HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CMS APPROVES MASSACHUSETTS MEDICAID 1115 WAIVER

This week our *In Focus* section comes to us from HMA Boston's Rob Buchanan. Rob provides background and overview on the recently approved 1115 Waiver in Massachusetts. On October 30, 2014, the Centers for Medicare/Medicaid Services (CMS) approved the Commonwealth of Massachusetts' request to extend the MassHealth Section 1115 Research and Demonstration Waiver through June 30, 2019. The agreement is a five-year extension of Massachusetts' 1115 waiver and represents $41.4 billion in spending including over $20 billion in federal revenue. It follows a three-year $26.75 billion waiver agreement that was originally set to expire June 30. Under the new agreement, the goals for the waiver remain the same as the Commonwealth's commitments for the 2011-2014 extension period, including:

- Maintain near-universal health care coverage for all eligible residents of the Commonwealth and reduce barriers to coverage;
- Continue the redirection of spending from uncompensated care to insurance coverage;
- Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

Background: Massachusetts 1115 Waiver

Early Coverage Expansions: 1997 - 2005

Massachusetts' 1115 waiver was initially implemented in July 1997 and has developed over time through amendments and renewals reflecting new priorities and the enactment of the Affordable Care Act (ACA). The waiver authorizes Medicaid higher-income eligibility standards for certain categorically eligible populations including pregnant women, parents or adult caretakers, infants, and children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with HIV. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings.

Health Care Reform Implementation: 2006 - 2011

In the 2005 extension of the waiver, CMS and the Commonwealth agreed to use federal and state Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were

dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). The SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting new insurance programs and financing mechanisms, including:

- **Commonwealth Care:** Commonwealth Care is a publicly-subsidized premium assistance program to help Medicaid ineligible adults with incomes below 300 percent of the federal poverty level (FPL) purchase coverage from private health plans via the state's exchange (the "Connector").
- **Designated State Health Programs (DSHP):** DSHP provides federal financial support for state health programs that historically were not eligible for federal Medicaid reimbursement.
- **Uncompensated Care:** Payments to providers are made for costs associated with uncompensated care (via the state's Health Safety Net Fund), which were anticipated to decrease over time.
- **Hospital Supplemental Payments:** These payments support certain safety-net hospitals for unreimbursed costs associated with providing services to Medicaid, Medicaid managed care, and uncompensated care patients.
- **Other Payments:** Other SNCP payments provide financial support to hospitals operated by the Departments of Mental Health and Public Health (DMH and DPH); payments also support services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).

Delivery System Transformation and ACA Alignment: 2011 - 2014

As the Commonwealth achieved significant progress in increasing access to health coverage, Massachusetts' 1115 waiver has evolved to include support for delivery system transformation and infrastructure expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care. In the 2011 extension of the waiver, CMS and the Commonwealth agreed to use federal and state Medicaid dollars for the following purposes:

- **Pediatric Asthma Pilot Program**: This program focuses on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma.
- **Early Intervention for Autism:** The waiver supports early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements.
- **Express Lane Eligibility**: The waiver enables the state to streamline procedures to renew MassHealth eligibility for individuals that are enrolled in the Supplemental Nutrition Assistance Program (SNAP) program, continuing efforts to reduce gaps in coverage and ensure that those who qualify for coverage receive it.

- **Delivery System Transformation Initiatives (DSTI):** Beginning in 2011, the SNCP included funding to support so-called Delivery System Transformation Initiatives (DSTI), a program with similarities to early Delivery System Reform Incentive Payment (DSRIP) programs in other states, notably California and Texas. DSTI provides $628 million in annual incentive payments to certain Massachusetts' safety net hospitals to support transformation into integrated care delivery systems and away from fee-for-service payments.

New 5-Year Waiver: 2014 - 2019

The most recent waiver continues to build upon the previous extensions, including the coverage, delivery system transformation, and payment reform goals articulated in the 2011 waiver. The new waiver supports Massachusetts' efforts to implement alternative payment methodologies (APM) that reward providers for delivering coordinated, high-quality, cost-effective care. Through APM programs like Massachusetts' ongoing Primary Care Payment Reform Initiative (PCPRI) and a Medicaid Accountable Care Organization (ACO) model, which is in an early development phase, MassHealth aims to promote positive health outcomes and increased value of care over quantity of services provided.

The waiver also expands the state implementation of pilot programs that target coordinated care and specialized services to children with severe asthma and autism through enhanced intervention and treatment, both of which were authorized in earlier versions of the waiver. The agreement also supports continued Health Connector subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage with incomes up to 300 percent of the FPL. The Commonwealth uses state funds to maintain pre-ACA benefit levels for this population through premium assistance and cost-sharing subsidies, but only the premium assistance portion is approved as an allowable waiver expenditure.

Despite these continued federal commitments to Massachusetts to meet the state's health care reform goals, it appears that some of the earlier concerns expressed by CMS in previous waiver negotiations continue to present issues. In the past, CMS expressed its intent to phase out federal reimbursement for DSHP—viewing the financing mechanism as transitional.[1] CMS also questioned whether Massachusetts had sufficiently redirected its spending from subsidizing providers of uncompensated care to subsidizing insurance coverage for individuals, as envisioned in the 2005 waiver agreement.[2] Therefore, while many of the original and more recent SNCP expenditure authorizations are included within the deal, Massachusetts is only authorized to make SNCP payments during the first three years of the five-year waiver period. [3] CMS makes clear that DSHP support will not be available in the last two years of the waiver.

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[1] Anthony S, R. Seifert, J. Sullivan, "The MassHealth Waiver and Beyond." Massachusetts Medicaid Policy Institute. Feb 2009. p. 13

[2] ibid

[3] One exception to the three-year timeframe is spending on Health Connector subsidies, which are authorized for the full-year waiver period.

The three-year authorization limit on SNCP expenditures also includes the DSTI program.[4] The waiver agreement states that the Commonwealth and CMS must collaborate to reach agreement on a redesigned SNCP structure for the final two-year period of the waiver, which creates some uncertainty about the long-term future of the DSTI program. According to the approval letter, CMS will expect the redesigned program to "align with system-wide transformation." John Polanowicz, the Massachusetts Secretary of Health and Human Services, stated that it is because of this agreement to revisit the last two years of the SNCP that the overall deal represents about $640 million less per year compared to the most recent three-year waiver.[5] If an amendment to the waiver for restructured SNCP provider payments is not approved, Massachusetts may resume making DSH payments under its Medicaid State Plan.

If you're interested in learning more about the Massachusetts waiver, email Rob.

[4] Funding for DSTI in the first three years of the waiver is contingent on the state receiving CMS approval on a DSTI master plan and hospital-specific DSTI plans for seven safety net hospitals.

[5] Norton M. "Capuano: Health care accord a 'bad deal' for state." State House News Service. Nov 9, 2014

HMA Medicaid Roundup

Arkansas

Republican Midterm Election Sweep Brings Medicaid Plan's Future into Question. On November 6, 2014, *AP*/the *Star Telegram* reported that Arkansas' Medicaid private option expansion program might be at risk in the wake of the Republican's sweeping victory in the midterm elections. The state's private option uses federal funds to purchase private insurance plans for 211,000 low-income residents. The program will require a three-fourths vote in the House and the Senate to continue. Republicans are sharply divided on the program, putting the solvency of the program into question. Incoming Senate President Jonathan Dismang, who helped design the private option, said the election results mean changes will have to be made to keep the program alive. Read more

California

HMA Roundup – Alana Ketchel (Email Alana)

LA County Health Department Alleged to Have Falsified Nursing Home Complaint Dates, Stalling Investigations. On November 10, 2014, *Kaiser Health News* reported that two employees of the Los Angeles County Public Health Department have accused the Department of falsifying the dates it received complaints about abuse, falls and pressure sores in nursing homes. State law dictates that investigations be started within 10 days of receipt of the complaint (or within 24 hours if the allegation involves imminent threat to a patient). Sharon Geraneo, assistant supervisor in the Department, notified officials of the alleged falsification of complaint dates in an August 6 email. In an October 7 letter to county, state and federal officials, Inspector Kimberly Nguyen reported that eleven complaints were entered later than they were received, by as much as 79 days. Read more

State Prepares for Transition of Rural, Medically Frail Population into Medi-Cal Managed Care. On November 10, 2014, the *California Healthline* reported that the state will launch the transition of 20,000 rural Medi-Cal seniors and persons with disabilities (SPDs) into Medi-Cal managed care health plans next month. Many of these beneficiaries are medically fragile and require extra medical attention and equipment; because of this, it is essential that the transition to managed care not result in any disruptions in care. The state has already shifted about 340,000 SPD beneficiaries in 16 mostly urban counties; there were many reports of disruption of care and failure to transfer patient records during this transition. State health officials say that they have learned from mistakes in their recent transition experiences, and the Department of Health Care Services (HCS) is conducting direct outreach into rural communities

to educate them on the managed care transition. HCS is also making sure health plans have data on people in advance of being enrolled in the health plans. Read more

Governor Brown Appoints DHCS Leadership. On November 10, 2014, Governor Brown appointed Claudia Crist to the position of deputy director of Health Care Delivery Systems at the California Department of Health Care Services. Read more

Medi-Cal Application Backlog Reduced, State Considers Fix. On November 7, 2014, the *California Healthline* reported that the state has reduced the backlog of Medi-Cal applications to about 170,000. To help address the remaining pending applications, the Department of Health Care Services is contemplating granting temporary Medi-Cal coverage to applicants younger than age 19 until the Department makes a final decision on their applications. Read more

Covered California Enrollment Expected to Jump 43 Percent. On November 7, 2014, the *San Francisco Business Times* reported that Covered California expects enrollment will jump to 1.7 million in the second year, adding 500,000 people. The second round of open enrollment begins November 15, 2014, and continues through February 15, 2015. The exchange has kicked off a nine-day bus tour to promote enrollment statewide. Read more

State Releases Geographic Managed Care RFA for Comment. On October 27, 2014, the Department of Health Care Services released a Request for Application (RFA) for health plans interested in serving the Geographic Managed Care (GMC) Medi-Cal population for Sacramento and San Diego counties. The RFA was released for stakeholder feedback and comments, due November 21, 2014. The final version of the RFA will be released by March 2015. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Connect For Health Exchange Significantly Exceeds Call Center Budget, Prompts Discussion on How to Manage Budget in the Future. On November 10, 2014, *Health News Colorado* reported that the Connect for Health Colorado exchange exceeded the $13.6 million budget for its call center operations for this fiscal year by $4 million. Exchange managers had planned to eventually operate on an annual budget of about $26 million; considering that budget, $4 million in overspending could have serious implications for financing other aspects of the exchange. Dr. Mike Fallon, a member of the exchange board, said that board members need to propose cuts elsewhere in the budget before he is willing to approve the call center expenses. Other board members countered Fallon, arguing that the exchange is underfunded and the board must instead consider hikes in the broad market assessment in order to raise money. Read more

Delaware

Release of RFP for Medicaid Fraud Control and Program Integrity. On November 7, 2014, the Delaware Department of Health and Social Services released a Request for Proposal (RFP No. HSS 14-053) for Medicaid Fraud Control and Program Integrity for the Division of Medicaid and Medical Assistance. The RFP seeks qualified applicants to design and implement a pilot

program for the purposes of preventing, detecting and reducing fraud, waste and abuse in the state's Medicaid program. The winner of the bid must implement strategies to reduce overutilization of services and must be able to monitor progress of these strategies. Questions regarding the RFP are due on November 21, 2014. The bid will open on December 24, 2014, and vendors will be selected by December 30, 2014 (tentative). The project will begin on January 5, 2015. Read more

Florida

HMA Roundup – Gary Crayton & Elaine Peters (Email Gary/Elaine)

Report Warns Safety-Net Hospital Could Lose Billions Without Medicaid Expansion. On November 11, 2014, the *Miami Herald* highlighted a report by Florida Legal Services which warns that opting out of Medicaid expansion in the state could cost billions of dollars in lost funding to safety-net hospitals treating the uninsured. Safety-net hospitals receive much of their funding from the federal government through the Disproportionate Share Hospital (DSH) program. But the federal government decided to cut $18 billion from this program over ten years beginning in 2016, with the assumption that states would expand Medicaid and thus shift the health care costs of low-income patients away from the DSH program. The report provides estimates of how much safety net hospitals around the state stand to lose each year. The report goes on to explain that if the state accepted the $5 billion a year in federal funds to expand Medicaid to an estimated 760,000 low-income Floridians, the new revenue would more than offset the anticipated loss of federal funding for hospitals that treat many uninsured patients. Read more

Cigna to Lower HIV Drug Costs for Some Florida Patients. On November 7, 2014, the *New York Times* reported that insurer Cigna will reduce out-of-pocket costs that patients in Florida must pay for HIV drugs, after advocacy groups accused the insurer's drug pricing system of being discriminatory. In May 2014, the AIDS Institute and the National Health Law Program filed a complaint with the Department of Health and Human Services' Office for Civil Rights arguing that Cigna and three other insurers placed restrictions on medications and/or high enrollee contribution requirements for HIV-positive consumers because of their disease status. Under the settlement with the Florida Office of Insurance Regulation, Cigna will place a $200 per month limit on the amount that patients have to pay for commonly prescribed HIV drugs. This limit will apply only to consumers who enroll in Cigna's 2015 plans through the new health insurance exchange. Cigna will no longer require prior authorizations for generic HIV drugs and will move these drugs into a lower cost generic tier. Read more

Georgia

HMA Roundup – Mark Trail (Email Mark)

DCH Releases Georgia Families Care Management Organization RFQC. On November 11, 2014, the Georgia Department of Community Health (DCH) released a Request for Qualified Contractors (ES-RQFC-40199-465) for Care Management Organizations (CMOs). DCH plans to release an RFP and contract with up to four qualified CMOs for the provision of the State's risk-based Medicaid managed care program, Georgia Families (over 1.3 million people are currently enrolled). It is not certain whether the state will contract with four

CMOs; the state is leaving itself the option of contracting with only three CMOs. In addition, one of the CMOs will serve the State's risk-based Medicaid managed care program, Georgia Families 360 (children and young adults in foster care, receiving adoption assistance or in the juvenile justice system).

Bidders must have a minimum of five years of experience covering at least 400,000 Medicaid members per month under risk-based contracts. There are also updated provider access requirements, including for therapies and vision. Qualified contractors must respond to the bid by December 10, 2014.

Idaho

Idaho Launches "Your Health Idaho", a State-Based Health Insurance Exchange. On November 12, 2014, *Kaiser Health News* reported that Idaho launched yourhealthidaho.org, the state's own state-based exchange. Idaho is one of a dozen states (and Washington, D.C.) that is running its own exchange this year; it is the only Republican-controlled state to be doing so. The state is using $35 million in federal funds to build its exchange and hopes to enroll 165,000 people through the exchange. Five health insurers and four dental carries will sell 198 plans on the exchange (52 more than last year). It is unclear whether the new exchange website will offer benefits over the federally-facilitated exchange website, which the state used with relatively little issue during the first open enrollment period. Read more

Kansas

Kansas Hospital Association Assembles Medicaid Expansion Proposal. On November 10, 2014, the Kansas Health Institute reported that Kansas hospitals are moving forward with plans to put a Medicaid expansion plan before lawmakers, despite the re-election of Governor Sam Brownback and conservatives' control of the Legislature. While Brownback has not given any indication that he might consider expansion, many feel that he and other lawmakers will reconsider as Disproportionate Share Hospital (DSH) funds to safety-net hospitals begin to be phased out in 2016. The Kansas Hospital Association has been working on an expansion plan that will be unique to the state. Read more

Louisiana

Jindal's Ex-Health Secretary Bruce Greenstein Denies Helping Former Employer CNSI Win State Medicaid Contract. On November 11, 2014, *AP*/the *Daily Journal* reported that former Louisiana health secretary, Bruce Greenstein, denies doing anything illegal to help his former employer, Client Network Services, Inc. (CNSI), obtain a $200 million Medicaid contract in the state last year. The state's contract with CNSI has since been terminated, and CNSI has sued the state for wrongful termination. In June 2014, Greenstein was indicted on nine counts of perjury for allegedly lying during his testimony during a Senate confirmation hearing. The Jindal administration accused Greenstein of inappropriate contact with CNSI during the bid process. Read more

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Steward Health Care System to Close Quincy Medical Center. On November 6, 2014, the *Boston Globe* reported that Steward Health Care System plans to close Quincy Medical Center, marking the biggest hospital closing in the state in at least a decade. Stewart bought Quincy Medical Center out of bankruptcy in 2011 and invested $100 million into the struggling hospital since then. Despite these investments, the hospital is on track to lose $20 million this year alone. Steward executives believe Quincy is struggling because there are too many hospital beds in the area; the hospital has many unoccupied beds and serves mainly low-grossing Medicaid patients. Steward is planning to close the hospital on December 31; the company said it would pay Quincy workers for 60 days and try to find them jobs at other Steward facilities. Read more

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Mid-Term Election Results Suggest Medicaid and Healthy Michigan Plan Will Not Face Major Changes. On November 4, 2014, Governor Rick Snyder was re-elected to his second (and final due to term limits) four-year term, beating his Democratic challenger, Mark Schauer, by four percentage points. Attorney General Bill Schuette and Secretary of State Ruth Johnson, both Republicans, were also re-elected. Although the Democrats had hoped to increase their minority presence in both the Senate and House of Representatives, that did not occur. In fact, the Democrats lost ground in both chambers.

With Governor Snyder's re-election and continued Republican control in the legislature, it is unlikely that major changes will occur related to Medicaid and the Healthy Michigan Plan (HMP – Medicaid expansion/reform). It is also very likely Governor Snyder will keep recently appointed Nick Lyon as Director of the Michigan Department of Community Health (MDCH), which administers the state's Medicaid program; however a new director of the Department of Human Services is envisioned since Maura Corrigan has announced her retirement at the end of the calendar year.

Michigan implemented the HMP on April 1, 2014, making Medicaid coverage available to individuals with income up to 133 percent of the federal poverty level. The state had estimated this would allow as many as 320,000 Michigan citizens to obtain health care coverage in 2014 and eventually as many as 470,000. The enrollment estimate for 2014 has already been significantly surpassed. MDCH reports that as of November 10, 2014, a total of 449,949 individuals has been approved for coverage in the HMP and more than 310,000 were enrolled in a Medicaid HMO as of October 1, 2014. Unless exempted from managed care enrollment, the remaining eligibles – about 140,000 individuals at this point – will also be enrolled in Medicaid HMOs within the next couple of months.

On November 5, 2014, MDCH released a letter announcing its intent to submit an amendment to its 1115 waiver, which supports the HMP, to expand the Medicaid program to include the MIChild (stand-alone Title XXI CHIP – Children's Health Insurance Program) population. This change will bring the

state into compliance with federal regulations requiring beneficiaries to have more than one health plan choice in each county (other than in Rural Exception counties – the Upper Peninsula in Michigan). The change will also provide additional services such as non-emergency medical transportation for enrolled children up to age 19. There are currently almost 36,000 children enrolled in the MIChild program, and the vast majority are enrolled with HMOs (or affiliated entities) already serving the Medicaid population.

New Hampshire

State Cancels April Deadline for Nursing Home Medicaid Managed Care. On November 4, 2014, the *New Hampshire Business Review* reported that the state Department of Health and Human Services has canceled its April 1, 2015, deadline to launch a Medicaid managed care payment system for nursing homes and community programs serving the frail elderly. DHHS commissioner Nick Toumpas said he plans to unveil a revised plan for Medicaid long-term care planning and reimbursement at the next commission meeting on November 6. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Insurance Marketplace Offerings and Premiums are Changing in 2015. On November 12, 2014, *NJ Spotlight* reported on the insurance carriers that will be offering Marketplace coverage in New Jersey in 2015, and the changes in monthly premium from the previous year's carriers. The 2015 Marketplace carriers and premium changes from last year are provided below:

Marketplace Carrier	Overall Premium Changes from 2014
AmeriHealth New Jersey	11 percent ↑
Health Republic Insurance of NJ	20 percent ↑
Horizon Blue Cross Blue Shield of NJ	No change overall; minor increases & decreases
Oscar Health Insurance	New Marketplace carrier in 2015
United Healthcare	New Marketplace carrier in 2015

Changes in premium from 2014 to 2015 were made to more accurately reflect the experience of the enrolled population. Given the changes to premium, insurance brokers and certified application counselors will encourage enrollees to reassess their current Marketplace selection as open enrollment season begins for coverage in 2015. Read more

Division of Aging Services Releases MIPPA 2014: Medicare Special Benefits Outreach and Enrollment Assistance RFP. On November 7, 2014, the Department of Human Services, Division of Aging Services (DoAS), Community Resources, Education and Wellness Unit released an RFP to increase the number of low-income Medicare beneficiaries in New Jersey who know about and apply for Medicare Part D, the Medicare Part D Low Income Subsidy (LIS), and/or a Medicare Savings Program (MSP), and to increase beneficiaries' awareness and use of free and reduced-cost preventive benefits covered by Medicare Part B.

DoAS anticipates that up to 10 awards of $40,000 each will be available for Area Agencies on Aging (AAAs), Aging and Disability Resource Connections

(ADRCs) and State Health Insurance Assistance Program (SHIP) lead agencies. Agencies may apply for only one grant, and no more than one grant will be awarded to any one county. The grant project period is December 1, 2014, through September 29, 2015.

DoAS estimates that 14.6 percent (or over 239,000) of seniors in New Jersey live on less than $16,755 per year (150 percent of the 2012 federal poverty level). Over 32,500 Medicare beneficiaries in New Jersey are eligible for, but not receiving, the Medicare prescription drug LIS/Extra Help. These numbers may keep growing as more people age into Medicare.

All proposals for this funding must be submitted through the state' SAGE online system by 3:00 pm November, 21, 2014. Applicants may begin completing their applications online November 13, 2014. Applicants may participate in a voluntary technical assistance conference call/Go-To-Training session on November 18, 2014. Email Dennis McGowan at dennis.mcgowan@dhs.state.nj.us to register for the session.

New Mexico

Human Services Secretary Sidonie Squier to Step Down. On November 6, 2014, *AP/Los Cruces Sun-News* reported that State Human Services Secretary Sidonie Squier is stepping down effective December 1, 2014. The Medicaid program is the state's most expensive health care program, operating with a $6 billion budget administered by the Human Services Department. Squier was criticized for halting payments to several mental health providers because of allegations of fraud and overbillings. These providers claimed that the halted payments put their operations under significant financial stress, forcing many to stop seeing patients. A spokesperson for Governor Susana Martinez said the administration hopes to have a permanent replacement for Squier by the time she leaves her post. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Health Exchange and Consumer Satisfaction. On November 10, 2014, the New York State Health Foundation released findings from a Harris Poll Online-conducted survey of individuals newly insured through the New York health exchange, New York State of Health. Ninety-two percent of New Yorkers who became newly insured under federal health care reform are completely or somewhat satisfied with their health insurance. They report feeling more "peace of mind" (91 percent) and "financial protection from big bills" (78 percent). Almost nine in ten (88 percent) report that getting the health care they need is within their reach since getting health insurance coverage. Medicaid enrollees report even greater overall satisfaction levels compared with individuals who enrolled in private coverage options. The survey finds mixed results regarding the affordability of coverage, and the cost burdens are greater for those with private coverage than for Medicaid enrollees. Nearly two-thirds of those with private coverage report that they stretch their household budget to pay their health insurance premium. Read more

Visiting Nurse Service of New York Settles Medicaid Fraud Suit. On November 6, 2014, *Capital New York* reported that Visiting Nurse Service of New York (VNSNY) has settled a civil suit filed by the US Attorney's office that claimed that VNSNY had enrolled Medicaid beneficiaries into its managed long-term care plan, VNS Choice, who did not qualify for the program, and were ineligible to receive MLTC benefits. As part of the settlement VNSNY will pay $35 million to the federal Medicaid program.

The lawsuit claimed VNSNY enrolled 1,740 people in VNS Choice who did not qualify for managed long-term care services. Eligibility for MLTC requires that beneficiaries must require a nursing home level of care and need at least 120 days of community-based long-term care services. In April 2013, the *New York Times* reported that VNS was recruiting new enrollees at social day care sites, and enrolling individuals who were non-medically eligible into the plan. The state suspended their enrollment for 6 months, and required that they reassess eligibility for any members receiving social day care as a plan benefit.

In a related story from August 2013, the *Wall Street Journal* reported that the House Oversight and Government Reform Committee investigated whether Governor Cuomo's office interfered with a Medicaid audit of VNSNY, to determine whether VNSNY received preferential treatment, perhaps because then-CEO of VNS, Carol Rafael, was a member of Cuomo's Medicaid Redesign Team.

New York City Health and Hospitals Corporation Facing Fiscal Challenges. This month, the Citizen's Budget Commission (CBC) released a report indicating that New York City's public hospital system, the Health and Hospitals Corporation, faces a troubled financial picture. The system ran a $668 million deficit in FY2013, and projects a $645 million deficit for the current fiscal year. The report indicates that its plans for closing its budget gap are risky, and may not be achievable. While HHC cares for 18 percent of all in-patients in the city, it provides care for 45 percent of the uninsured. In 2012, 70 percent of clinic visits and 43 percent of emergency room visits by uninsured patients were to HHC facilities. The CBC report identifies four challenges that HHC will have to address: successful implementation of cost controls; growing enrollment in its managed care plan, MetroPlus; financing care for the uninsured, including retaining current resources (principally DSH) and promoting an equitable division of responsibility for the uninsured with the voluntary sector; and creating a more rational and stable financial relationship with the city. Read more

Medicaid Redesign Team Social Determinants of Health Work Group. The Medicaid Redesign Team's (MRT) Social Determinants of Health workgroup has released a final set of recommendations to the state regarding priority areas for intervention toward improved population health and decreased disparities. The workgroup's charge was to provide guidance to the Department of Health on how best to address the social determinants of health (SDH) to promote health, improve wellbeing and decrease/eliminate disparities due to the SDH. A primary focus of the workgroup was on issues related to employment. These included workforce development and job training; expanded/continued Medicaid coverage to promote employment of persons with mental, physical or developmental disabilities; incentivizing worksite wellness programs; and expanding work benefits to target low-income workers who are likely to be Medicaid recipients. The work group identified 12 areas of recommendations:

- Earned Sick Time
- Advancing Community Health Worker Workforce
- Paid Family Leave Insurance
- Advancing Community-Based Prevention
- Advancing Additional Peer Specialist Positions
- Strengthening Current Infrastructure
- Development of Certified Peer Specialist – DSRIP
- Disability Equity in State Hiring
- Benefits Advisement and Web-Based Calculator
- Providing Transportation and Employment Opportunities
- Regional Economic Development Councils
- Supported Employment/ Education

Regional Differences in Health Insurance Coverage. In October, the New York City Independent Budget Office (IBO) released a report that looked at regional differences in health insurance coverage across the State of New York. IBO created a baseline comparison of three regions of the state—New York City, upstate, and the downstate suburbs—before implementation of the Affordable Care Act, examining regional differences in 2012 in the rates of enrollment in Medicaid and employer-sponsored health insurance plans, as well as the shares of residents without health insurance. In looking at the variations, IBO considered the extent to which regional demographic and labor-market conditions explained the differences. Among its findings:

- In 2012, New York City had a larger share of its population enrolled in Medicaid and a smaller share enrolled in employer-sponsored health insurance than upstate or the downstate suburbs.
- The city also had higher rates of uninsured than the rest of the state.
- Even within the same industry, workers who reside in New York City had lower rates of employer-sponsored health insurance than their counterparts elsewhere in the state.
- Two explanations for the city's low rate of participation in employer-sponsored insurance are posited: that it has a larger share of low-income, part-time workers than the rest of the state, and that a large share of the city's labor force is foreign born. Read more

Ohio

Ohio Medicaid Costs Expected to be $470 Lower than Expected. On November 7, 2014, Northeast Ohio Media Group reported that the cost of Ohio's Medicaid program is expected to be about $470 million less than originally estimated in the current two-year budget. The anticipated savings is largely attributed to the high number of new Medicaid expansion enrollments and low number of new enrollments into traditional Medicaid, which costs the state significantly more than Medicaid expansion enrollments. The state anticipated 377,000 enrollees under expanded Medicaid by next June; now it expects nearly 100,000 more than that. Meanwhile, new enrollment into traditional Medicaid fell short of state projections. The state reports that $350 million of the $470 million in anticipated savings will be the state's share. Such savings is significant as Governor Kasich lobbies the General Assembly to continue Medicaid expansion in the next two-year budget. Read more

Kasich Will Try to Keep Medicaid Expansion in New Budget. On November 7, 2014, the *Ohio Dispatch* reported that Governor John Kasich will keep expanded Medicaid coverage in the state's next two-year executive budget proposal, despite the fact that expansion received criticism from Republican lawmakers last year. Kasich argued that expanding Medicaid will result in a lower uninsured population rate, greater financial stability for hospitals, and help for those with health issues that prevent them from working. Read more

Oregon

77,000 Oregonians Lose Medicaid Coverage for Missing Renewal Window. On November 6, 2014, the *Statesman Journal* reported that 77,000 Oregon Health Plan enrollees had their Medicaid coverage terminated for failing to renew their coverage by the November 1 deadline. The Oregon Health Authority is helping people who received closure notices get reinstated. The process will repeat for another group of enrollees whose renewal deadline is December 31; some of those people are already being contacted. Read more

Oregon Health Authority Releases Oregon Health Plan Care Coordination RFP. On November 5, 2014, the Oregon Health Authority released a Request for Proposals (RFP #3882) from qualified proposers to provide a statewide program of care coordination services for the Oregon Health Plan Medicaid fee-for-service Members with or without Medicare. The comprehensive statewide Oregon Health Plan Care Coordination (OHPCC) program shall include care coordination, disease and intensive care management, and nurse triage and advice line services with the goal of improving outcomes for fee-for-service members. The contract period will run from April 1, 2015, through June 30, 2018. Step One proposals are due by December 4, 2014. Read more

Pennsylvania

HMA Roundup – Matt Roan (Email Matt)

Governor-Elect Tom Wolf May Scrap "Healthy Pennsylvania" Program in Favor of Traditional Medicaid Expansion. On November 10, 2014, the *Citizens' Voice* reported that Governor Tom Corbett's Healthy Pennsylvania Medicaid expansion plan could be scrapped by Governor-elect Tom Wolf in favor of traditional Medicaid expansion. Corbett's Healthy Pennsylvania would use federal funds to subsidize private health insurance for about 600,000 low-income Pennsylvanians. Enrollment for the program is slated to begin December 1, and the state has already spent more than $45 million in federal and state money preparing for it. Read more

South Carolina

Governor Haley Selects Christian Soura as Next State Medicaid Director. On November 10, 2014, the *State* reported that Governor Nikki Haley has named her former deputy chief of staff, Christian Soura, as the state's next Medicaid director. Soura joined the Haley administration in 2011 as an "efficiency expert;" and later became the deputy chief of staff for budget and policy. If confirmed by the State Senate, Soura will take over the $7 billion-a-year agency from current Director, Tony Keck, on November 20. Read more

Tennessee

Haslam in Talks with Feds about Medicaid Expansion. On November 10, 2014, *AP*/the *Washington Times* reported that Governor Bill Haslam is continuing to talk with federal officials about Medicaid expansion in Tennessee before the legislative session begins in January. Haslam spoke with HHS Secretary Sylvia Mathews Burwell last week and even brought up expansion when President Obama called him last week to congratulate him on his election win. Read more

Texas

Pharmaceutical and Therapeutic Committee Will Not Review Hepatitis C Agents at Upcoming Meeting. On November 10, 2014, the Texas Health and Human Services Commission announced that hepatitis C Agents (such as the drug Sovaldi) will not be reviewed at the November 21 Pharmaceutical & Therapeutics (P&T) Committee meeting. Per state policy, a drug is not added to the approved drug list until the P&T Committee reviews it. HHSC says a review of hepatitis C Agents will take place at a future P&T meeting at which time the committee will hear all related testimony. Hepatitis C Agents have not been reviewed by the Drug Utilization Review (DUR) board and they do not appear on the agenda for the board's upcoming meeting on November 20. The P&T Committee will not add drugs to the formulary until clinical guidelines are decided by the DUR board. The next DUR board meeting is January 29, 2015.

Washington

HMA Roundup – Doug Porter (Email Doug)

Funding Opportunity Announced for the Accountable Community of Health Initiative. On November 7, 2014, the Washington Health Care Authority announced a funding opportunity for the next phase of the Accountable Community of Health (ACH) Initiative. The ACH Initiative is a key component of Healthier Washington's Community Empowerment and Accountability investment, which is one of five investment areas along with Practice Transformation, Payment Redesign, Analytics, Interoperability and Measurement, and Project Management (see here for Healthier Washington grant proposal). The first step in the ACH Initiative started earlier this year with six-month Community Health Planning grants. The Initiative now moves to the next phase, with two ACH Pilot grant opportunities to test participating organizations' structure and governance, as authorized through E2SHB 2572. The opportunity provides up to $300,000 total for two Pilot ACH organizations to demonstrate how the core functions of an ACH will ensure success in design and execution of a regional initiative that makes progress toward achievement of better health, better care and lower costs in the pilot community. Pilot ACH applications are due December 8 and expected to be announced in January 2015. Read more

National

KHN's Phil Galewitz Speaks on Future of Medicaid Expansion in Non-Expansion States, What to Expect During 2015 Insurance Enrollment. On November 12, 2014, *Kaiser Health News* (KHN) Correspondent Phil Galewitz discussed the future of Medicaid expansion on KHN's *Enrollment Encore* video series. Galewitz expects several more states to expand Medicaid next year; possible candidates are Utah, Indiana and South Dakota. Meanwhile, Florida and Texas are not likely to expand Medicaid next year. Galewitz also discussed major concerns of state Medicaid directors going into the second open enrollment period on November 15. Read more

Feds Provide Conservative Estimate of Health Insurance Enrollment Growth During Second Open Enrollment Period. On November 11, 2014, the *New York Times* reported that the Obama administration estimates 9.1 million people will sign up for health insurance during the second open enrollment period. This estimate is significantly lower than the estimate of 13 million people provided by the Congressional Budgeting Office. While it appears that the conservative estimate might be part of an effort by federal officials to lower the public's expectations and make the goal easier to surpass, HHS Secretary Sylvia Mathews Burwell explains that the estimate was the result of reasonable considerations by health policy experts in her department, based on observations of enrollment reductions after the first open enrollment period. Read more

Studies of Patient Survey Data Indicate that Shortage of Medicaid Doctors May Not be an Issue. On November 11, 2014, the *New York Times* reported on a longstanding fear amongst lawmakers, patient advocates and health care consumers that too few doctors will accept Medicaid patients due to the relatively low reimbursement rates Medicaid provides. While several studies show that Medicaid patients often have more trouble getting a doctor's appointment or experience delays in care compared to privately-insured patients, other studies of large, national patient survey data sets suggest that Medicaid, in fact, offers access to quality health care that is comparable to private insurance. Read more

Revamped HealthCare.gov Website Opens for Window Shopping Ahead of Open Enrollment. On November 9, 2014, the *New York Times* reported that the revamped HealthCare.gov website is open for a "window shopping" period during which consumers can compare health plans ahead of the November 15 open enrollment start date. CMS Principal Deputy Administrator Andrew Slavitt said that the new website includes more information on plans and provider networks and will be easier to use than the site which debuted at last year's open enrollment. The site will allow consumers to sort plans based on premium amount as well as the size of the deductible. The website will also be able to accommodate consumers applying for insurance from their smartphones or tablet computers. Read more

Supreme Court to Hear Newest Challenge to ACA Insurance Subsidies. On November 7, 2014, the *Washington Post* reported that the Supreme Court plans to hear another case brought forth by a lawsuit targeting ACA federal subsidies that help millions of Americans buy health insurance. According to the lawsuit, wording in the ACA legislation dictates that only those Americans who purchase insurance through state-based exchanges (and not a federally-

facilitated exchange) qualify for federal subsidies to pay for their insurance plans. Only one-third of states have their own exchanges, meaning millions of Americans could lose their subsidies if the challenge holds. The case will be decided by the end of the court's term in June. Read more

HRSA Awards $51.3 Million in ACA Funding to Support Mental Health and Substance Abuse Treatment. On November 6, 2014, the Health Resources and Services Administration (HRSA) announced $51.3 million in ACA funding to support 210 health centers in 47 states, the District of Columbia and Puerto Rico to establish or expand behavioral health services for nearly 440,000 people. Earlier this year, HHS awarded $54.5 million in ACA funding for 223 other health centers to expand behavioral health services. Read more

Need to Fund Safety-Net Hospitals Could Persuade Non-Expansion States to Consider Medicaid Expansion. This month, *Governing Magazine* reported that states that have rejected Medicaid expansion must address federal changes to the way safety-net hospitals are funded in order to keep such facilities financially viable. Safety-net hospitals receive much of their funding from the federal government through the Disproportionate Share Hospital (DSH) program. But the federal government decided to cut $18 billion from this program beginning in 2016, with the assumption that states would expand Medicaid and thus shift the health care costs of low-income patients away from the DSH program. States that have opted out of expansion must now consider ways of coping with this major change in budgeting, even if it means accepting some form of Medicaid expansion, in order to accommodate the healthcare needs of low-income residents. Read more

Industry News

Kindred Announces Definitive Agreement to Acquire Centerre Healthcare. On November 12, 2014, Kindred Healthcare, Inc. announced that it has signed a definitive merger agreement to acquire Centerre Healthcare Corporation, a national company dedicated to operating 11 Inpatient Rehabilitation Hospitals with 612 beds, for a purchase price of approximately $195 million in cash. The company's Inpatient Rehabilitation Hospitals are geographically aligned with five targeted Kindred Integrated Care Markets. The addition of Centerre's facilities to the Kindred portfolio will make Kindred on of the largest operators of Inpatient Rehabilitation Hospitals in the country. Read more

Cynthia J. Brinkley Joins Centene Corporation as Executive VP of International Operations and Business Integration. On November 11, 2014, Centene Corporation announced that Cynthia J. Brinkley has joined the company as executive vice president, International Operations & Business Integration. In this new position, Brinkley will coordinate and direct Centene's international operations, which include its investments in Ribera Salud, S.A., a health management group based in Valencia, Spain. Brinkley was formerly vice president of Global Human Resources at General Motors; before that she held various senior roles at AT&T/SBC Communications. Read more

Health Care Executive Group Forms Guidon Partners. On November 10, 2014, *PE Hub* reported that a group of 14 health care executives have formed Guidon Partners, a group that will invest in growth companies and management buyouts. Guidon Partners will work with experienced investors to identify, finance and support growth companies as they build new products, expand into new markets, invest in new technology and start making a profit. The group will also co-invest alongside larger private equity firms in company spinoffs, turnaround and leveraged buyouts. Read more. The founders of Guidon Partners are listed here:

- Joel Ackerman (Former Managing Partner, Warburg Pincus)
- Jim Carlson (Former CEO, Amerigroup Corporation)
- Paul Diaz (CEO, Kindred Healthcare)
- Fred Dunlap (Former CEO, XLHealth)
- Herb Fritch (President, Cigna-Healthspring)
- Vicky Gregg (Former CEO, Blue Cross Blue Shield of Tennessee)
- Bill Goss (Former Managing Director, Cain Brothers)
- Bob Margolis, MD (CEO Emeritus, HealthCare Partners)
- Tim McDonald (Former SVP, Strategic Initiatives, Amerigroup Corp.)
- Tom McDonough (Former President, Coventry Health Care)
- Nick Pace (Former General Counsel, Amerigroup Corporation)
- Greg Roth (Former CEO, Team Health)
- Greg Scott (Former CEO, APS Healthcare)
- Joe Swedish (President and CEO, Wellpoint)

Extendicare to Sell US Business for $870 Million. On November 10, 2014, *McKnight's* reported that Extendicare will sell nearly all of its US operations to an investor group in an $870 million deal. Extendicare has roughly 160 facilities in the US; it will keep just 10 skilled nursing facilities. Extendicare leadership announced last year that it intended to sell off its US business, explaining that the US healthcare market was "volatile and risky" in the wake of health care reform. The purchasers will assume about $635 million in mortgage loans and other debt, and Extendicare will receive about $222 million in net cash. The deal is expected to close in the second quarter of 2015. Read more

Neighborhood Health Plan CEO to Step Down. On November 5, 2014, the *Boston Globe* reported that Deborah C. Enos will step down as Chief Executive Officer of Neighborhood Health Plan effective February 1, 2015. Neighborhood Health Plan (acquired by Partners HealthCare in 2012) has about 330,000 members; about 60 percent are Medicaid (MassHealth) beneficiaries. The nonprofit health plan has a projected operating loss of $99 million for the 12-month period that ended September 30. Enos explained that her departure is unrelated to the financial performance of the health plan. Enos will be succeeded by David Segal, who is currently Neighborhood's Chief Operating Officer. Read more

Kindred Names David Causby as President-Elect of Kindred at Home. On November 5, 2014, Kindred Healthcare announced that upon closing of the company's previously announced acquisition of Gentiva Health Services, Inc., which is expected in the first quarter of 2015, David Causby will become the President of the combined *Kindred at Home* business. Mr. Causby is currently the company's Chief Operating Officer; in his new position he will be responsible for the company's home health, hospice, palliative and community care offerings. He will also work to advance the company's integrated care delivery model and "Continue the Care" strategy. Causby will report to Benjamin A. Breier, Kindred's President and Chief Operating Officer. Read more

RFP Calendar

Date	State	Event	Beneficiaries
December 19, 2014	Missouri	Proposals Due	398,000
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	Application			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: *"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 Celebrates Nurse Practitioner Week

National Nurse Practitioner Week (November 9-15) is held annually to celebrate these exceptional health care providers and increase awareness of the significant contributions NPs make to the health of millions of Americans. HMA would like the opportunity to recognize one of its NPs, Linda Follenweider, who, along with other nurses and physicians at HMA, brings years of clinical experience and leadership experience to the firm.

Linda Follenweider, APN, Principal

Linda is an Advance Practice Nurse (APN) and board certified Family Nurse Practitioner with many years of clinical experience. Linda has provided expertise and assistance to several large public health systems across the country in workforce development; team based care, care management, care transitions, training and critical decision making skills for nurses and healthcare staff as well as assisting in scope of practice and model of care and work flow redesign. She has worked as an NP She has created individualized curriculum and trainings for system clients pertinent to their nursing workforce.

Linda continues her clinical work as part of the Emergency Medicine Group in one of the busiest Emergency Departments in the state. Linda was the Clinical Director of Asthma for the Bureau of Cook County where she created a new role for advanced practice nurses and linkage for asthma care in the Cook County Hospital and Health System, a population severely affected by asthma and access to care. She has worked as a NP and the Clinical Services Manager for Evercare (a division of United Health Group), and has also worked as a NP and the Clinic Manager at a Chicago FQHC. Linda served as a NP at the Joliet Correction Center and Stateville Penitentiary, maximum security prisons in the state of IL.

Linda was named the Advanced Practice Nurse of the Year for the state of Illinois in 2009 by the Illinois Society for Advanced Practice Nursing.

HMA WELCOMES

Pat Dennehy, DNP, Principal – San Francisco, California

Pat comes to HMA most recently from the University of California, San Francisco School of Public Health, where she served as the Director of Glide Health Services for the past 15 years. In this role, Pat developed and funded the integration of primary care, behavioral health, and substance abuse treatment services. She led the clinic through Title 22 licensure as a primary care practice; facilitated the membership of Glide into the San Francisco Community Clinic Consortium; successfully completed 330 H grant applications; partnered with the University of Michigan on a five-year Agency for Healthcare Research and Quality (AHRQ)-funded project for implementing electronic health records in community health settings; implemented an EHR system at Glide; and was invited to a White House meeting that hosted 80 national nursing leaders for discussion on the ACA implementation with HRSA and President Obama's administrative leaders.

Prior to her role as the Director of Glide Health Services, Pat worked in various other positions over her 26-year career with UCSF. She served as the Practice Manager for Dermatology and ENT as well as an Administrative Nurse Practitioner and General Medicine Nurse Practitioner for the Ambulatory Care Center. Pat also worked for Marin Treatment Center as a Nurse Practitioner Supervisor and was a Women's Health Nurse Practitioner for the Ching-Ning Clinic.

Pat received her Doctorate as a Nurse Practitioner from Rush University in Chicago. She received her Master of Science in Nursing from the University of California, San Francisco and her BS/FNP in Nursing from Sonoma State University. She is a certified Nurse Practitioner in California and is a member of the American Nurses Association, American Academy of Nurse Practitioners, and a member of the Leadership Council CA Regional Action Committee Future of Nursing. She received the Dr. Francis Curry Award in 2014 and the James Irvine Leadership Award in 2012.

Heidi Arthur, LMSW, Principal – New York, New York

Heidi comes to HMA most recently from SAE & Associates where she served as the Vice President for the past five years. In this role, Heidi was responsible for managing operations, project design, client relations, and new business for the

private behavioral health consulting firm. She provided strategic planning, program development, and capacity-building technical assistance to non-profit organizations throughout the country. Additional accomplishments for Heidi at SAE included establishing and maintaining a system for effective coordination and reviewing multistage grant proposal development and organizational capacity-building consulting projects; advising project teams regarding development of new approaches/application of appropriate evidence-based practices to address population needs, reach new populations, and align strategically with reform goals and organizational mission; and writing news briefs and updates, presenting at conferences, and facilitating webinars. Additionally, Heidi was a Senior Consultant with SAE for several years before being promoted to the Vice President role.

Prior to her work with SAE, Heidi was an Independent Consultant for several years. She also served as the Program Manager for Special Projects for Spence-Chapin Services for Families and Children where she was responsible for project development and implementation of a citywide child welfare training initiative and two targeted community-based initiatives. Additional positions that Heidi has held include Clinical Coordinator for Children's Services with the NYS Office of Mental Health; Senior Program Consultant with the Project Liberty Implementation Unit with the NYC Department of Health and Mental Hygiene; and Client Services Coordinator with the Region Ten Community Services Board in Charlottesville, Virginia.

Heidi received her Master of Science degree in Social Work from Columbia University School of Social Work. She received her Bachelor of Science degree in Psychology (Magna cum laude) from Mary Washington College.