HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 5, 2014

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

THIS WEEK

IN FOCUS

MISSOURI ISSUES MEDICAID MANAGED CARE REQUEST FOR PROPOSALS

This week our *In Focus* section reviews the request for proposals (RFP) issued by Missouri's HealthNet Medicaid managed care program on November 3, 2014, to rebid contracts across all three managed care regions. MO HealthNet Managed Care currently contracts with three MCOs, each serving all three managed care regions, which cover 54 out of 114 counties in the state in a band that extends from St. Louis to Kansas City. The RFP does not expand the geographic of population scope of MO HealthNet. Newly awarded contracts will take effect on July 1, 2015.

Link to RFP Website: http://archive.oa.mo.gov/bids/b3z15077.htm

RFP Overview

- **Scope:** MO HealthNet Managed Care currently serves 398,000 beneficiares across the state's three managed care regions. Calendar year 2013 per-member per-month capitation rates averaged around $210, for just over $1 billion in annual capitation payments, as detailed in the table below pulled from Mercer's rate certification report.

CY 2013 Enrollment/Rate Data	Central	East	West	All Regions
Member Months	952,254	2,417,919	1,550,543	4,920,716
Average Monthly Enrollment	**79,355**	**201,493**	**129,212**	**410,060**
Blended PMPM	$198.50	$206.74	$222.39	$210.08
Total Capitation Payments	**$189,022,419**	**$499,880,574**	**$344,825,258**	**$1,033,728,251**

Source: Mercer Data Book, October 10, 2014

- **Covered Populations:** MO HealthNet Managed Care covers parents/caretakers, children, refugees, pregnant women and newborn children, as well as the foster care and foster-related populations.
- **Excluded Populations:** Dual eligibles, the aged, blind, and disabled (ABD) population, and select waiver populations are excluded from managed care enrollment in Missouri.
- **Contract Awards/Term:** The RFP indicates MO HealthNet intends to award a maximum of three contracts which will serve all three regions beginning July 1, 2015, the start of state fiscal year 2016. Contracts will be for an initial term of one year, to expire June 30, 2016, and may be extended for up to two additional option years, through June 30, 2018.
- **Risk Adjustment:** MO HealthNet began risk adjustment for Medicaid MCO rates in 2013. The state, along with its actuary, Mercer, developed a risk adjustment methodology applying a blended approach of the MedRx and CDPS+Rx risk models. Most rate cells for the MO HealthNet managed care population are risk adjusted.
- **Health Insurance Provider Fee (HIPF):** The RFP indicates that MCOs will be reimbursed for the full amount of the HIPF, with estimated monthly HIPF adjustments included in the capitation rates, to be reconciled at the end of the year with the full amount of the HIPF.
- **Performance Withhold:** A 2.5 percent withhold will be applied to capitation rates, to be earned back on five broad categories of measures: (1) Encounter Data Completeness/Accuracy; (2) Provider Panel Directory Completeness/Accuracy; (3) Healthy Children and Youth (HCY)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participant Ratio; (4) Case Management; and (5) Medicaid Reform and Transformation Activities. Metrics and requirements are included in the full RFP document.

Evaluation Criteria

RFP responses will be evaluated on the following criteria, with quality and access accounting for 60 percent of the overall scoring. There is no price component to the bid, as plans must indicate their acceptance of state-developed risk adjusted rates for each of the three regions in their RFP response.

Evaluation Criteria	Possible Points	Percent
MBE/WBE Participation	**10**	**5%**
Organizational Experience	**10**	**5%**
Method of Performance	**20**	**10%**
Quality	**60**	**30%**
Access to Care Total	**60**	**30%**
Primary Care	*15*	*8%*
Specialty Care	*15*	*8%*
Dental Care	*15*	*8%*
Behavioral Health	*15*	*8%*
Medicaid Reform/Transformation Total	**40**	**20%**
Personal responsibility	*10*	*5%*
State provider incentive program	*10*	*5%*
Local Community Care Coordination Program	*10*	*5%*
Accountability/Transparency	*10*	*5%*
Total Points Possible	**200**	

RFP Timeline

Proposals are due to the state on December 19, 2014. As of the RFP release, there does not appear to be a target date for contract award announcements. However, new contracts will be implemented on July 1, 2015.

RFP Milestones	Date
RFP Released	November 3, 2014
Pre-Proposal Conference	November 10, 2014
Proposals Due	December 19, 2014
Contract Awards	TBD
Implementation	July 1, 2015

Current Medicaid MCO Market

As of September 2014, Aetna's HealthCare USA was the largest MO HealthNet managed care plan, with nearly 60 percent market share across all three regions. WellCare's Missouri Care plan has around 25 percent of the market, while Centene's Home State Health Plan enrolls roughly 16 percent.

WellCare had previously served the MO HealthNet program under it's Harmony Health Plan product until the state consolidated to only three health plans across all three regions in July, 2012. However, WellCare was able to reenter the state by purchasing Aetna's Missouri Care contract, which Aetna was forced to sell as part of the acquisition of Coventry in early 2013.

September 2014 Enrollment	Central	Eastern	Western	All Regions	Mkt. Share
HealthCare USA (Aetna)	39,065	119,120	75,606	233,791	58.7%
Home State Health Plan (Centene)	7,918	36,563	20,620	65,101	16.4%
Missouri Care (WellCare)	29,794	39,304	30,083	99,181	24.9%
Total Enrollment	**76,777**	**194,987**	**126,309**	**398,073**	

Source: MO HealthNet Medicaid Managed Care RFP

HMA Medicaid Roundup

Alabama

Alabama Forsakes $1.4 Billion This Year and Over Next Three Years by Opting Out of Medicaid Expansion. On October 30, 2014, the Alabama Media Group reported that the state of Alabama could have received $1.4 billion in federal funds this year if it had opted to expand Medicaid under the Affordable Care Act. The state would also receive this amount every year for the next three years before the federal government decreased its 100 percent match rate. Doug Hoffman, a navigator with Enroll Alabama, has produced an infographic depicting how much each county in the state is forsaking without Medicaid expansion. Read more

California

HMA Roundup – Alana Ketchel (Email Alana)

Voters Oppose Propositions 45 and 46, Support Proposition 47. On November 5, 2014, the Secretary of State announced that the two most significant statewide health-related propositions on the California ballot did not pass. Proposition 45 would have allowed stronger regulation of health insurance premiums. Proposition 46 would have raised the medical malpractice cap and would have required hospitals to randomly test their doctors for alcohol and drug abuse. Proposition 47 did pass, which reduces some criminal penalties. The anticipated savings will go to support anti-truancy, mental health and drug treatment programs. Read more

State Expands Open Data Portal. On November 4, 2014, the *California Healthline* reported that the California Health and Human Services Agency has released a website that the public can use to access non-confidential health data. The California Department of Public Health and the Office of Statewide Health Planning and Development (OSHPD) have contributed data, and others are expected to join. Potential products of the data portal include applications that combine data to show correlations, for example, between asthma patients' ED use and income. The portal is available here.

Covered California Announces Proposed Rates and New Features for 2015 SHOP Plans. On November 3, 2014, Covered California announced proposed rates for the 2015 Small Business Health Options Program (SHOP). Small businesses can expect to see a statewide weighted average premium increase of 5.2 percent for the 2015 plan year. As the "active purchaser," the exchange was able to keep increases low for a majority of SHOP customers. New to SHOP next year is the dual-tier option, which allows employers to offer plans at two metal tiers as long as they are contiguous (e.g., the Bronze and Silver levels, Silver and

Gold levels, or Gold and Platinum levels). Also new to SHOP is the addition of embedded children's dental coverage (through Delta Dental's dental HMO or Access Dental Plan's dental HMO). Read more

Covered California Experiencing Glitches. On November 3, 2014, the *California Healthline* reported that some Covered California applicants have received multiple conflicting notices regarding their eligibility. Exchange staff attributes the problem to a computer glitch and believes the issue affects only a small number of applicants. The exchange's website was also taken down for maintenance briefly last week to correct error messages that consumers and brokers were receiving when they tried to complete transactions. Read more

DHCS Announces 1115 Waiver Renewal Workgroups. On October 30, 2014, the Department of Health Care Services updated the meeting dates for five stakeholder workgroups that will support the state's renewal of its Medicaid 1115 Waiver. Workgroup topics include: (1) Delivery System Reform Incentive Program 2.0, (2) Medicaid-funded Housing/Shelter (3) Workforce (4) Safety Net Financing and (5) Managed Care Plan / Provider Incentives. There will also be a one-day workshop on the topic of Federal/State shared savings. Read more

L.A. County Officials Demand Details on Reduced Nursing Home Penalties. On October 29, 2014, *Kaiser Health News* reported that the Los Angeles County Board of Supervisors ordered the public health department to provide an update on the nursing home inspection process. The order comes after a recent *Kaiser Health News* report that penalties in three patient deaths had been reduced without explanation. The Board also ordered the department to report the percentage of inspectors' recommended citations that had been changed by their supervisors. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Accountable Care Collaborative Achieves Record Savings and Improved Outcomes. On November 3, 2014, the Colorado Department of Health Care Policy and Financing announced it has achieved about $100 million in gross savings on medical services with its Accountable Care Collaborative (ACC) program. This is more than double the amount of cost avoidance achieved by the program last fiscal year. After accounting for payments to providers and regional care collaborative organizations, the program's net savings for state fiscal year 2013-14 was approximately $31 million. The ACC program was created in 2009 to improve client health and reduce overutilization of services. Read more

Georgia

HMA Roundup – Mark Trail (Email Mark)

DCH Releases Enterprise Data Solution RFQC. On October 30, 2014, the Georgia Department of Community Health (DCH) released an electronic Request for Qualified Contractors ("eRFQC") soliciting proposals from suppliers interested in providing an enterprise data warehouse with supporting business intelligence tools which address decision support, enhanced clinical data analytics and population health management. The eRFQC will not result in a contract reward; rather, it will establish a list of qualified suppliers who will be

eligible to participate to win future contracts from DCH. Statements from qualified suppliers will be accepted until November 14, 2014. Read more

Medicaid Expansion in the South: How Arkansas and Kentucky Have Fared Since Adopting Expansion Programs. On October 29, 2014, Georgia Health News reported on the effect of Medicaid expansion programs in Kentucky and Arkansas. Kentucky and Arkansas are the only states in the Southeast to have expanded Medicaid in some form; Arkansas developed a "private option" alternative to Medicaid expansion, and Kentucky opted for conventional expansion (despite several Republican bills to stop it). Both states have reported decreases in uncompensated care and ER visits and increases in insured patients. Read more

Idaho

Shift to Medicaid Managed Care Causes Behavioral Health Service Cuts for Some Beneficiaries. On October 31, 2014, the *Idaho Statesman* reported that some Medicaid beneficiaries receiving community-based mental health and rehabilitation services are losing these services as the state's Medicaid program becomes privatized through a managed care contractor, Optum. Read more

Kansas

Department of Health and Environment Releases MMIS RFP. On October 23, 2014, the Kansas Department of Health and Environment released an RFP (RFP EVT0003406) for technical and business services for the takeover and operation of the existing Medicaid Management Information System (MMIS) and the implementation and operation of a modular MMIS to modernize and replace the current system. A pre-proposal conference was held on October 29, 2014. Questions are due by December 1, 2014, and proposals are due by January 21, 2015.

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

CMS Approves Massachusetts Medicaid 1115 Waiver. On October 31, 2014, the Massachusetts Department of Health and Human Services announced the first-ever five-year, $41.4 billion Medicaid waiver agreement with CMS. The 1115 waiver will bring in more than $20 billion in federal revenue to the Commonwealth (the state will pay the rest) to help improve care of patients through continued health care delivery transformation. The Commonwealth highlights these key components of the waiver:

- This is CMS' first five-year extension of the waiver, giving the state a solid span of time with which to increase coverage and continue work on delivery system transformations
- The waiver provides $230 million annually for three years for the continued transformation of the state's safety net hospitals into integrated care delivery systems and away from fee for service payments

- The waiver supports the state's approach to rewarding providers for delivering coordinated, efficient care through payment programs like the Primary Care Payment Reform Initiative and the Medicaid ACO model
- The waiver provides $771 million over three years for designated state health programs that provide comprehensive community-based health services for Medicaid eligible individuals.
- The waiver will help keep healthcare affordable for low- and middle-income residents
- The waiver expands programs providing specialty services to children with severe asthma and autism
- The waiver will support expedited MassHealth eligibility determination, thus reducing the likelihood of gaps in care.

In 2011, CMS renewed the state's Medicaid waiver with a three-year, $26.75 billion contract. Read more

Michigan

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

Healthy Michigan Plan Enrollment. Enrollment in the Healthy Michigan Plan (HMP) continues to grow. The Michigan Department of Community Health (DCH) reports that between April 1 and November 3, 2014, a total of 439,975 individuals were approved for HMP coverage.

The DCH updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the newly approved HMP beneficiaries reside in the state's five largest counties:

October 27, 2014 Healthy Michigan Plan Enrollment	
Wayne	120,749
Macomb	33,577
Oakland	32,619
Genesee	28,229
Kent	22,176
Five-County Total	**237,350**
Statewide Total	**439,975**

With few exceptions, new HMP beneficiaries are required to enroll in the Medicaid Health Plans (HMOs) to receive their health care benefits. As of October 1, 2014, there were a total of 310,345 HMP beneficiaries enrolled in the HMOs. HMP enrollment totals by health plan are expected to increase again in November as newly eligible individuals continue to enroll in the program and choose an HMO or are assigned to an HMO if they do not select a plan.

October 2014 Healthy Michigan Plan Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	22,157	3,330	25,487
CoventryCares of MI	2,932	3,688	6,620

HAP Midwest Health Plan	11,323	7,631	18,954
Harbor Health Plan, Inc.	745	1,778	2,523
HealthPlus Partners	16,697	2,558	19,255
McLaren Health Plan	30,025	7,872	37,897
Meridian Health Plan of MI	52,332	24,143	76,475
Molina Healthcare of MI	26,488	10,461	36,949
PHP Mid-MI Family Care	2,081	972	3,053
Priority Health Choice, Inc.	18,340	3,791	22,131
Total Health Care	7,392	4,190	11,582
UnitedHealthcare Comm. Plan	29,637	10,438	40,075
Upper Peninsula Health Plan	9,339	5	9,344
Total	**229,488**	**80,857**	**310,345**

Duals in Medicaid HMOs. The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow – there were 54,142 duals enrolled in Medicaid HMOs in October, an increase of 636 since September. All Medicaid HMOs have duals enrolled, although the numbers vary dramatically across plans.

A Medicaid HMO member who gains Medicare coverage and remains in the HMO is categorized as auto-assigned or voluntarily enrolled based on the means through which the member was initially enrolled in the HMO. Duals enrolled in a Medicare Advantage Special Needs Plan (SNP, or D-SNP) for their Medicare benefits but receiving Medicaid on a fee-for-service basis are auto-assigned to the related Medicaid HMO if applicable. Any dual is able to "opt out" of the HMO and receive Medicaid benefits on a fee-for-service basis.

Molina Healthcare of Michigan has the most duals receiving Medicaid services from an HMO, 24.3 percent of the total; UnitedHealthcare Community Plan has a 21.8 percent market share; Meridian Health Plan of Michigan has 18.3 percent (but the most voluntary enrollees); and the other 10 plans share the remaining 35.6 percent of the market.

Eight of the 13 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as D-SNPs to provide Medicare benefits for duals in Michigan: HAP Midwest Health Plan, HealthPlus Partners, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan and Upper Peninsula Health Plan. As of October 1, 2014 these eight D-SNPs had a combined enrollment of 23,015 duals for whom they provide Medicare services; 48.5 percent of the duals that are enrolled in a D-SNP are enrolled in the Molina plan, 29.9 percent are enrolled in the UnitedHealthcare plan and the remaining 22.3 percent are spread across the other six plans. Not all of the duals enrolled in these D-SNPs are eligible to receive full Medicaid benefits. Some only receive assistance from the Medicaid program with Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

There is one additional D-SNP in Michigan, Fidelis SecureCare of Michigan, Inc. It does not hold a Medicaid contract but has been approved by the state as a potential Integrated Care Organization (ICO) in the state's duals demonstration. As of October 1, 2014, Fidelis had 955 enrollees in its D-SNP. It is also an approved Medicare Advantage Institutional SNP (I-SNP) with 255 enrollees.

CSHCS Children in Medicaid HMOs. The Michigan Department of Community Health (DCH) requires children (and a few adults) receiving

services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program to enroll in Medicaid HMOs. As of October 1, 2014, there were 17,093 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs – a decrease of 518 since September**.** All Medicaid HMOs except Harbor Health Plan, Inc. have CSHCS/Medicaid enrollees, although the numbers vary across plans.

Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most CSHCS/Medicaid enrollees receiving their services from an HMO, 25.2 percent of its enrollment. CSHCS/Medicaid enrollees represent 17.3 percent of Molina Healthcare of Michigan's enrollment and 16.9 percent of UnitedHealthcare Community Plan membership. The other nine plans share the remaining 40.6 percent of CSHCS/Medicaid enrollees.

See more Michigan updates in HMA's The Michigan Update

Nebraska

Prison System Could Spend Millions on New Hepatitis C Treatment. On November 2, 2014, the *Lincoln Journal Star* reported that the Nebraska Department of Correctional Services is trying to obtain adequate funds from the state to pay for expensive hepatitis C drugs for inmates. The Department must treat 72 inmates per year with a new hepatitis C treatment, Sovaldi along with other antiviral drugs, a cocktail which would cost the system about $11.7 million for fiscal year 2015-2016. In fiscal 2013, before Sovaldi came on the market, Nebraska Medicaid paid $922,000 for treatment of hepatitis C. The Department has submitted a budget request outlining the costs for the treatment; Omaha Senator Heath Mello said that he has reviewed the request and will meet with the Legislature's fiscal office in the next couple of weeks for a more in-depth briefing. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid Expansion Helps St. Joseph's Lift Credit Rating. On November 5, 2014, North Jersey Media Group reported that St. Joseph's Healthcare System had its credit rating raised by Moody's Investors Services for the first time to investment grade. Moody's reported that Medicaid expansion in New Jersey has allowed St. Joseph's to benefit from increased reimbursement rates, decreased uncompensated care, and a focus on expense management. The healthcare system, which has hospitals in Paterson and Wayne, reported spending $99 million in cash flow from operations in the most recent fiscal year, three times its operating cash flow three years ago. Read more

Managed Long Term Services and Supports (MLTSS) Contract Provisions Released. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has uploaded a copy of the July 1, 2014 Medicaid managed care contract to its website, which incorporates the provisions for the MLTSS program that began on July 1, 2014. Four managed care organizations are providing MLTSS to Medicaid enrollees. Article 9 of the contract is new and covers the majority of contract changes associated with MLTSS, including:

- Coordination and continuity of care provisions

- Care management standards, processes, and system requirements
- Considerations for institutional or community-based MLTSS placement
- Participant direction and the Personal Preference Program under MLTSS
- Money Follows the Person as it relates to MLTSS
- Behavioral health standards under MLTSS
- Critical incident reporting
- Quality management and performance improvement requirements.

The contract also sets forth MLTSS provider network requirements in Article 4.8, an MLTSS Services Dictionary and Behavioral Health Services Dictionary in Appendix B.9.0 and B.9.9, respectively. It also describes eight MLTSS-specific capitation rates in Appendix C. In addition, the state has defined 40 MLTSS performance measures at the end of Article 9 that must be met in Year 1.

A complete copy of the contract can be found here.

New York

Formation of new PPS in Brooklyn Stagnates Due to Financial Instability of Lead Hospital. On November 4, 2014, *Crain's HealthPulse* reported that financially-strapped SUNY Downstate Medical Center does not anticipate passing the financial stability test, meaning that the hospital will not be able to lead the formation of a new Brooklyn integrated care network. SUNY Downstate was supposed to be the lead hospital in the formation of a performing provider system, which would have included Downstate, Brookdale, Interfaith and Kingsbrook Jewish hospitals. At this point, these members are considering abandoning the effort and joining other PPS systems. Read more

DSRIP Vital Access Provider Exception Appeals Posted for Public Comment Period. On November 4, 2014, the New York State Department of Health announced that the DSRIP Safety Net Definition page has been updated to include the pending Vital Access Provider (VAP) Exception appeals for a 30-day public comment period. These VAP Exception appeals are being provided for a 30-day public comment period ending on December 3, 2014. The Department is currently reviewing the attached VAP Exceptions and making recommendations for inclusion in the DSRIP safety net process. The approval of these exception appeals is contingent upon obtaining approval from the CMS.

Questions related to the Vital Access Provider Exception or DSRIP safety net process should be emailed to BVAPR@health.ny.gov. All other questions can be directed to DSRIP@health.ny.gov.

NYU Langone – Cobble Hill Emergency Department Opens on LICH Site. On October 30, 2014, *Crain's HealthPulse* reported that NYU Langone received all final government and regulatory approvals to operate an emergency department at the site of Long Island College Hospital. The hospital finalized site preparations and staff assignments, and NYU Langone – Cobble Hill opened on October 31. NYU Langone is still working with the state Department of Health and the FDNY on acceptance of 911 ambulances on site for transfer to hospitals. Read more

Brooklyn-Based Nonprofit Receives $75,000 Grant to Design Medicaid Managed Care Network for Persons with Intellectual and Developmental Disabilities. On October 30, 2014, *Crain's HealthPulse* reported that the New York Integrated Network for Persons with Intellectual and Developmental Disabilities was awarded a $75,000 grant from the New York Community Trust to create a developmental disability integrated support and care coordination organization. The Brooklyn-based nonprofit will assemble a network of agencies that will provide a full range of coordinated health and social services using capitation payments. The grant money will go specifically towards hiring consultants to assist in business planning and to conduct an analysis of other provider-led managed care plans serving high-needs groups. Read more

North Carolina

Governor Pat McCrory Weighing Medicaid Expansion in North Carolina. On October 30, 2014, the *News & Observer* reported that Governor Pat McCrory is considering expanding Medicaid in North Carolina. In recent months McCrory said he is open to considering offering Medicaid to as many as 500,000 low-income individuals; last year he signed into law a Republican-backed bill prohibiting expansion without approval from the General Assembly. State Department of Health and Human Services Secretary Aldona Wos said she soon plans to present McCrory with expansion options. Read more

Pennsylvania

HMA Roundup – Matt Roan (Email Matt)

Judge to Rule on Closure of Community Health Centers. On November 2, 2014, the *Pittsburgh Post-Gazette* reported that officials from the PA Department of Health and the Service Employees International Union (SEIU) are awaiting a ruling from the State Supreme Court in a dispute over the closure of 26 state-run community health centers. The Governor's budget for the fiscal year 2013-2014 proposed the closure of the centers as part of an overall consolidation effort that would include community health nurses providing more services in the field. The Budget calls for the closure of 26 health centers, but in July a judge ordered the closures to stop while the lawsuit was being litigated. The legal dispute centers on a 1996 law that was passed to combat efforts at the time to privatize the health centers. The law prohibits the state from reducing the scope of services or the number of health centers below 1995 levels. The *Pittsburgh Post-Gazette* has also uncovered documents that show that the Department of Health's own staff, including a Department Attorney warned against the closures. A committee charged with developing a plan for re-organizing the state health centers recommended closure of only 15 centers. It is not clear how the Department arrived at the 26 closures included in its ultimate plan. Read more

Lehigh Valley Super-Utilizer Partnership Faces Challenges in Curbing Frequent ER Use. On November 2, 2014, the *Allentown Morning Call* reported on that an initiative funded through an ACA grant has faced challenges in addressing the way the healthcare system serves healthcare "super-utilizers." The Lehigh Valley Super-Utilizer Partnership was launched in 2012 with a goal to enroll 477 high need patients in the program, which provides care coordination and support services, based on the model created by Dr. Jeffrey

Brenner at the Camden Coalition. As of October, the partnership has enrolled only 86 patients. Program leaders attribute the low enrollment rate to difficulty executing agreements with local hospitals. The program's original goal of achieving $13 million in healthcare savings now seems unlikely. The data analysis phase of the project has just begun; once that analysis is available, the Lehigh Valley Super Utilizer Partnership will be able to assess the impact of the program on the patients they have been able to enroll. Read more

Judge Rules that Highmark Did Not Violate Consent Decree with New Medicare Plan Offering. On October 31, 2014, the *Pittsburgh Post-Gazette* reported that a state judge has ruled that Highmark was not in violation of a state-brokered consent decree between Highmark and UPMC when it created a new Medicare Advantage plan offering that excludes UPMC providers from its network. State officials had argued that the new Highmark plan violated terms of the consent decree that required Highmark to include UPMC providers in plans serving vulnerable populations, including Medicare recipients. The Court ruled that the provision did not explicitly require Highmark to include UPMC in all Medicare Plan offerings and that there was no violation of the decree. A spokesperson from UPMC said that the ruling has made clear that the consent decree did not include all of the consumer protections that state officials intended and that the ruling raises doubts about the strength of other consumer protections in the decree as the current contracts between UPMC and Highmark expire at the end of the calendar year. Read more

Study Shows Improved Preventive Dental Utilization Among PA Children on Medicaid. On November 3, 2014, *NewsWise* reported that a new study published by the Children's Hospital of Pennsylvania (CHOP) has found improvements in the utilization of preventive dental services among children on Medicaid in Pennsylvania. The study compared dental utilization rates in 2005 with those in 2010 and found that while there was an increase in overall utilization from 2005 to 2010, only 60 percent of children are obtaining the recommended dental services. Utilization among Latino children improved markedly during the study period. Sixty-three percent of Latino children ages 5-10 years received preventive dental care in 2010 compared to only 35 percent in 2005. The next phase of the study will examine the key drivers of the improved utilization patterns. Read more

National

Election Results Unlikely to Affect Medicaid Expansion Outlook. On November 5, 2014, the *New York Times* reported that the re-election of Republican governors in Florida, Wisconsin, Maine, and Kansas means that Medicaid expansion stances in these states will likely remain unchanged. The *Times* highlights the implications of election results in these and several other states:

- **Maine**: The legislature has voted for expansion five times, but Governor LePage has vetoed all of these attempts.
- **Alaska**: While Governor Sean Parnell opposes expansion, the state could decide to expand Medicaid in order to provide more comprehensive services to low-income Alaskans and to relieve financial obligations of Indian Health Services.

- **Wisconsin**: Governor Walker opposes expansion, partially because the state already had relatively generous Medicaid eligibility rules before the ACA.
- **Florida**: While Governor Scott has indicated support for expansion in recent months, he has never forcefully advocated for it. There is no sign that Scott will make the issue a priority, especially in the face of strong opposition from the new state House speaker Steve Crisafulli. About 848,000 Floridians would be covered under expanded Medicaid.
- **Kansas**: Brownback signed legislation last year prohibiting any governor from accepting Medicaid dollars without legislative approval.
- **Arkansas**: While the state has rolled out a "private option" Medicaid expansion alternative, the program is conditional upon annual approval by a three-fourths majority in the legislature. Now that Democrats have lost numbers in the legislature, the private option program could be at risk.

  Pennsylvania: While former Governor Tom Corbett approved expansion in the state (set to begin in January), newly elected Democrat Tom Wolf might make changes to this program to address concerns from lawmakers in his party. Read more.

Marketplace Premiums to See Modest Increase in 2015. On October 31, 2014, *Bloomberg* reported that health insurance premiums on the federally-facilitated exchange will increase 6 percent on average in 2015, much lower than the double-digit increases predicted by ACA skeptics. A combination of new entrants and increased price competition amongst insurers drove the modest premium increase. Healthcare.gov CEO Kevin Counihan is urging those who signed up last year to review their available options for next year, as their current insurers' rates may have changed. Read more

Insurers Anticipate Substantial Increases in Customers for 2015 Enrollment. On October 30, 2014, *Reuters* reported that privately held and non-profit health insurers offering plans through the federal health care exchange anticipate substantial increases in customers in 2015. The insurers anticipate customer growth of at least 20 percent; some even cited the potential of doubling their number of policyholders. The insurers formed these impressions based on significant increases in call center volume and decreases in insurance premium pricing for 2015 plans, which could generate greater consumer interest. Read more

Rural Hospitals Still Struggle, Despite ACA Provisions Designed to Help Them. On October 29, 2014, the *California Healthline* reported on the challenges faced by rural hospitals in an area of mergers, acquisitions, economic recovery, and declining payments for caring for the uninsured. According to data compiled by the American Hospital Association, there are 1,980 rural community hospitals in the U.S. Since the ACA was signed into law, the number of rural hospital closures has increased; thirteen have closed this year alone. The ACA has established provisions that could boost the resiliency of rural hospitals, but a number of barriers have prevented these facilities from taking advantage of such provisions. Read more

Industry News

Kindred Names Benjamin A. Breier Chief Executive Officer-Elect. On October 30, 2014, Kindred Healthcare, Inc. announced that Benjamin A. Breier will become Chief Executive Officer on March 31, 2015. Mr. Breier will also become a member of Kindred's Board of Directors on the same date. Breier joined Kindred in 2005 as President of the Rehabilitation Division and was named President of the Company's Hospital Division in 2008. He was promoted to Chief Operating Officer in 2010 and assumed the additional responsibilities of Company President in 2012. Breier will succeed Paul J. Diaz who will become the Executive Vice Chairman of the Kindred Board of Directors. Read more

Generation Growth Capital Invests in Accurate Home Care. On November 3, 2014, private equity firm Generation Growth Capital, Inc. announced that it has invested in Accurate Home Care (AHC), LLC. Accurate Home Care provides comprehensive home health care services to patients of all ages and care requirements in Minnesota, Illinois and Iowa. AHC CEO Amy Nelson will retain a significant portion of the ownership. Senior financing was provided by Anchor Bank, and mezzanine financing was provided by Exmarq Capital Partners. Read more

Aetna to Acquire Insurance Exchange Technology Provider bswift. On November 3, 2014, Aetna announced that it has entered into an agreement to acquire privately held bswift, which provides a technology platform that offers a retail shopping experience for health insurance exchanges and employers nationwide. The company also offers benefits administration technology and services to employers. The purchase price is approximately $400 million. Read more

Subsidiary of Community Health Systems Acquires South Carolina Hospital. On November 3, 2014, Community Health Systems (CHS) announced that a subsidiary has acquired operational control of Gaffney Medical Center, a 125-bed hospital in Gaffney, South Carolina. The acquisition was effective November 1, 2014. Previously, the facility was owned through a joint venture between Novant Health and a subsidiary of Health Management Associates, Inc. (no relation to Health Management Associates) which was acquired by CHS in January 2014. As a result of the transaction, Novant no longer retains an economic interest in the hospital. CHS' affiliates now own and operate nine acute care hospitals in South Carolina. Read more

WellCare Health Plans to Outsource IT Quality Assurance. On November 2, 2014, the *Tampa Bay Business Journal* reported that information technology quality assurance for WellCare Health Plans will be outsourced to Accenture, resulting in the elimination of 57 positions at WellCare. Public Relations director Crystal Warwell Walker said the company "will make every effort to retain impacted associates in other positions within the company as we make this

transition." The majority of employees affected by this layoff will be senior quality assurance analysts. Read more

WellCare Sued by Former Employees. On November 3, 2014, Health News Florida reported that WellCare Health Plans, Inc. has been sued by several former employees who claim the insurer wrongfully took payments from the federal and state government for inpatient hospital stays it never covered. The lawsuit, filed in the U.S. District Court in Tampa in May 2013, had been sealed while the U.S. Attorney's Office decided whether to join in the case. Last week the case was unsealed after federal prosecutors decided not to intervene. Read more

RFP Calendar

Date	State	Event	Beneficiaries
December 19, 2014	Missouri	Proposals Due	398,000
December, 2014	Georgia	RFP Release	1,250,000
January 1, 2015	Michigan Duals	Implementation	70,000
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
January/February, 2015	Michigan	RFP Release	1,500,000
February 1, 2015	South Carolina Duals	Implementation	68,000
February 1, 2015	Louisiana	Implementation	900,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
July 1, 2015	Washington Duals	Implementation	48,500
July 1, 2015	Missouri	Implementation	398,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
January 1, 2016	Georgia	Implementation	1,250,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

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
Arizona		98,235	Not pursuing Financial Alignment Model						
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	Alameda Alliance; 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; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
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; Health Spring; Humana; Meridian Health Plan; Molina
Iowa		62,714	Not pursuing Financial Alignment Model						
Idaho		22,548	Not pursuing Financial Alignment Model						
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; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000	N/A			8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
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	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000	N/A			5/23/2014	3/1/2015	4/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2015	9/1/2015 11/1/2015 1/1/2016	UnitedHealthcare
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	Not pursuing Financial Alignment Model						
Totals	**11 Capitated 5 MFFS**	**1.35M Capitated 513K FFS**	***10***			***11***			

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

HMA News

HMA Upcoming Webinar: *"Medicaid in an Era of Health and Delivery System Reform"*

Friday, November 7, 2014
2:00 PM Eastern
Register Here

Medicaid is in the process of transforming itself from a program that simply pays medical bills to one that focuses on value, high quality, care coordination and health outcomes. While the majority of states have opted to expand Medicaid under the ACA, even more have implemented payment and delivery system reforms including medical homes, Accountable Care Organizations, medical and behavioral health integration efforts, and greater reliance on managed care for traditional Medicaid enrollees as well as dual eligibles, long-term care recipients, and people with chronic illnesses.

Capturing the scope of these dramatic changes is the Kaiser Family Foundation's 14th annual 50-state Medicaid budget survey: Medicaid in an Era of Health and Delivery System Reform, conducted with Health Management Associates and with the cooperation of the National Association of Medicaid Directors. During this webinar, co-authors Vern Smith, Kathy Gifford, and Eileen Ellis will highlight the survey's findings and provide perspective on what it all means for the future of Medicaid.

HMA Upcoming Webinar: *"A Healthcare Win for Veterans and States: Strategies for Enhancing Veterans' Benefits by Facilitating Access to the V.A. System"*

Wednesday, November 12, 2014
1:00 PM Eastern
Register Here

One state that has had tremendous success helping veterans take full advantage of their V.A. benefits is Washington. The state's Veterans Benefit Enhancement project is viewed as a model that could be expanded nationwide. Confirmed speakers Bill Allman, Veteran's Program Manager, Washington State Health Care Authority, and HMA's Doug Porter, Principal (Olympia, WA) will present on the following topics:

1. A case study of Washington's Veterans Benefit Enhancement project and the best practices that have made this initiative a success.
2. Other states' approaches to successfully help veterans get the benefits they deserve through the V.A. and avoid the potential of financially crippling medical bills.
3. The prevalence of eligibility for V.A. benefits and failure to enroll – and the resulting economic implications.
4. The type of outreach efforts most successful in helping veterans through the V.A. enrollment process.

HMA Upcoming Webinar: *"Public Health Departments in the Era of Delivery System Reform"*

Wednesday, November 19, 2014
2:00 PM Eastern
Register Here

Health reforms cannot fully succeed without a strong public health component; yet, traditionally public health efforts and health care delivery systems have remained separate silos. As health reform underscores the need for a population approach to health care delivery restructuring, health departments can play an enhanced role in bringing communities together to develop integrated approaches that ensure services meet the needs of those they are meant to serve.

This webinar explores the importance of local and state health department involvement and leadership in the discussions and decision-making processes related to health care delivery and finance reforms. It will feature officials from three public health departments who have experience as leaders in community-wide health reform initiatives.

Speakers

- Jillian Jacobellis, PhD, Deputy Advisor, Colorado Department of Public Health and Environment
- Patricia Harrison, Deputy County Executive for Human Services, Fairfax County
- Leticia Reyes, Division Chief, Illinois Department of Public Health

HMA Moderators

- Pat Terrell, Managing Principal, Chicago
- Joan Henneberry, Managing Principal, Denver
- Margaret Kirkegaard, M.D., Principal, Chicago

HMA WELCOMES

Meggan Schilkie, Principal – New York City

Meggan comes to HMA from the New York City Department of Health and Mental Hygiene where she has worked in several roles over her 10 years with them. Her most recent role was the Chief Program Officer, Bureau of Mental Health where she oversaw $200M of health and human services. In this role, Meggan managed the operations for a Bureau of 12 offices and 180 staff members. She served in a leadership role in Healthcare and Medicaid Reform implementation for New York City. Some of her accomplishments include use of rigorous analytic approaches to utilization and billing data to model and generate cost savings of a $1B city/state initiative to create affordable housing with supports for special populations; dramatically expanded the Department's data systems and IT infrastructure to improve efficiency, decision making, and performance while increasing the accountability of vendors; secured and implemented a Federal Health Care Innovation Grant to restructure psychiatric crisis services in NYC; and restructured a portfolio of contracts from cost-based to performance-based, reducing overhead and improving efficiency in

monitoring and management. While at the Department of Health and Mental Hygiene, Meggan also served as Deputy Director for the Bureau of Mental Health, Senior Advisor and Directory for the Office of the Executive Deputy Commissioner for Mental Hygiene; Special Assistant to the Executive Deputy Commissioner for Mental Hygiene; and Legislative Liaison for the Bureau of Intergovernmental Affairs.

Prior to her work with the NYC Department of Health and Mental Hygiene, Meggan served as a Policy Advocate for the Coalition of Voluntary Mental Health Agencies for over six years. Here she managed a $500k grant program providing crisis counseling to children and families post-9/11. She also analyzed city, state, and federal budgets; drafted lobbying documents; and created budget proposals on behalf of the Coalition.

Meggan received her MBA from Columbia University with an emphasis on Strategy and Management. She received her BA in Theater from Fordham University where she graduated with Departmental Honors.