HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 9, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

NCQA'S MEDICAID HEALTH INSURANCE PLAN RATINGS 2015 - 2016

This week, our *In Focus* section reviews the annual Medicaid health plan ratings released in September by the National Committee for Quality Assurance (NCQA). NCQA has previously provided annual rankings and quality scores of private commercial health plans serving employers and the individual market, Medicare Advantage plans, and Medicaid managed care organization (MCO) health plans. **However, for 2015-2016, NCQA has implemented a new ratings methodology, "which classifies plans into scores from 0 to 5 in 0.5 increments--a system similar to CMS' Five-Star Quality Rating System."** This is a shift away from outright ranking of plans against each other, and toward rating them individually on a zero-to-five scale, with NCQA stating that only those plans awarded a 4.5 or 5 are to be considered "highest-rated" For 2015-2016, only eleven Medicaid MCOs across the country were awarded a 4.5 or 5.

Below, we briefly summarize the NCQA rating methodology, highlight those highest-rated Medicaid plans nationally, and provide an overview of how the larger multistate Medicaid MCOs performed in this year's NCQA report.

NCQA Methodology Overview

NCQA ratings are based on three types of quality measures:

1. measures of clinical quality;
2. measures of consumer satisfaction; and
3. results from NCQA's review of a health plan's health quality processes.

NCQA rates health plans that report quality information publicly. The clinical quality measures include prevention and treatment measures, which are a subset of the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

Consumer satisfaction measures come from the HEDIS survey measurement set—Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2—a validated survey overseen by the Agency for Health Care Quality (AHRQ). Consumer satisfaction measures assess patient experience with care, including their experiences with doctors, services and customer service.

Prevention measures assess the proportion of eligible members who received preventive services, like prenatal and postpartum care, immunizations and cancer screenings.

Treatment measures assess the proportion of eligible members who received the recommended care for conditions such as diabetes, heart disease and mental illness.

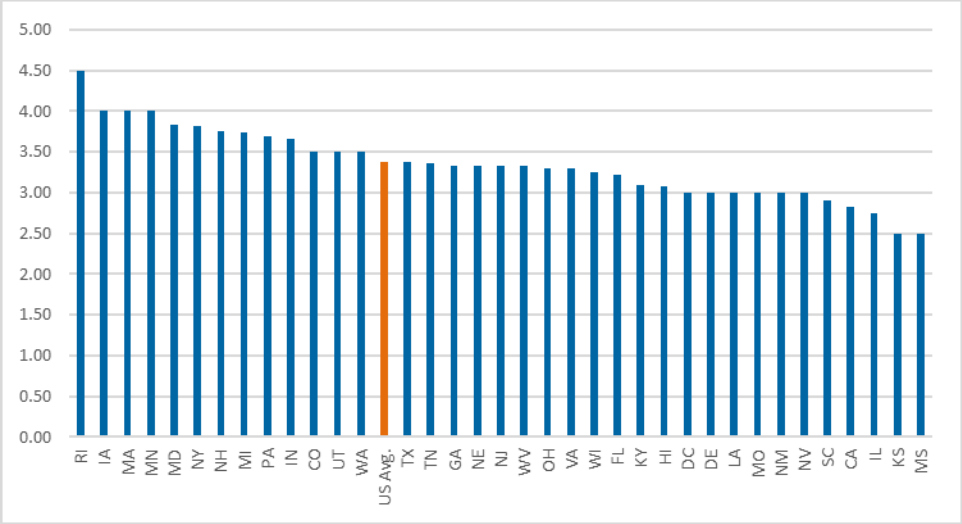
A detailed methodology document for the 2015-2016 ratings is available here.

Highest-Rated Medicaid MCOs for 2015-2016

As was the case under the previous ranking methodology, the highest-rated Medicaid MCOs for 2015-2016 are largely local and regional health plans, with only UnitedHealthcare's Rhode Island plan achieving a rating of 4.5 or higher. Kaiser Foundation's Hawaii plan was the only Medicaid MCO to receive a rating of 5 for 2015-2016. AmeriHealth Caritas, Anthem, Meridian, UnitedHealthcare, and Molina all have plans receiving a rating of 4 by NCQA.

2015/2016 Rating	Plan Name	States	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
5	Kaiser Foundation Health Plan - Hawaii	HI	Yes	4	4.5	4
4.5	Capital District Physicians' Health Plan	NY	Yes	4	4	4
4.5	Fallon Health	MA	Yes	4	4.5	4
4.5	Jai Medical Systems	MD	Yes	*i*	4	4
4.5	Neighborhood Health Plan	MA	Yes	3.5	4.5	4
4.5	Neighborhood Health Plan of Rhode Island	RI	Yes	4	4.5	4
4.5	Priority Health	MI	Yes	4	4	3.5
4.5	Security Health Plan of Wisconsin	WI	Yes	4	3.5	4
4.5	THP-Network Health	MA	Yes	3	4.5	4
4.5	UnitedHealthcare Community Plan	RI	Yes	3.5	4.5	4
4.5	Upper Peninsula Health Plan	MI	Yes	4	4	4

Rhode Island, Iowa, Massachusetts, Minnesota, and Maryland are the top five states in terms of average Medicaid MCO rating. New York, New Hampshire, Michigan, Pennsylvania, Indiana, Colorado, Utah, and Washington joined them in ranking above the U.S. average. Mississippi, Kansas, Illinois, California, and South Carolina make up the bottom five.



Overview of Larger and Multi-State Plan Ratings

Overall, most of the larger and multi-state health plans averaged ratings slightly under the national average for health plan ratings in 2015/2016. Both Meridian and AmeriHealth Caritas averaged ratings across their plans above the national average. The table below summarizes the number of plans rated and average rating by health plan, and excludes those plans without a rating for 2015/2016.

Health Plan	Number of Plans Rated	Average 2015/2016 Rating
Aetna	10	3.20
AmeriHealth Caritas	6	3.42
Anthem	14	3.25
Centene	10	3.10
Humana	2	2.75
Meridian	3	4.00
Molina	11	3.18
UnitedHealthcare	17	3.24
WellCare	9	3.11
All Other Rated Plans	*67*	*3.56*
Total (All Rated Plans)	**149**	**3.38**

Full rankings available at: http://healthplanrankings.ncqa.org/

HMA Medicaid Roundup

Arkansas

Governor Hutchinson to Hire Firm to Finish Medicaid Eligibility and Enrollment System. On December 3, 2015, *Arkansas Online* reported that Governor Asa Hutchinson has instructed the state Department of Human Services to hire a company to act as a systems integrator and finish implementation of the Medicaid eligibility and enrollment system. The unfinished system has doubled its expected cost and has been blamed for delays in processing applications and reviewing eligibility of those already enrolled. DHS said the department had already planned to hire a systems integrator to coordinate a phase of the project involving expanding the system to handle enrollment for all Medicaid recipients. Governor Hutchinson will also establish a statewide committee and a policy oversight committee to guide the system project. Read More

California

HMA Roundup – Don Novo (Email Don)

Adventist Health to Take Over Health Net's 13,000 Medi-Cal Members in King County. On December 8, 2015, *The Fresno Bee* reported that Adventist Health Plan will oversee consumer health benefits of 13,000 Medi-Cal members in Kings County for Health Net. Adventist Health/Central Valley Network operates four hospitals and 32 community clinics. Affected patients will keep their primary-care doctors and specialists and use the same hospitals. Read More

Attorney General Approves Deal for Hedge Fund to Manage Daughters of Charity Health System. On December 4, 2015, *SF Gate* reported that California's Attorney General Kamala Harris approved a deal for BlueMountain Capital Management, a New York-based hedge fund, to manage Daughters of Charity Health System. The deal is considered the state's largest and most complex nonprofit hospital transaction. One of the restrictions of the deal is a requirement that four of the network's hospitals — including Seton Medical Center, O'Connor and St. Louise Medical Center — remain as acute-care medical centers with emergency services for 10 years. Daughters of Charity has been losing $150 million a year. Under BlueMountain, Integrity Healthcare will manage the hospitals for up to 15 years and pay $100 million for the option to purchase the system at a certain point. This agreement also provides for $180 million in capital improvements for the Daughters' sites. Daughters of Charity will be renamed Verity Health System. Read More

Twenty-three California Hospitals are identified as top performers by Leapfrog's 2015 Hospital Survey. The 2015 Annual Leapfrog Hospital Survey identified 23 top performing California Hospitals, two of which are Children's Hospitals. Hoag Memorial, Kaiser, University of California, St John's of the Pleasant Valley, and Children's Hospital of Los Angeles and Orange County were among the California top performing hospitals ranked by Leapfrog. The annual Leapfrog Survey is a list of hospitals that performed at the highest levels nationally, based on Leapfrog's quality and safety standards. More than 1,600 hospitals report on those standards through the annual Leapfrog Hospital Survey. More details and the complete list of top performers can be found here.

Connecticut

Fight Over Medicaid Cuts Intensifies between Hospitals and Governor. On December 7, 2015, *ctpost* reported that hospitals have launched television ad campaigns targeting Governor Dannel P. Malloy for cutting Medicaid reimbursements. The Connecticut Hospital Association accused Malloy of reneging on Medicaid reimbursement rates and is threatening to sue the state over lost revenue. Malloy responded by shaming health care executives over their salaries and profit margins, calling it a "hospital industrial complex." He said that to restore the $240 million in funding on top of a $500 million increase the hospitals are seeking, the state would be forced to increase taxes. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Children's Medical Services to Resume Enrollment Next Month after Backlash. After facing extensive criticism for removing 9,000 children with special health needs from the Children's Medical Services program between May and September of this year, the Florida Department of Health announced that they would reopen the program to new enrollees next month. The department faced a backlash from the media and state Senate by removing children with chronic and serious medical conditions as part of a wholesale reorganization of the program in conjunction with a law that moved the plan from fee-for-service to state-run managed care. The issue drew wide attention after a piece from the *Miami Herald* on December 5, 2015. Read the story here. A hearing was held aimed at adopting a new screening tool that would address some of the criticism. In September, an administrative law judge ruled that the Department of Health could not use the now-former screening tool without adopting it through a formal rule-making process. Since then, new enrollments in Children's Medical Services have been on hold pending the rule-making process under way. Read More

State Officials Readying Proposals for Mental Health Reform for 2016. On December 7, 2015, *Sayfie Review* reported that state leaders are working on 2016 proposals to improve mental health. Governor Rick Scott proposed an increase of $19 million for mental health and substance abuse treatment services in his recommended budget. Others include Representative Charles McBurney's bill to create a statewide framework for counties to offer treatment-based mental health courts and State Senator Rene Garcia's sweeping reform bill. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Authorities Shut Down 12 Unlicensed Care Homes for Elderly, Disabled. On December 2, 2015, *The Baltimore Sun* reported that state and local authorities shut down 12 Georgia unlicensed care homes for the elderly and disabled. Eight people who ran the homes in Gwinnett County were arrested and charged with exploitation of an at-risk adult. Residents were unattended at times and were forced to give up food stamps and Social Security benefits in exchange for rent. All residents are being relocated. Read More

Indiana

Governor Pence Says Federal Evaluation of the Healthy Indiana Plan is Biased. On December 9, 2015, *IndyStar* reported that Governor Mike Pence sent a letter to the U.S. Department of Health & Human Services (HHS) asking that the federal review of Indiana's alternative Medicaid plan be dropped because the independent evaluator, Urban Institute, is a biased source. Indiana's expansion waiver runs through January 31, 2018. One of the conditions of the waiver, however, is that the demonstration be evaluated. The state has until mid-2016 to submit an interim evaluation. Read More

Iowa

Aetna Asks DHS to Stop Medicaid Managed Care Implementation. On December 3, 2015, *Sioux City Journal* reported that Aetna Better Health is asking the Iowa Department of Human Services to immediately halt the implementation of the Medicaid managed care contracts. Aetna filed a request for a stay in program implementation and has filed a review of the proposed decision. The company requested the final ruling by December 9. WellCare stated it will also appeal the decision after an administrative judge proposed removing the company's contract. Read More

Three Major Hospitals and More Providers Sign Up for Iowa's New Medicaid Managed Care Program. On December 3, 2015, *KCRG* reported that the University of Iowa Hospital and Clinics, UnityPoint Health, and Genesis Health System have signed contracts with the state to participate in the new Medicaid managed care program. The three hospitals represent 3,300 providers including doctors, nurses, and specialists. Iowa has approximately 7,500 physicians in the state. As of November 30, United Health Care of the River Valley had signed up 85.4 percent of the physicians, WellCare 40.6 percent, AmeriGroup Iowa 36.1 percent, and AmeriHealth Caritas Iowa 11 percent. Read More

Louisiana

Legislative Audit Finds Medicaid Nonemergency Medical Transportation Deficient. On December 7, 2015, *The Advocate* reported that a legislative audit report concluded that the state Department of Health and Hospitals failed to properly oversee the $18 million-a-year program providing nonemergency medical transportation to Medicaid recipients. The audit found little-to-no monitoring to ensure rides were medically necessary or occurred at all. On

December 1, 2015, five Medicaid managed care companies took over the transportation program. State Medicaid director Ruth Kennedy said the companies are contractually obligated to "safeguard Medicaid funds against unnecessary or inappropriate use of services." Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Senate Bills Introduced Would Delay Horizon's OMNIA Plan. On December 7, 2015 *NJBIZ* reported that State Senators Joseph Vitale and Nia Gill introduced bills to address "concerns with the process of approving tiered networks in the state." Senate bill S3300 would place a moratorium on the implementation of tiered network health benefits plans until January 1, 2017. This would delay the implementation of Horizon Blue Cross and Blue Shield of New Jersey's OMNIA plan and any other benefit plans with tiered networks. Senate bill 3286 would establish certain standards for health benefits plans with tiered networks, and S3287 would require carriers to disclose selection standards for the placement of health care providers in a tiered health benefits plan network, as well as establish an oversight monitor to review for compliance. *NJBIZ* gave an update on December 9, 2015, reporting on the industry's response to the bills with concerns that the existing insurance regulations are outdated and do not contemplate the monitoring of tiered networks. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

EmblemHealth Leaving Managed Long Term Care Market. *Crain's HealthPulse* reports that EmblemHealth has announced that it is withdrawing from managed long-term care as of January 1, 2016. New York's managed long-term care (MLTC) program covers individuals who are dually eligible for Medicare and Medicaid and require community-based long-term care services, such as home health and personal care services. EmblemHealth had about 1,300 MLTC members, a number that has been consistent since the mandatory MLTC program was implemented. EmblemHealth is partnering with GuildNet, the largest MLTC plan in the state, to take over its MLTC members. Read More

The New York Medicaid Management Information System (NYMMIS) Update. The NYS Department of Health continues to work with Xerox Healthcare, LLC on the design and development of NYMMIS. In early 2016, all new provider enrollments (enrollments for providers who are not currently enrolled in the New York Medicaid program), will be handled by NYMMIS. Other functionality and activities will be added in releases throughout 2016 and 2017. Providers and other interested parties are being encouraged to sign up for the ListServ on the Interim NYMMIS website in order to stay up-to-date on process changes related to NYMMIS: http://www.interimnymmis.com/

Patient Centered Medical Home Incentive Program. A recent NYS Department of Health Medicaid Update contains information about changes to the Patient Centered Medical Home Incentive program, which will be effective January 1, 2016. Reimbursement for PCMH incentive payments will be updated to reflect the program changes. Incentives for providers recognized at level 2 or level 3 under the National Committee for Quality Assurance's (NCQA's) 2011

standards will be reduced and incentives for providers recognized at level 2 or level 3 under NCQA's 2014 standards will be increased. The table below summarizes the Medicaid Managed Care (MMC) per member per month (PMPM) payment and the Medicaid fee-for-service (FFS) 'add-on' amounts by provider type and recognition status. These changes continue the state's continued efforts to raise the bar on its expectations for PCMH.

	NCQA Level 2 2011/2014 Standards	NCQA Level 3 2011/2014 Standards
MMC - PMPM	$2.00 / $6.00	$4.00 / $8.00
Institutional	$7.75 / $23.25	$12.50 / $25.25
Professional	$6.75 / $20.50	$14.50 / $29.00

Ohio

HMA Roundup – Mel Borkan (Email Mel)

A Quarter of Ohio Prisons Enrolling Inmates in Medicaid Under Expansion. On December 7, 2015, *WOSU Radio* reported that approximately one-fourth of Ohio prisons are enrolling inmates in Medicaid. By the end of 2016, the prison system expects every eligible inmate to have access. After Governor John Kasich expanded Medicaid, the prisons and state Medicaid and Mental Health Departments teamed up to get inmates enrolled. A pre-release Medicaid enrollment pilot program that began 15 months ago at a women's prison showed successful results. Read More

Ohio's Infant Mortality Commission Wraps Up Work in Early 2016. The Infant Mortality Commission, co-chaired by Senator Shannon Jones and Representative Stephanie Kunze, is developing recommendations for a report expected in 2016. To date the Commission has been developing a compendium of all of the state's initiatives and programs that help babies make it to their first birthday. This work will be made available publicly to help inform local efforts, but expect additional recommendations from the Commission, including best practices currently available, like smoking cessation programs and long acting reversible and progesterone birth control options. The Commission has also looked at social determinants of infant mortality, such as housing and homelessness. It is anticipated that the Commission's report and recommendations will be sent to the General Assembly in the first few months of next year. Read More

Partnership of Mercy Health and Summa Health Creates Largest Clinically Integrated Network in Ohio. *Gongwer Ohio* is reporting that Mercy Health and Summa Health have partnered to create Advanced Health Select. The first provider networks will be Mercy Health Select and NewHealth Collaborative, the accountable care organizations operated by the hospitals. Michael D. Connelly, president and chief executive officer of Mercy Health, said in a statement that "Combining the strengths of Mercy Health Select and NewHealth Collaborative puts us at the forefront of healthcare transformation." Read More For a copy of the release, click here.

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Update on Coordinated Care Organizations. Over the past few months, FamilyCare, a Coordinated Care Organization (CCO) with 128,000 Medicaid members in Multnomah, Washington, Clackamas and Marion counties, has been in conflict with the Oregon Health Authority (OHA, the state's Medicaid agency) over 2015 rates, which OHA retroactively lowered for the Portland-area CCO. OHA believes it overpaid FamilyCare by $55 million in the first eight months of 2015, and wants the funds returned so that they can be redistributed. Most of this amount is related to the differences in rates for the expansion population between the initial and revised 2015 rates.

FamilyCare had not signed its 2016 contract (with reimbursement rates based on the disputed 2015 rates) by November 24, when the OHA director sent a letter to the other 15 CCOs that serve Medicaid clients in Oregon, inviting them to declare their interest in covering FamilyCare's members in the event that FamilyCare did not continue its coverage. The deadline to declare interest was December 2. Six CCOs sent in binding letters of interest - Health Share, Pacific Source, Trillium (Centene), Willamette Valley Community Health, Eastern Oregon CCO (Moda Health), and Columbia Pacific CCO.

In December, the Oregon Legislative Counsel issued an opinion that OHA cannot reclaim funds paid to CCOs for past periods. This could be helpful to FamilyCare's pending legal case, although Legislative Counsel opinions are themselves not binding and do not have the force of law. Legislative Counsel opinions are prepared in order to help legislators develop and consider legislative proposals. This opinion was prepared in response to a request by Senator Chip Shields. Read more here and here.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Feds Come Down Against Hershey-Pinnacle Merger. The Federal Trade Commission (FTC) informed PinnacleHealth System and Penn State Milton S. Hershey Medical Center it will oppose joining the two health care systems. Over the next few days, leaders of the two organizations will consult with lawyers and "carefully examine our options" on whether to continue to try to merge the two organizations. The FTC and Pennsylvania Attorney General Kathleen G. Kane announced they are taking legal action to block the proposed merger of the two largest health systems in the Harrisburg area. The FTC alleges that the combination of Penn State Hershey and PinnacleHealth System would substantially reduce competition in the area surrounding Harrisburg, which includes Dauphin, Cumberland, Perry, and Lebanon Counties. Read More

State Supreme Court: UPMC Can't Terminate Highmark Medicare Advantage Contracts. The Pennsylvania Supreme Court has ruled Pittsburgh-based UPMC cannot drop Highmark's Medicare Advantage plan members from its network. The court's ruling means about 182,000 seniors enrolled in Highmark's Medicare Advantage plans will not have to pay higher, out-of-network rates through June 2019. UPMC spokesman Paul Wood said the health system will comply with the ruling. Read More

Wolf Administration Continues Efforts to Increase Community Living Availability. Governor Tom Wolf and Department of Human Services (DHS) Secretary Ted Dallas today announced that the commonwealth has successfully transitioned the first Pennsylvania resident into an apartment through the Section 811 Project Rental Assistance (PRA) program. DHS and the Pennsylvania Housing Finance Agency (PHFA) were awarded $8.6 million in March 2015 and $5.7 million in 2013 to prevent individuals with disabilities from being unnecessarily institutionalized or falling into homelessness. Section 811 PRA provides rental subsidies for permanent affordable rental housing and ensures that needed supportive services are available to extremely low-income persons with disabilities, many of whom are hoping to transition out of institutional settings and back to the community. Read More

Lawsuit Alleges Lack of Services for Adults with Autism. The Disability Rights Network of Pennsylvania filed the federal lawsuit against the Pennsylvania Department of Human services on behalf of three individuals with autism and mental illness who are institutionalized and cannot access community-based autism services. All three adults have been recommended for release but remain in institutions because of lack of services in their communities, the lawsuit alleges. One is in prison and two are in state hospitals, according to a news release from the Disability Rights Network. The lawsuit aims to address service disparities for adults with autism so that they will have options other than being institutionalized. Read More

CHIP Move May Benefit Kids. A bill to move the Children's Health Insurance Program (CHIP) from its current home in the Insurance Department to the Department of Human Services won House approval last week. The proposal now goes to the Senate. The heads of the two agencies involved think it will benefit children of low-income families enrolled in CHIP. The Department of Human Services already oversees programs for health, human services and the federal-state medical assistance program. CHIP provides health coverage for uninsured children and teens who are not eligible for or enrolled in Medicaid. There are about 10,000 children in Pennsylvania who transition between the CHIP and Medicaid programs each year because their families' income fluctuates between financial eligibility thresholds. Human services should be able to better coordinate services for those families if it can administer both programs, DHS Secretary Ted Dallas and Insurance Commissioner Teresa Miller said. Read More

South Dakota

Governor Daugaard Proposes Medicaid Expansion During Budget Address. On December 8, 2015, *Argus Leader* reported that Governor Dennis Daugaard announced a plan to expand Medicaid during an address to unveil his proposed budget plan. Daugaard stated he would not move forward, however, if additional state funds were required. Expansion will largely depend on CMS to update a policy on funding 100 percent of funds for Medicaid-eligible American Indians through the Indian Health Service or tribes. Read More

Utah

Governor Herbert Will Not Propose New Expansion Plan; To Wait on Legislators' Next Steps. On December 3, 2015, *Lexington Herald Leader* reported

that Governor Gary Herbert will not propose a new Medicaid expansion plan after being rejected twice by lawmakers this year. Herbert will wait on legislators' next steps on Medicaid to see if they propose anything. Lawmakers intend to look at expansion in 2016, but may wait until 2017 to see if a Republican wins the presidential race, according to Herbert's chief of staff Justin Harding. Read More

Virginia

Hospitals Reverse Position on Bed Tax; Money Could be Used for Potential Expansion. On December 3, 2015, *The Washington Post* reported that state hospitals have reversed their position on a bed tax. The provider assessment would draw down a federal match and the money could potentially be used to expand Medicaid without using state funding. The Virginia Hospital and Healthcare Association laid out six conditions in a letter to Governor Terry McAuliffe, including keeping the program in the private sector. Read More

National

Report Shows Nonprofit Hospitals Built Financial Cushion to Absorb Operating Unpredictability. On December 6, 2015, *Forbes* reported that nonprofit hospitals' liquidity levels have significantly improved under the Affordable Care Act (ACA). A report from Fitch Ratings found that the hospitals have built a "solid financial cushion to absorb potential operating volatility" in 2016. From the increased coverage under the ACA, clinical volumes in 2015 were higher than expected, especially in Medicaid expansion states. In previous years, inpatient admissions were flat or falling. Read More

CMS Finalizes Rule to Retain Funding for Medicaid Technology Upgrades. On December 3, 2015, *Modern Healthcare* reported that CMS finalized a rule to make funding permanent for Medicaid system upgrades for enrolling residents. In 2011, CMS increased the matching rate for money states spent on building Medicaid eligibility and enrollment systems from 50 percent to 90 percent; maintenance and operations from 50 percent to 75 percent. The funding was set to expire in December but the rule will keep funds permanent. The agency expects to spend $3 billion between fiscal 2016 and fiscal 2025 on implementing the proposed regulation. There are currently 28 states with old systems that need replacement. Read More

Industry News

Kaiser Permanente to Acquire Group Health Cooperative in Washington. On December 4, 2015, *Modern Healthcare* reported that as Kaiser Permanente readies to acquire Washington-based Group Health Cooperative, the insurer is becoming "more of a national player." The acquisition, set to close next year, will expand Kaiser's geographic reach in Washington, in addition to a market presence in California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington, D.C. Read More

Clearview Capital Completes Sale of Senior Care/Active Day, Inc. On December 9, 2015, Clearview Capital announced that it completed the sale of its interests in Senior Care/Active Day, Inc., to Audax Privite Equity Fund IV after ten years of ownership. Senior Care/Active Day operates 80 adult day health centers across 11 states, serving approximately 4,000 members on a daily basis. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
December 11, 2015	Pennsylvania MLTSS/Duals	DRAFT RFP Comments Due	450,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 5, 2016	Nebraska	Proposals Due	239,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
February 5, 2016	Nebraska	Letter of Intent to Contract	239,000
March 15, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
June, 2016	Oklahoma ABD	RFP Released	177,000
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	Proposals Due	177,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
March 1, 2017	Virginia MLTSS	Implementation	130,000
TBD 2017	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 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	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179	116,538
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	48,779	53,136
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657	12,366
Michigan		9,216	14,867	28,171	35,102	42,728	37,072	36,335
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942	8,005
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428	61,333
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355	1,359
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737	52,232
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138	28,644
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,287**	**369,948**

HMA NEWS

New this week on the HMA Information Services website:

- **West Virginia** to Competitively Bid Medicaid Managed Care Contracts, Dec-15 Opportunity Assessment
- **Mississippi** Medicaid Managed Care Enrollment Rises 168%, Nov-15 Data
- Public documents such as the **New Jersey** Newsletter on Medicaid Expansion Population's LTC and Behavioral Health Benefit Changes, Dec-15, and the **Florida** Governor's Proposed Budget and Related Documents, FY 2016-17
- Plus upcoming webinars on *"Building Population-Based Integrated Delivery Systems for Vulnerable Populations"* and *"Transgender Transitioning: Implications of New Health Insurance Coverage Guidelines"*

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 Releases Medicaid Managed Care White Paper

In *"The Value of Medicaid Managed Care,"* HMA authors Lisa Shugarman, Jaimie Bern, and Jessica Foster review the literature describing the evolving Medicaid delivery system, focusing specifically on the growth of Medicaid managed care in the form of comprehensive risk-based managed care (RBMC) organizations. The paper, prepared for United HealthCare, also explores the role of Medicaid RBMC relative to the fee for service (FFS) delivery system and draws comparisons of the experience of these delivery systems from the perspective of the Medicaid beneficiary, the provider, and the state. The paper concludes by sharing lessons learned from the last decade of Medicaid managed care expansion. Read More

HMA Webinar Replays Available:

- ***"Trends in State Medicaid Programs: Emerging Models and Innovations"***
- ***"Medicaid Enrollment and Spending Trends: An Inside Look at Findings from the 15th Annual Kaiser 50-State Medicaid Budget Survey"***
- ***"Outreach and Enrollment: Maximizing Medicaid and Marketplace Penetration"***

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Olympia and Seattle, Washington; Portland, Oregon; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC.

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