5 (1 bonus pt. available)
Women Business Enterprise Subcontractor Commitment	5 (1 bonus pt. available)
Indiana Veteran Business Enterprise Subcontractor Commitment	5 (1 bonus pt. available)
Total:	**100 (103 if bonus awarded)**

RFP Timeline and Contract Awards/Terms

The non-cost proposal components of the RFP response are due to the FSSA on January 7, 2016, to be followed by more than three months of evaluation. On April 1, 2016, short-listed bidders will receive capitation rate data books and will be required to submit cost proposals by May 11, 2016. Awards are anticipated in June 2016.

Table 2 – RFP Timeline

RFP Milestone	Date
RFP Released	October 5, 2015
Pre-Proposal Conference	October 20, 2015
Deadline to Submit Written Questions and Intent to Respond Form	October 22, 2015
Response to Written Questions	November 9, 2015
Submission of Proposals (excluding pricing components)	**January 7, 2016**
Rates and Data Book Released	April 1, 2016
Rate Presentation	April 12, 2016
Deadline to Submit Rate Questions	April 15, 2016
Response to Rate Questions	April 29, 2016
Submission of Pricing Components of Proposal	**May 11, 2016**
Award Recommendation	**June, 2016**

Indiana FSSA intends to award three or four contracts statewide to serve both programs; however, the final number of awardees may be greater or less than intended, depending on what is determined to be in the best interests of the State.

Contracts terms will be for four years, with two optional one-year extensions, bringing the total available contract term to six years.

Existing Hoosier Healthwise/HIP Market

As of August 2015, there were just over 900,000 members enrolled in either Hoosier Healthwise or HIP. MDWise, a local non-profit MCO, is the largest in terms of market share, with close to 350,000 members (38.4 percent). The other two MCOs serving the programs are publicly-traded for-profit MCOs, Anthem and Centene, with 34.8 percent and 26.8 percent of the market, respectively.

Table 3 – Hoosier Healthwise, HIP Enrollment – August 2015

Health Plan	Hoosier Healthwise	Healthy Indiana Plan (HIP)	Total Hoosier Healthwise/HIP	Market Share
MDWise	244,777	101,139	345,916	38.4%
Anthem	192,906	120,629	313,535	34.8%
MHS (Centene)	169,646	71,260	240,906	26.8%
Total Enrollment	**607,329**	**293,028**	**900,357**	

In last year's Hoosier Care Connect RFP, MDWise, Anthem, and Centene's Managed Health Services were the three winners. The state also received bids from Advantage Health Solutions, CareSource, and Magellan.

Link to RFP, Related Documents

http://www.in.gov/idoa/proc/bids/RFP-16-035/

HMA Medicaid Roundup

Arkansas

Consultant Group to Release Medicaid Expansion Recommendations Report to Task Force. On October 3, 2015, *The Washington Times* reported that the consultant, The Stephen Group, will release a report to lawmakers on Arkansas' hybrid Medicaid expansion recommendations. The report will go beyond the private option, according to Rep. Charles Collins. It is expected to assess changes Governor Hutchinson requested to limit benefits and eligibility, look at broader changes to Medicaid, and address how to find over $50 million in savings. Read More

California

HMA Roundup – Don Novo (Email Don)

State Court Rules Blue Shield of California and Anthem Blue Cross May Need to Pay State Health Premiums Tax. On October 1, 2015, *California Healthline* reported that Blue Shield of California and Anthem Blue Cross may qualify as health insurers and subsequently need to pay the state's gross health premiums tax. The California Second District Court of Appeals ruled that the plans' businesses seem to be built on selling and administering indemnity-based insurance policies. However, the two plans argue that they are regulated by the Department of Managed Health care, not the California Department of Insurance, and should therefore not be subject to the tax. The Court of Appeals has sent the case back to the lower court, in part to clarify whether or not the two companies qualify as insurers that need to pay the gross premium tax. Read More

Bill to Cap Out-of-Pocket Costs on Specialty Drugs Awaiting Governor Vote. On October 1, 2015, *California Healthline* reported that with the high cost of specialty drugs garnering national headlines and gaining a foothold in the presidential race, California legislators sent a bill to Governor Brown that would put a cap on Californians' prescription drug spending. Out-of-pocket costs for a 30-day supply of prescription would cap at $250. Governor Brown has until Oct. 11 to sign or veto the bill. Read More

Too Few Dentists at Health Clinics Causing Patients to Forgo Treatment. On September 30, 2015, *California Health* reported that the UCLA Center for Health Policy Research found that the state could significantly improve access to dental care, particularly for low-income and uninsured people, if dentists were available at more health clinics. A third of California's health clinics offer no dental services, another third are part of an organization that does offer dental care, but at another site. The study identified that the state's rural Northern and

Sierra health centers are more likely to offer joint medical and dental services at co-located sites. Read More

Four California Organizations Awarded Grants to Help Improve Patient Care. On September 30, 2015, *California Healthline* reported that HHS has awarded 39 organizations -- including four California-based entities -- a total of $685 million in grants to help improve patient outcomes and communication. The grants will be used to support various ambulatory programs, including continuing education and training providers on how to use patient data to improve care. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Medicaid Drives Historic Coverage Gains In Colorado. Colorado's uninsured rate has plummeted from a recent high of 15.8 percent four years ago to 6.7 percent this year, and the success of the Affordable Care Act in Colorado is almost entirely the result of Medicaid expansion, according to a much anticipated survey from the Colorado Health Institute. The survey found that nearly one in three of the state's 5.3 million residents now get insurance through Medicaid or other public health insurance programs. With nearly 1.3 million Coloradans now on Medicaid, the state has the fourth fastest-growing Medicaid program in the country behind Kentucky, Oregon and Nevada, according to an analysis earlier this year from the federal Centers for Medicare & Medicaid Services.

Health Clinics Adopting Medical Home/Coordinated Care Models. More Colorado health clinics are adopting medical home or coordinated care models, with nearly 200 recognized medical homes in the state covering nearly 40% of residents, according to the Colorado Health Foundation. The model can save money and improve care, but barriers to adoption include creating a team culture, integrating data and settling on a reimbursement structure, the report says. Read More

Connecticut

Hospital Cuts May End Up 25 Percent Higher. On October 2, 2015, *The CT Mirror* reported that that the state is holding back additional payments to hospitals not part of the $192 million Medicaid cut. A spokesperson for the governor's budget office stated the decision whether to pay them will depend on whether the state has enough money to keep the budget in balance. Hospitals have yet to receive first-quarter payments, which in previous years, are made in August. Hospital officials have warned that cuts could lead to layoffs and service reductions. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Granted Fourth Temporary Extension for LIP Program. On September 30, 2015, *Politico Florida* reported that the federal government provided an extension for the Low Income Pool program to operate through October 14. Along with the extension, the Centers for Medicare and Medicaid Services gave

approval to spend up to $41.6 million in supplemental Medicaid dollars to avoid provider disruptions. This is the fourth temporary extension granted to the state, totaling $250 million in LIP funds, or 25 percent of the authorized $1 billion funding for fiscal year 2015-16. Read More

Florida Children and Youth Cabinet Seeking to Expand KidCare to Children of Legal Immigrants. On October 5, 2015, *Sayfie Review* reported that the Florida Children and Youth Cabinet is proposing to lawmakers to eliminate a five-year waiting period for children of legal immigrants to receive KidCare coverage. The proposal would cover nearly 25,000 children and cost $1.4 million. This will be the fourth year the measure was proposed. It passed the Senate in 2014 and 2015 but failed to pass the House. Supporters hope the backing of the Cabinet will change House leaders' minds. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

St. Francis Hospital to Sell to LifePoint Health. On October 2, 2015, the *Ledger-Enquirer* reported that St. Francis Hospital announced that it reached an agreement to sell the hospital to LifePoint Health. The deal has been sent to the Attorney General's Office for review and approval. Terms were not disclosed. Last year, St. Francis faced a $30 million deficit, which was deemed an accounting inaccuracy. The Chief Financial Officer at the time was relieved of his position on Nov. 14. Since then, the hospital has been for sale. LifePoint was the third company to enter into exclusive talks. Read More

Iowa

Iowa to Move Ahead with Privatization of Medicaid. On October 2, 2015, *The Des Moines Register* reported that a judge declined to delay the privatization of Iowa's $4.2 billion Medicaid program. Unsuccessful bidders protesting the awards stated that Iowa's process in selecting the companies was unjust and that the winning bidders had allegations of nepotism, fraud, and inaccuracies. The state argued that a delay would derail the plan to privatize and cost the state tens of millions of dollars in projected savings. One plan has appealed the judge's decision and will request an expedited Supreme Court ruling before the Oct. 9 signing. Read More

Kansas

Kansas Delays Medicaid Waiver Integration. On October 6, 2015, *Kansas Health Institute* reported that state officials announced they will delay the integration of seven Medicaid support services waivers for six months. Kansas Department of Health and Environment and Kansas Department for Aging and Disability Services leaders said they want to gather more input on the consolidation plan and incorporate stakeholder feedback. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Blue Cross Blue Shield Extends Revised PPO Hospital Contracts to 300,000 Members. On October 5, 2015, *The Boston Globe* reported that Blue Cross Blue Shield of Massachusetts signed Partners HealthCare, Steward Health System, and Lahey Health to contracts aimed at slowing rising medical costs. The contracts provide incentives to improve quality and care coordination, regardless of cost, to improve health outcomes. The health systems, in addition to Mount Auburn Hospital, will extend the reimbursement contracts to a combined 300,000 PPO members. Blue Cross has similar agreements in place for approximately 600,000 HMO members. Read More

Steward Health System Improving Emergency Services, Responding to Competition to Win Patients. On October 5, 2015, *The Boston Globe* reported that Steward Health Care System is investing in emergency services to attract more patients to community hospitals from larger and more expensive teaching hospitals and urgent care centers. The upgrades have helped boost patient numbers at the emergency departments 6 to 14 percent. Read More

Michigan

HealthPlus to Merge with Health Alliance Plan Due to Financial Struggles. On October 5, 2015, *Detroit Free Press* reported that the proposed merger of HealthPlus of Michigan and Health Alliance Plan is a result of financial necessity. In 2014, HealthPlus lost $23.5 million on $502 million in revenues, and $11.1 million the previous year. Earlier this year, HealthPlus sold its Medicaid and MIChild contracts to Molina. It currently has 120,000 members. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Evaluator Releases Year 1 MLTSS Implementation Report. The Rutgers Center for State Health Policy released its Year 1 report of stakeholder feedback for New Jersey's MLTSS implementation. Rutgers found that in the first nine months of operation under the state's contracted managed care organizations, home and community based service utilization increased by four percent and nursing facility utilization decreased by 1,500 individuals. The evaluators conducted telephone interviews with 34 key informants and summarized the findings by theme:

1) stakeholders believed the state was receptive to their input but did not always incorporate their recommendations into the program design;
2) the phased in implementation has been valued and positively received;
3) while the integration design may benefit consumers, it has presented a learning curve for consumers and care team members;
4) despite continuity of care provisions, consumers experienced anxiety during their transitions and some providers experienced claims payment delays;

5) quality metrics are still in development as are metrics for the program's impact on the health of the enrollees who receive MLTSS;
6) anecdotal reports exist of reductions in hours of service and eligibility determinations although there is insufficient data to document this;
7) MLTSS includes vulnerable enrollees, many of whom are isolated and may have difficulty communicating problems with their care;
8) a significant increase in the usage of self-directed services has occurred contemporaneous with the transition to MLTSS;.
9) administrative burdens associated with credentialing and contracting, obtaining authorization for services, filing claims, and in the timeliness of payment under MLTSS have affected providers;
10) providers express uncertainty regarding their future under the MLTSS model;
11) certain stakeholders expressed optimism regarding increased coordination of services from integration of acute, long-term, and behavioral services with MLTSS;
12) certain stakeholders see potential for increased LTSS quality oversight under managed care; and
13) concerns over the state's capacity to oversee and monitor MLTSS were expressed by stakeholders. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Dual Demonstration Losing Enrollment. On September 30, 2015, *Modern Healthcare* reported that as of Sept. 1, only 7,280 individuals have enrolled in New York's Fully Integrated Duals Demonstration while 57,375 have opted-out. Between August and September, nearly 400 dropped out. Approximately 124,000 were eligible as of Jan. 1. The demonstration is set to end December 31, 2017, but the state's Medicaid director has expressed interest in continuing the program. Read More

DSRIP Project Approval and Oversight Panel (PAOP). As part of the DSRIP program requirements outlined by CMS, NYS was required to convene a stakeholder panel to review DSRIP applications scored by an independent assessor and to advise the Commissioner of Health whether to accept, reject or modify those recommendations. The Department of Health has decided to continue the work of the panel, the Project Approval and Oversight Panel (PAOP), to serve as advisors and reviewers of Performing Provider Systems' status and project performance during the 5-year DSRIP program. The PAOP is scheduled to meet with all the upstate-based DSRIP Performing Provider Systems in Albany on November 9th-10th. The meeting is structured as an update session for the panel members and an opportunity for the panel members to check in with each of the PPSs. The meeting is open to the public, but there will be no public comment period. No pre-registration is required. The meetings will be webcast and can be viewed live here.

The Future of Managed Long Term Care and FIDA. On September 29, 2015, the Department of Health and CMS hosted a stakeholder forum on the future of

managed long term care and New York's duals demonstration program, FIDA. As part of the forum, the state released a white paper with draft ideas for modifications. The state has posted the white paper on the Medicaid Redesign Team website, and is seeking feedback and stakeholder input to the document. Comments will be accepted through October 9.

Medicaid Costs for Diabetes Care. The NYS Comptroller Tom DiNapoli released a report detailing the cost to NYS's Medicaid program for individuals with diabetes. It indicates that NY spent over $1.2 billion for diabetes-related care to 460,000 Medicaid beneficiaries. Over a five-year period, annual diabetes-related expenditures for Medicaid recipients grew by $293.7 million, or 31 percent (13.8 percent, adjusted for medical care cost inflation), to $1.2 billion. Over the same time period, total New York Medicaid spending increased $9.4 billion, or 21 percent (4.7 percent, adjusted for inflation), to $54.9 billion in SFY 2013-14.

Montefiore and St. Luke's Cornwall Hospital Announce Partnership. St. Luke's Cornwall Hospital announced that they will join Montefiore Health System, entering into a passive parent relationship, with Montefiore as the parent organization. St. Luke's includes 2 campuses with a total of 242 beds and a community-based out-patient facility. Montefiore has been expanding its operations and now consists of eight hospitals and an extended care facility -- a total of 2,747 beds. Primary and specialty care is provided through a network of more than 150 locations across the region. The St. Luke's Board of Trustees will remain intact, comprised of its existing community leaders; joining the Board will be three members-at-large from MHS. The partnership has been approved by the Boards of both St. Luke's and Montefiore and is pending regulatory review and approval by the Federal Trade Commission.

Olmstead Housing Subsidy Program. The New York State Department of Health announced the availability of state funds to establish a rental subsidy and transitional housing support service program for high-need Medicaid beneficiaries. Up to $10 million is available for a two-year program. This pilot program targets Medicaid beneficiaries who require nursing home levels of care, are homeless or unstably housed, have experienced at least one episode of 120 consecutive days in a nursing home over the most recent two year period, and have the ability to live safely in the community. Funds will be awarded to a single provider capable of administering a state-wide initiative. More information at the Grants Gateway website.

Access to Health Care for New York City Immigrants. New York City Mayor Bill de Blasio established a Task Force on Immigrant Health Care Access with the goal of increasing access to health care services among immigrant populations. The task force brought together City agencies, health care providers, immigrant advocates, and public health experts to identify key barriers to health care access and recommend steps the City can take to help immigrants overcome them. In a recent report, the task force reviewed the current delivery system as experienced by immigrants, with a focus on barriers to access to care, and laid out the following recommendations.

1. Create a direct access health care program to provide uninsured immigrants and others with access to coordinated primary and preventive health care services.

2. Expand the capacity of the New York City health care system to provide culturally and linguistically competent primary and preventive health care services to immigrants.
3. Conduct public education and outreach on health care and coverage options for immigrants and the organizations that serve them.
4. Increase access to high-quality medical interpretation services.

The report can be found here.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's Insurance Commissioner Holds Public Hearing on Surprise Balance Billing. Pennsylvania's Insurance Commissioner Teresa Miller held a public hearing on the issue of surprise balance billing, an issue where a consumer -- after receiving a service from a health care provider that is in-network for the consumer's health insurance-- receives a bill for a portion of the care. In many cases, consumers exhausted all reasonable options to ensure that the doctors they saw were in-network but still encountered an out-of-network service provider or facility at some point during their care. Throughout the hearing, testimony focused on a need to remove consumers, many of whom took the time and effort to fully research their options to make sure the doctors and facilities are in-network, from the middle of billing disputes. Full video of the hearing and written testimony from interested parties will be available at www.insurance.pa.gov. Read More

Texas

Texas Health and Human Services to Soften Children's Therapy Cuts. On October 1, 2015, *The Texas Tribune* reported that the Texas Health and Human Services commission announced that it will make less drastic cuts to therapy for children with disabilities following a lawsuit, vocal protests, and lawmaker backpedaling over the original cuts. It is still unclear how the health commission will modify the cuts and whether the announcement will have any bearing on the lawsuit. Read More

Lieutenant Governor Defends Medicaid Cuts to Children's Therapy. On September 30, 2015, *The Texas Tribune* reported Lieutenant Governor Dan Patrick released a statement defending the Legislature for cutting $350 million in state and federal funding for therapy for children with disabilities. Patrick stated that the therapy services were a target for fraud and that the Health and Human Services Inspector General was calling for a crackdown on excessive therapy services. Critics of the cuts have expressed the view that the Legislature arbitrarily instructed the Texas Health and Human Services Commission to reduce funds for eliminating waste, fraud, and abuse without considering the potential impact on the vulnerable population. A state judge sided with therapists and families of children with disabilities by delaying the cuts. Read More

Utah

First Public Hearing Held on UtahAccess+. On October 6, 2015, the first public meeting was held on Governor Herbert's Medicaid expansion plan, UtahAccess+. No action or vote was taken on the plan. The earliest the plan can start is next summer. Read More

Governor Herbert Asks Lawmakers to Make Changes to UtahAccess+. On October 5, 2015, *Deseret News* reported that Governor Gary Herbert stated that changes may need to be made to the latest Medicaid expansion plan, UtahAccess+. Herbert will leave it to House Speaker Greg Hughes and legislative leaders to decide what needs to be done to make the plan favorable to lawmakers, especially those in the House, where the Healthy Utah proposal stalled in the 2015 Legislature. The Legislature's Health Reform Task Force has scheduled a three-hour meeting to discuss the proposal. Read More

National

Problems Plague Rollout of New Medicaid Enrollees; Community Health Centers Opening to Increase Networks. On October 2, 2015, *Kaiser Health News* reported that over 950 new community health centers have opened up and that thousands have been expanded or modernized to care for the influx of new Medicaid enrollees from the Affordable Care Act. However, problems have plagued the enrollment of new patients. In California, three million more people than expected signed up for Medicaid. Other states, including Kentucky, Michigan, Oregon, and Washington also saw surges exceed projections. As a result, patients have been forced to seek care in emergency rooms due to a lack of large enough provider networks and doctors limiting the number of Medicaid patients in their practices. Read More

Report Finds Medicaid Agency Leaders' Compensation Inadequate. On September 29, 2015, *Fierce Health Payer* reported that according to a Milbank Memorial Fund report analyzing the state of the Medicaid program administration, compensation for Medicaid agency leaders is inadequate. A 2013 survey showed that only 9 percent of Medicaid directors earned over $200,000 a year, and 23 percent earned between $150,000 and $200,000. Corporate CEOs earn approximately 10 to 20 times as much. As a result, Medicaid directors stay only two-thirds as long in their jobs as leaders in the private sector. Read More

Some States Looking at Work Requirements for Medicaid. On September 30, 2015, *The PEW Charitable Trusts* reported that certain states are looking to impose new limits on Medicaid eligibility, including work requirements and a five-year lifetime limit. In Arizona, Governor Doug Ducey is asking the federal agency to approve changes which would require new applicants to have a job, be looking for a job, or be in job training to qualify for Medicaid. Additionally, the applicant would contribute their own money into a health savings account, which can only be accessed if they met work requirements or engaged in certain types of healthy behavior. Recipients would also be limited to five years of coverage as adults. The federal government has yet to ever approve work requirements or lifetime limits on eligibility; however, CMS has approved health savings accounts in Arkansas, Indiana, and Michigan. CMS has stated that states may promote employment through state programs but could not do so under the Medicaid program. Read More

Industry News

Providence Service Corporation Names David Shackelton as CFO. On October 1, 2015, Providence Service Corporation announced that it has appointed David Shackelton as its new Chief Financial Officer, effective immediately. Shackelton was serving as the interim CFO after James M. Lindstrom, former CFO, was appointed as Chief Executive Officer. Read More

Epic Health Services Acquires Unifour Nursing. Epic Health Services Inc., a Dallas-based provider of pediatric skilled nursing and therapy, announced that it has acquired Unifour Nursing, a Newton, N.C.-based provider of pediatric and adult home care services. No financial terms were disclosed. EHS is a portfolio company of Webster Capital. Read More

Providence Health Plan Names Mike Cotton as New CEO. On October 5, 2015, *The Lund Report* reported that Providence Health Plan has announced Mike Cotton as the new chief executive officer, effective October. Cotton was previously vice president and chief operating officer for Humana's dual eligible and Medicaid programs. Providence Health Plan serves over 500,000 members. Read More

Active Day/Senior Care Acquires ElderWatch Plus. On October 6, 2015, Clearview Capital announced that one of its portfolio companies, Active Day/Senior Care acquired ElderWatch Plus, an adult day health services center located in Philadelphia. The name of the company has been changed to Senior Care of Overbrook Park. Active Day/Senior Care now operates 11 adult day health centers in Pennsylvania, and a total of 75 centers across the country. Read More

Employers Turn to BeneStream to Screen Low-Wage Workers for Medicaid Eligibility. On October 5, 2015, *Crain's New York* reported that under the Affordable Care Act requirement to provide health care to workers or face fines, employers are turning to a health startup that screens and enrolls low-income workers for Medicaid. The requirement can be especially difficult in low-wage industries. Through BeneStream, the employer sends a list of names of workers who may be eligible for Medicaid. The workers are contacted, screened, and applied to Medicaid, if eligible, using BeneStream's software. Sending workers to Medicaid, however, is controversial. Since Medicaid is funded by the state and federal government, the employer does not contribute to premiums. Additionally, finding doctors under Medicaid coverage can be difficult for employees. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 16, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January 15, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	450,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care (*exiting demo*); Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	4/1/2016	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***12***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452	116,470	117,307
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170	51,631	49,663
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671	17,518	17,337
Michigan					9,216	14,867	28,171	35,102	42,728
New York	17	406	539	6,660	7,215	5,031	7,122	9,062	8,028
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871	62,418	59,697
South Carolina		83	1,205	1,398	1,366	1,317	1,388	1,380	1,530
Texas			58	15,335	27,589	37,805	44,931	56,423	45,949
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507	29,200	29,176
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**	**379,204**	**371,415**

HMA News

New this week on the HMA Information Services website:

- **California** Medicaid Managed Care Enrollment is Up 9.9%, Aug-15 Data
- Market Share for **New York** Medicaid MCOs, Sep-15 Data
- Public documents such as **New York** LTC Draft White Paper and HRSA 340B Drug Pricing Guidance
- Plus upcoming webinars on *Emerging Tools and Technology for Consumer Engagement in Health Care* and *Risk-Ready Primary Care: The Next Wave in Practice Transformation for a Value-Based Future*

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Welcomes…

Janine Stuart, Principal – New York, New York

Janine recently joined HMA's Investment Services team to work with the investment community as they evaluate healthcare services transactions. Prior to joining HMA, Janine worked for eight years at Marwood Group, a healthcare research and advisory firm, providing legislative and regulatory consulting services to investors and healthcare corporations. In this role, Janine managed numerous relationships with leading financial sponsors, healthcare lenders and corporate healthcare clients. Prior to consulting, Janine worked for four years in operations and finance as an administrator at a leading academic medical center in New York. Janine received her Bachelor of Science degree in Finance and Marketing from the University of Maryland, and a Master of Public Administration degree in Health Policy and Management from New York University.

Sarah Barth, Principal – New York, New York

Prior to joining HMA, Sarah served as the director of integrated health and long-term services at the Center for Health Care Strategies (CHCS). In this role, she primarily worked on CHCS' initiatives to help state, federal, and health plan partners advance integrated models of care for managed long-term service and supports systems and individuals who are dually eligible for Medicaid and Medicare.

She was the project director for Promoting Integrated Care for Dual Eligibles (PRIDE), a consortium of high-performing health care organizations identifying and testing innovative strategies to enhance and integrate care for high-cost, high-need populations. She also led Implementing the Roadmaps: Innovations in Long-Term Supports and Services, a project providing technical assistance to 10 states transforming LTSS systems to managed care delivery and promoting community-based living. Sarah additionally worked on CHCS efforts regarding

social impact financing, payment and delivery reform, and Medicaid leadership development.

As a consultant, Sarah worked closely with several state Medicaid programs; nonprofit foundations; and managed health care organizations. She also has more than 18 years of experience in Medicaid administration, working for both New Mexico and Massachusetts.

In New Mexico, Sarah oversaw long-term services programs, managing all aspects of the design, waiver submissions to the Centers for Medicare & Medicaid Services and implementation of the Coordination of Long-Term Services program. She worked at the Massachusetts Medical Assistance Division for 12 years on the state's Medicaid program, briefly serving as the legislative director for Health and Human Services for the Massachusetts Governor's Office. At Massachusetts Medicaid, she developed legislative and media strategies, oversaw large interagency projects, and contributed to state health care reform initiatives.

Sarah has a law degree from Suffolk University Law School and a bachelor's degree from the University of Pennsylvania.