HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 3, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

WYOMING RELEASES SHARE PLAN MEDICAID EXPANSION PROPOSAL

This week our *In Focus* section reviews Wyoming's Medicaid expansion proposal released on November 26, 2014. Known as the SHARE Plan, which stands for Wyoming's Strategy for Health, Access, Responsibility, and Employment, the proposal would provide a more traditional Medicaid expansion than states like Arkansas and Iowa. Individuals ages 21-64 below 100 percent of the federal poverty level (FPL) would receive a Medicaid alternative benefits plan (ABP) with limited cost sharing, and providing the ten essential health benefits under the Affordable Care Act (ACA). Individuals ages 21-64 with incomes between 100 and 138 percent FPL would also receive a Medicaid ABP, but would be subject to variable monthly premiums, as well as additional requirements under an 1115 Waiver. Below, we summarize the arguments and

support for the SHARE Plan and provide additional detail on the structure of the expansion proposal.

SHARE Plan Expansion Groups Overview

The table below provides a summary of the SHARE Plan expansion proposed for two groups: those with incomes above 100 percent FPL and those with lower incomes. The primary difference between the two groups is the application of a monthly premium requirement for individuals with higher incomes.

SHARE Plan Expansion Group	Group One: Higher Income	Group Two: Lower Income
Eligibility Requirements	Ages 21-64; 101-138% FPL; not Medically Frail	Ages 21-64; 0-100% FPL; not Medically Frail
Access to Healthcare	Medicaid provider network; administered by Medicaid program	Medicaid provider network; administered by Medicaid program
Benefits	ACA's Essential Health Benefits; non-emergency transport; family planning services, and access to certain essential community health providers as required by Medicaid.	ACA's Essential Health Benefits; non-emergency transport; family planning services, and access to certain essential community health providers as required by Medicaid.
Cost-Sharing Requirements	Monthly premium based on income and household size, ranging from under $20 to over $50 per month. Additional co-payments may be required. Non-payment of premiums could lead to disenrollment. Cost-sharing not to exceed 5 percent of income.	No premium requirement. Co-pays for certain services required "as appropriate and allowed by federal regulations."
Premium Reductions for Healthy Behaviors	Meeting certain health challenges could reduce next year's premium.	N/A
Medical Assessment	Comprehensive health assessment to be conducted annually.	Comprehensive health assessment to be conducted annually.
Case Management	Individuals with complex needs would be referred to Medicaid's health and utilization review program.	Individuals with complex needs would be referred to Medicaid's health and utilization review program.
Work Assistance Benefit	Participants to be enrolled in work assistance benefit program at time of enrollment (could include job training, job-matching services, and résumé assistance). Would not impact Medicaid eligibility, but goal is for high level of integration.	Participants to be enrolled in work assistance benefit program at time of enrollment (could include job training, job-matching services, and résumé assistance). Would not impact Medicaid eligibility, but goal is for high level of integration.

Argument for SHARE Plan Expansion

The SHARE Plan proposal outlines several key arguments, not only for the expansion of Medicaid in Wyoming, but also for the SHARE Plan structure as

opposed to alternative Medicaid expansion designs. Arguments for overall expansion include the following:

- Expanding Medicaid will provide access to health care for an estimated 17,600 Wyoming residents, many of which currently fall into the "coverage gap" where federal subsidies for Marketplace coverage is unavailable due to low incomes.
- The state's economy is poised to benefit under expansion with an additional $100 to $120 million in federal funds flowing to Wyoming each year, and an estimated 800 new jobs created as a result.
- Expanding Medicaid would allow for a reduction in current state General Fund safety net health care programs and the Wyoming Department of Health (WDH) estimates these reductions would offset additional cost outlays in state General Funds under expanded Medicaid.
- Medicaid Disproportionate Share Hospital (DSH) cuts, although delayed, will impact Wyoming providers in coming years and without expansion, many low-income adults will use emergency departments as their primary source of care.
- The SHARE Plan proposal also references a September 2014 WDH report that found increased levels of uncompensated care resulted in higher prices paid by insurers. Expanding Medicaid and reducing uncompensated care has the potential to lower prices and reduce cost-shifting in the commercial health insurance market.

Additionally, the proposal details why an alternative Medicaid expansion design, such as Arkansas' or Iowa's, where individuals receive premium support to purchase insurance through the Marketplace, was not pursued. WDH estimates that a "private option" expansion with full premium assistance would cost 132 percent of what a traditional Medicaid expansion would cost in Wyoming. This is due to the fact that Wyoming's Marketplace premiums are among the highest in the nation. WDH estimates that the SHARE Plan would cost 95 percent of what a traditional Medicaid expansion would cost.

SHARE Plan Development and Next Steps

Although Wyoming's legislature did not pass legislation authorizing an expansion of Medicaid, it did pass an amended 2014 Budget Bill, authorizing the Governor's administration, the WDH, and the Wyoming Department of Insurance to begin negotiations with CMS on an expansion proposal. However, that amended budget bill still does not allow for Medicaid to be expanded without final legislative approval.

It has been reported that CMS has responded favorably to the SHARE Plan proposal, although no formal proposal has been submitted for CMS approval. Governor Matt Mead also strongly supports the SHARE Plan and has asked legislators to provide an alternative for coverage if they do not approve the plan. If the SHARE Plan is approved by Wyoming lawmakers during the 2015 Legislative Session, the state believes coverage could likely begin in January 2016.

Link to Wyoming's SHARE Plan:

http://www.health.wyo.gov/Media.aspx?mediaId=16452

HMA Medicaid Roundup

California

HMA Roundup – Pat Dennehy (Email Pat)

State Senator Renews Call for Coverage for Undocumented Immigrants. On December 1, 2014, *the California Healthline* reported that State Senator Ricardo Lara plans to reintroduce a bill that would expand Medicaid and subsidized coverage to undocumented immigrants and would create an Office of New Americans to assist undocumented immigrants. The action comes after President Obama's executive action on immigration. Read more

California Owes Payments to Agents Who Helped with Exchange Sign-Ups. On December 1, 2014, the *California Healthline* reported that commissions to some insurance agents who helped with the enrollment during the exchange's first open enrollment period have been delayed for months. For example, about 2,200 agents are owed a total of $2 million for helping residents enroll in Medicaid through the exchanges. Read more

New UC-Berkeley Study Shows Need for Payment Reform. On November 26, 2014, the *California Healthline* reported on a new UC-Berkeley study which found that the costs per patient for hospital-owned physician groups are higher than for groups owned by physicians themselves. Per-patient costs are what insurers pay to providers, clinical labs and drug manufacturers for a patient's care. Analyzing data for 4.5 million patients treated by integrated medical groups and independent practice associations in California from 2009 to 2012, the study found that per-patient costs for groups owned by hospitals were 19.8 percent higher than groups owned by physicians themselves. These findings contradict hopes that consolidating physicians with hospitals would make patient care more efficient. As hospital- and multiple hospital-owned groups are increasing in number, the study suggests a need to shift to a payment model that rewards care coordination rather than volume. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

State Selects Gretchen Hammer as Next Medicaid Director. On November 26, 2014, the Department of Health Care Policy and Financing announced that Gretchen Hammer has been selected as the state's new Medicaid director. As director, Hammer will oversee the Department's Health Programs Office. Ms. Hammer was the Executive Director of the Colorado Coalition for the Medically Underserved and served as past Chair and Member of the Board of Directors for Connect for Health Colorado. She will join the Department on January 5, 2015. Read more

Connect for Health Enrolls 9,719 in First Two Weeks of Open Enrollment. On December 2, 2014, the *Denver Post* reported that 9,719 individuals signed up for health insurance on the Connect for Health Colorado exchange in the first two weeks of open enrollment. That figure includes renewals and new customers. During the last open enrollment period, the state enrolled about 148,000 Coloradans in private insurance. The Department of Health Care Policy and Financing reported that Medicaid enrollment grew by 12,533 during the same two-week period. Read more

Substance Use Disorder Benefit Coverage. On October 30, 2014, the Department of Health Care Policy and Financing opened a 45-day public comment period regarding the proposed Substance Use Disorder Fee-for-Service (SUD FFS) Benefit Coverage Standard. During this time, the public is welcome to read the standard and to submit recommended changes.

Connecticut

HMA Roundup – Rob Buchanan (Email Rob)

Medicaid Plan to Cover Home Therapies for Those Under 21 with Autism. On November 24, 2014, the *Hartford Courant* reported that the Connecticut Department of Developmental Services (DDS) is working with other state agencies to draft a plan that would cover a full range of Autism home therapies for those less than twenty-one years of age. CMS is requiring that all states cover Autism Spectrum Disorder (ASD) services for people under 21. The proposed plan would cover many interventions including applied behavior analysis and pivotal response training, as well as reimbursement of both licensed practitioners and non-licensed providers. Connecticut's Autism Spectrum Disorder Advisory Council has until December 15 to make any recommendations for the plan. The program would start January 1, 2015. Read more

Florida

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

Florida Health Choices Marketplace to Begin Selling ACA-Compliant Health Plans. On December 2, 2014, the *Tampa Bay Times* reported that Florida Health Choices, Florida's health insurance marketplace will start selling plans that comply with the ACA in the next few weeks. Marketplace CEO Rose Naff said that the marketplace wants "to provide consumers who don't use healthcare.gov with easy access to comprehensive health insurance." Naff said that four insurers have agreed to offer comprehensive plans. Until now, the marketplace only sold limited benefit and discount plans. Read more

AHCA Releases Statewide Medicaid Enrollment Figures for November 2014. The Agency for Health Care Administration (AHCA) reported the November enrollment numbers for the Managed Medical Assistance (MMA) program. About 2.75 million (76.8 percent) of the state's 3.59 million Medicaid beneficiaries have been enrolled into an MMA Plan; this includes 2.61 million beneficiaries enrolled in Standard MMA plans and 135,000 beneficiaries enrolled in Specialty MMA plans. Staywell (WellCare), Sunshine Health (Centene), and Amerigroup continue to have the largest presence statewide. Comprehensive statewide MMA enrollment (by region) is provided in the table below.

Statewide Medicaid Enrollment - November 2014									
Total MMA	Type	R1	R2	R3	R4	R5	R6	R7	R8
MMA STANDARD CAPITATED	MMAC	87,699	96,188	226,532	261,948	158,645	362,377	338,012	187,061
MMA SPECIALTY CAPITATED	MMASC	222	2,458	538	5,238	4,419	7,237	8,703	483
MMA CHILD WELFARE CAPITATED	MMACC	860	673	1,833	2,280	1,730	3,042	2,305	1,528
MMA CHILDREN'S MEDICAL SERVICES	CMSMA	1,688	4,828	6,385	5,622	3,986	8,101	8,692	4,939
SUBTOTAL SMMC		90,469	104,147	235,288	275,088	168,780	380,757	357,712	194,011
PACE	PACE					151			227
FEE FOR SERVICE*	FFS	27,119	27,349	71,778	77,171	58,401	102,385	103,249	49,699
FEE FOR SERVICE - out of state	FFS								
TOTAL ALL		117,588	131,496	307,066	352,259	227,332	483,142	460,961	243,937

Total MMA	Type	R9	R10	R11	TOTAL	Market Share	Oct-14	Diff
MMA STANDARD CAPITATED	MMAC	221,205	218,431	474,740	2,632,838	73.20%	2,612,123	20,715
MMA SPECIALTY CAPITATED	MMASC	4,923	4,434	9,357	48,012	1.30%	48,838	-826
MMA CHILD WELFARE CAPITATED	MMACC	2,150	2,186	2,419	21,006	0.60%	22,493	-1,487
MMA CHILDREN'S MEDICAL SERVICES	CMSMA	5,300	7,146	5,592	62,279	1.70%	63,627	-1,348
SUBTOTAL SMMC		233,578	232,197	492,108	2,764,135	76.80%	2,747,081	17,054
PACE	PACE	102		419	899	0.00%	863	36
FEE FOR SERVICE*	FFS	67,410	72,366	174,342	831,269	23.10%	841,075	-9,806
FEE FOR SERVICE - out of state	FFS				1,604	0.00%	1,683	-79
TOTAL ALL		301,090	304,563	666,869	3,597,907	100.00%	3,590,702	7,205

Note: LTC total is excluded from enrollment total as already included in MMA and FFS.

* Fee For Service: 383,152 eligible for MMA; 449,721 excluded from MMA (QMB, SLMB, QI, Family Planning Waiver, Pregnant Woman, Breast and Cervical Cancer Program, Aliens, Children in Emergency Shelter Care, DJJ, SIPP, and Medical Needy)

Corrections Secretary Mike Crews Resigns. On November 24, 2014, the *Tampa Bay Times* reported that Governor Rick Scott's corrections chief Mike Crews is resigning. Crews is the first state agency head to step down since Scott's re-election in November. Read more

Georgia

HMA Roundup – Mark Trail (Email Mark)

Medicaid Director Jerry Dubberly to Step Down. On December 1, 2014, *Georgia Health News* reported that State Medicaid Director Jerry Dubberly has submitted his resignation to the Department of Community Health. Dubberly served as Medicaid Director for six years. He will step down on January 2, 2015 and will pursue a position in the private sector. Read more

Idaho

Idaho Issues Medicaid Dental RFI. On November 21, 2014, the Idaho Department of Health and Welfare released a Request for Information (RFI 15000279) related to the operation and management of Idaho Medicaid's Dental program. Information obtained through responses to the RFI may be used to refine the requirements for an RFP, which may be released at a later date; assist in projecting a budget for acquiring the services; and to identify potential vendors who may be interested in providing a competitive proposal. Responses to the RFI must be submitted to the Department by December 12, 2014.

Indiana

FSSA Announces Contractors Selected for Hoosier Care Connect. On November 26, 2014, the Indiana Department of Family and Social Services announced the selection of Anthem Blue Cross and Blue Shield, MDwise, Inc. and Managed Health Services of Indiana, to provide coordinated healthcare services to the approximately 84,000 aged, blind and disabled (ABD) Medicaid

enrollees who will qualify for the new Hoosier Care Connect program starting next year. Hoosier Care Connect, set to roll out on April 1, 2015, was established to better coordinate the healthcare needs of Medicaid recipients age 65 and over and ABD children and adults in order to improve health outcomes. The health plans selected to serve individuals in Hoosier Care Connect were chosen based on their experience serving complex populations and their approaches to care management. The announcement from the Indiana Department of Administration can be found here.

IDOA Releases Medicaid Program Enrollment Broker Services RFP. On November 26, 2014, the Indiana Department of Administration released an RFP (RFP 15-036) for enrollment broker services for the existing Medicaid managed care programs (Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect). The contractor will be responsible for educating enrollees, facilitating enrollment, and maintaining the Hoosier Healthwise, HIP and Hoosier Care Connect Helplines. The term of the contract is four years, with options for two one-year renewals. The bidder's conference will take place on December 6, 2014, and proposals are due January 16, 2015.

Louisiana

Louisiana Medicaid Claims Processing Contract Still Up in the Air. On December 1, 2014, the *Advocate* reported that the state Department of Health and Hospitals will be asking the Louisiana Legislature for permission to extend its current Medicaid Management Information Systems (MMIS) contract as the state continues to look for a new private contractor. The state had signed a $200 million contract with Client Network Services, Inc. (CNSI) to take on MMIS services, but decided to terminate the contract 20 months ago amid allegations of improprieties in the way it was awarded. The state then had to extend the contract of the firm that previously held the contract, Molina Healthcare Inc. State health executives want to extend Molina's contract yet again in order to have time to develop specifications for a new privatized MMIS system. Read more

Maine

HMA Roundup – Rob Buchanan (Email Rob)

Individuals with Disabilities to Gain Supportive Services through MaineCare in Lawsuit Settlement. On November 24, 2014, the *Portland Press Herald* reported that the recent settlement of a class action lawsuit against the state will grant hundreds of Maine adults with autism and intellectual disabilities access to housing and other supportive services through MaineCare, the state's Medicaid program. Eighteen individuals filed the lawsuit in 2013; the state argued that there was not enough money in the budget to cover supportive services for these individuals. The state must provide about $7 million to cover services for those affected by the settlement. Read more

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Cambridge Health Alliance Selects Renée Kessler as Next Executive VP and COO. On November 28, 2014, the *Cambridge Chronicle & Tab* reported that the Cambridge Health Alliance (CHA) has named Renée Kessler as its executive vice president and chief operating officer. Kessler will be responsible for the operations of CHA's three hospital campuses and its network of primary and specialty care centers. Kessler is currently Chief Operating Officer of St. Thomas Midtown Hospital in Nashville and has over 25 years of experience in health systems operations. Read more

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Integrated Care for Dual Eligibles Delayed. On November 24, 2014, the Michigan Department of Community Health (MDCH) announced that implementation of its integrated delivery system of health care for dual-eligibles will now be delayed until March 1, 2015. Implementation of the "duals demonstration" was targeted to begin January 1, 2015, with the voluntary enrollment process starting in December 2014. As this demonstration involves "some of the most vulnerable" people in the state, MDCH Director Nick Lyon said it is essential that the program be ready to launch, and by waiting until March "we are continuing on a responsible course to ensure that our residents will receive the best care coordination possible."

There are four demonstration regions and implementation will occur in phases. The first phase involves the Upper Peninsula region and an eight-county region in southwestern Michigan: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren. The second phase involves the single-county regions of Macomb and Wayne Counties.

For the first phase, individuals will start receiving information about enrollment in January and will begin the enrollment process in February. Individuals targeted for enrollment who do not voluntarily do so will be "passively enrolled" in May but will have the ability to opt out of the demonstration and receive care either on a fee-for-service basis or through other Medicare and/or Medicaid managed care organizations. At this time, the timeline for the other two regions is unchanged.

Medicaid Managed Care Enrollment Activity. As of November 1, 2014, there were 1,530,305 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled in 13 Medicaid Health Plans (HMOs); this is an increase of 75,342 since October. The enrollment total reflects an increase of 41,130 HMP enrollees since October and an increase of 34,212 non-HMP Medicaid enrollees. This is the first month since June 2014 that the non-HMP Medicaid managed care enrollment number has increased. Even with this increase, the total number of non-HMP Medicaid managed care enrollees in November – 1,178,830 – is well below the June enrollment figure of 1,330,638.

Healthy Michigan Plan Releases Latest Enrollment Report. Enrollment in the Healthy Michigan Plan (HMP) continues to grow. The Michigan Department of Community Health (MDCH) reports that since launching the program on April

1, 2014, enrollment has grown to 461,217 as of December 1. The MDCH updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the enrolled HMP beneficiaries reside in the state's five largest counties:

December 1, 2014 Healthy Michigan Plan Enrollment	
Wayne	125,952
Macomb	35,731
Oakland	34,617
Genesee	29,051
Kent	23,386
Five-County Total	**248,737**
Statewide Total	**461,217**

With few exceptions, new HMP beneficiaries are required to enroll in the Medicaid Health Plans (HMOs) to receive their health care benefits. As of November 1, 2014, there were a total of 351,475 HMP beneficiaries enrolled in the HMOs. HMP enrollment totals by health plan are expected to increase again in December 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.

November 2014 Healthy Michigan Plan Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	24,744	3,835	28,579
CoventryCares of MI	3,339	3,973	7,312
HAP Midwest Health Plan	13,236	8,891	22,127
Harbor Health Plan, Inc.	774	1,985	2,759
HealthPlus Partners	18,571	2,807	21,378
McLaren Health Plan	33,419	8,861	42,280
Meridian Health Plan of MI	59,326	27,514	86,840
Molina Healthcare of MI	29,984	12,263	42,247
Priority Health Choice, Inc.	20,396	4,130	24,526
Sparrow PHP	2,397	1,106	3,503
Total Health Care	8,510	4,671	13,181
UnitedHealthcare Comm. Plan	34,187	12,201	46,388
Upper Peninsula Health Plan	10,348	7	10,355
Total	**259,231**	**92,244**	**351,475**

New Hampshire

HMA Roundup – Rob Buchanan (Email Rob)

State Submits Premium Assistance Waiver for Health Care Expansion to CMS. On November 20, 2014, the state Department of Health and Human Services submitted a waiver to CMS that will allow the 24,000 low-income enrollees of the New Hampshire Health Protection Program to enroll in private health plans on the state's federally-facilitated marketplace beginning in 2016.

The waiver also establishes a mandatory qualified health plan premium assistance program for individuals in this group. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Aetna Better Health to Serve the New Jersey Medicaid Marketplace in 2015. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) released a newsletter about Medicare dual special needs plan (D-SNP) program changes reported in the October 8, 2014 edition of the HMA Roundup. Page three of the newsletter provides a list of the Medicaid managed care contractors that will serve NJFamilyCare enrollees under its acute care program in 2015, which includes a new managed care organization, Aetna Better Health. Aetna Better Health will enter the market serving Medicaid beneficiaries in the following eight counties: Bergen, Camden, Essex, Hudson, Middlesex, Passaic, Somerset and Union. Aetna will not offer a D-SNP product in New Jersey in 2015. The complete list of New Jersey Medicaid managed care contractors in 2015 is provided below.

NJ FAMILYCARE (MEDICAID) HMO PLANS AND SERVICE AREAS AVAILABLE IN CALENDAR YEAR 2015*

HMO Plan	Service Areas By County
Aetna Better Health	Bergen, Camden, Essex, Hudson, Middlesex, Passaic, Somerset & Union Counties
Amerigroup New Jersey, Inc.	All Counties Served, Except Salem County
Horizon NJ Health	All Counties Served
United Healthcare Community Plan	All Counties Served
Wellcare	Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex & Union Counties

NJ D-SNP PLANS AND SERVICE AREAS AVAILABLE IN CALENDAR YEAR 2015*

NJ D-SNP Plan	Service Areas by County
Amerivantage Specialty + Rx	Bergen, Burlington, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic, Somerset & Union Counties
UnitedHealthcare Dual Complete	Essex, Monmouth, Ocean & Union Counties

**As of January 1, 2015. Service Areas are subject to change.*

State to Allow Medicaid to Cover In-Home Elder Care. On November 30, 2014, the *Record* reported that a new amendment to the state's Medicaid program will allow elderly or disabled beneficiaries who earn too much for full Medicaid assistance to receive help through the creation of a trust account at a bank. Any income an elderly or disabled receive above the Medicaid eligibility limit of $2,163 a month will be deposited into an irrevocable trust account, with withdrawals permitted for qualified living expenses and the portion of care that individuals can afford. Medicaid will cover the rest of the cost of their care. The amendment is in response to protest against old Medicaid rules, which advocates argued were forcing people into nursing homes prematurely since the state offered no financial assistance in paying for home or non-institutional care. Read more

Department of Human Services Terminates CASS contract with Hewlett Packard. On November 28, 2014, the Star-Ledger reported that the state terminated a seven-year, $118.3 million contract with Hewlett Packard to build a social service information system designed to modernize the way it administers services to over 1.5 million New Jersey residents in Work First New Jersey – (General Assistance and Temporary Assistance for Needy Families), SNAP, Child Care, Medicaid and NJ FamilyCare. The Consolidated Assistance Support System (CASS) was originally scheduled to launch in October 2013 and would have replaced an array of antiquated data systems with a built-in rules engine that would have completed an individual's eligibility application for benefits and services across multiple programs in one step. The termination comes after repeated delays in the state's efforts to implement CASS. Read more

RFI for Children's System of Care System Administrator Released. On November 28, 2014, New Jersey's Division of Purchase and Property released a Request for Information (RFI) on behalf of the Department of Children and Families, Division of Children's System of Care to solicit comments from the vendor community and any interested party for an upcoming reprocurement of the Contracted System Administrator for the Children's System of Care term contract (T1932). The purpose of this contract is to 1) to provide a Contracted System Administrator (CSA) for the Children's System of Care service delivery model, and 2) provide its Management Information System (MIS). The State seeks feedback on the draft Scope of Work. RFI responses may be sent to Angela Breland-Jackson at angela.breland-jackson@treas.nj.gov. Responses are due by December 15, 2014 by 10:00 am. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

NY Congressional Delegation Intervenes on Delayed Vital Access Provider Program Payments. Congress member Bill Owens has sent a letter to CMS requesting that they expedite payments to the state for its Vital Access Provider program (VAP). The awards, which had been announced by Governor Cuomo in September, have been delayed as CMS continues to negotiate with the state over Medicaid Upper Payment Limit calculations. $106 million in funding had been committed to hospitals treating a high percentage of elderly and lower-income populations, particularly projects at facilities chosen because they are struggling financially. The letter, signed by 16 members of the NYS delegation, urges the federal agency to expedite payments to the state. The Upper Payment Limit issue is also holding up approval of several pending Medicaid state plan amendments.

MLTC and FIDA Plans. The New York Health Access website recently posted an update on implementation of the duals demonstration in New York, Fully Integrated Dual Advantage (FIDA). The New York Health Access website includes a list of plans that currently participate in the Medicaid managed long-term care program and notes which ones will be participating in the FIDA demonstration, along with their affiliated Medicaid Advantage Plus plan. Three managed long term care (MLTC) plans will not be participating in FIDA: Extended MLTC, HHH Choices, and United Healthcare. The New York Health Access website was created by a group of legal services attorneys and paralegals who work in the field of health and public benefits law in New York State. Its three organizational sponsors are the Empire Justice Center, the Legal Aid

Society, and the New York Legal Assistance Group's Evelyn Frank Legal Resources Program.

New York State of Health Update. In preparation for open enrollment, the New York health exchange, New York State of Health, (NYSOH) hosted a training webinar for agents and brokers to review health plan offerings for the coming year. Very little has changed from the 2014 offering, and a number of plans are expanding into additional geographic areas. Wellcare is newly entering the market; EmblemHealth, Fidelis Care, Health Republic, Healthfirst, MVP and North Shore are expanding their service areas. One plan, Today's Options, has decided to leave the individual market due to low enrollment. A link to the webinar presentation, and a recording of the session, can be found on the NYSOH website.

Capital Restructuring Financing Program. As part of the Medicaid Redesign efforts, NYS is making available $1.2 billion in capital financing. The money is meant to support hospitals in implementing their Delivery System Reform Incentive Program (DSRIP) efforts. While capital financing was included as part of NYS's initial waiver request to CMS, that portion of the request was denied. In response, a capital restructuring financing program was included in the 2014-15 state budget. An RFA for the program was released, with applications due February 20, 2015. Projects are intended to support the DSRIP goals of "transforming the system into a more rational patient-centered care system that promotes population health and improved well-being for all New Yorkers."

Eligible capital projects include:

- Capital projects that support development of primary care service capacity (including primary care services co-located with outpatient behavioral health care services, consistent with any applicable Federal requirements)
- Asset acquisitions
- Capital projects that support consolidation of service lines among providers
- Improvements to infrastructure
- Capital projects that support closures, mergers, and/or restructurings
- Capital projects that support development of tele-health infrastructure
- Capital projects that support development of coordinated co-located ambulatory care services including primary care, specialty care, surgery, urgent care, and diagnostic imaging
- Capital projects leading to integrated delivery systems that strengthen and protect continued access to essential health care services
- Other transformational capital projects which further DSRIP Program Goals

Cost of Immigration Reform for NYS Medicaid Program. On December 1, 2014, *Capital New York* reported that the President Pro Tem of the NY State Senate, Senator Dean Skelos, has raised concerns about the implications of President Obama's immigration reform and its impact on New York's Medicaid program. New York provides Medicaid coverage to immigrants who are undocumented, but are permanent residents. These individuals are referred to

as PRUCOL (Persons Residing Under Color of Law). According to a Department of Health Informational Letter, "The term "PRUCOL alien" refers to an alien who is permanently residing in the United States with the "knowledge and permission or acquiescence" of the federal immigration agency and whose departure from the U.S. the agency does not contemplate enforcing." Individuals covered as a result of their PRUCOL status are not eligible for federal funding, and are covered by state-only dollars. Skelos believes that as a result of the President's action more than 300,000 individuals would newly qualify for Medicaid under the PRUCOL definition. In a letter to the NY Senate delegation he states that this could generate an additional $1.1 – 2 billion in Medicaid expenses for NYS. He goes on to argue that the Federal Medical Assistance Percentage (FMAP) for NYS, currently at 50 percent, should be increased as a means of financing this "unfunded mandate." FMAP, or the percentage the federal government pays, was written into the Social Security Act and is based on per-capita income of state residents. **Increasing** FMAP would require Congress and the President to change the law. Read more

Oklahoma

OHCA Releases Care/Case Management Modernization Planning and Procurement RFI. On October 17, 2014, the Oklahoma Health Care Authority (OHCA) released an RFI for Care/Case Management Modernization Planning and Procurement. OHCA seeks to replace their current care/case management system with a centralized care/case management system that will not only coordinate activities between units within the agency, but also between other agencies who are stakeholders in the care/case management process. RFI Responses were due on November 26, 2014. Read more

Pennsylvania

HMA Roundup – Matt Roan & Ashley Derr (Email Matt/Ashley)

Governor-Elect Tom Wolf Appoints Estelle Richman to Lead Medicaid Expansion Pursuit During Transition. On November 21, 2014, the *Patriot-News* reported that Governor-Elect Tom Wolf has selected Former Public Welfare Secretary Estelle Richman to serve as Medicaid Advisor on his Transition Team. Richman served six years as the Public Welfare Secretary under Governor Rendell, leaving in 2009, to take a position as CEO of the U.S. Department of Housing and Urban Development. Richman will pursue efforts involving full Medicaid Expansion and will conduct an extensive review of Governor Tom Corbett's Healthy Pennsylvania Plan. Read more

Governor-Elect Wolf's Transition Team Addresses Fate of Healthy PA Waiver. On December 1, 2014, the *Pittsburgh Post-Gazette* reported Governor-Elect Tom Wolf plans to transition from Healthy PA (which began open enrollment on December 1) to full Medicaid Expansion after he is sworn in on January 20, 2015. According to Estelle Richman, Medicaid Advisor for Wolf's Transition team, coverage for any individual who enrolls in Healthy PA will not be interrupted during a transition to traditional Medicaid expansion. Richman stated that the transition should be as invisible as possible for consumers. Impending changes include a shift to a single benefit template, rather than the low-risk and high-risk Medicaid plans and the Private Coverage Option which are a part of Healthy PA. The Wolf Administration plans to continue using Medicaid Managed Care

plans to deliver services. Currently, all but one of the Healthy PA Private Coverage Option plans also operate Medicaid Managed Care plans, which Richman predicts will also ease the transition to traditional expansion. Read more

Advocates Identify Glitches in Healthy PA Rollout. On December 1, 2014, the *Patriot-News* reported that enrollment began for Healthy PA, Governor Tom Corbett's Medicaid Expansion alternative. As enrollment progressed, advocates identified some delays and glitches in the system. The Healthy PA call center experienced heavy call volumes, at times placing people on extended hold. While the Pennsylvania Department of Human Services acknowledged some wait times for callers, they reported that the website for online registration loaded quickly and seemed to be functioning well. Advocates also were concerned that the state enrollment website told consumers that they were only eligible if they earned no more than 133 percent of the federal poverty level (FPL) and directed some consumers to the federally run marketplace. This failed to take into account the 5 percent income disregard which would make consumers eligible up to 138 percent FPL. Regardless of those concerns, advocates urged people to sign up quickly so that their new coverage would be effective for the January 1, 2015 launch of Healthy PA. Read more

Gift Card Program for Medicaid Recipients Visiting the Dentist Comes Under Fire. On November 28, 2014, The Tribune-Democrat reported that Gateway Health Plan, a Medicaid managed care plan, has come under fire for its program encouraging Medicaid Recipients to visit the dentist by offering a $25 Walmart gift card. Many conservative leaders have questioned the practice, including State Rep. Michelle Brooks who plans to introduce a bill that would bar the use of tax dollars for such programs. Gateway officials and the Pennsylvania Department of Human Services defend the incentive, stating that they encourage innovative strategies to increase participation in preventive care. Read more

UPMC Doctors May Be Out of Network for Some Highmark Customers. On November 25, 2014, the *Pittsburgh Post-Gazette* reported that Highmark plans to terminate its commercial contracts with 700 UPMC Physicians starting on January 1, 2015. As a result, roughly 145,000 seniors enrolled in Highmark Health's Freedom Blue or Security Blue Medicare Advantage plans and who seek care at an in-network UPMC Hospital may be treated by an out-of-network physician. Highmark said it would offer UPMC physicians Medicare-only reimbursement contracts; however, UPMC doctors have no plans to sign such a contract. Both organizations disagree on how the contract terminations will impact billing processes moving forward. Highmark says that due to a consent decree, brokered by state regulators earlier this year, UPMC physicians should continue to bill Highmark at in-network rates. Alternatively, UPMC views the contract termination as a unilateral and material move, allowing them to withdraw from the consent decree arrangement with Highmark allowing the UPMC physicians to bill Highmark as out-of-network providers. Read more

Pennsylvania Medical Society Discusses Medicare Rule Changes. On November 24, 2014, The Pennsylvania Medical Society held a conference call to discuss a series of new Medicare rules that go into effect on December 31, 2014. The new rules will impact a broad spectrum of patient care and the sustainable growth rate (SGR) on the consolidation of health care services. Dennis Olmstead, Chief Medical Economist for the Pennsylvania Medical Society, expressed concern that the impending changes will hinder access to care

and place a major financial burden on physicians. According to Olmstead, the new rules will cost Pennsylvania $470 million for the care of elderly and disabled, equating to $12,000 per physician. Read more

Pennsylvania Department of Public Welfare Officially Changes Name to Department of Human Services. On November 24, 2014, as a result of Act 2014-132, the Pennsylvania Department of Public Welfare officially became the Pennsylvania Department of Human Services. Governor Tom Corbett signed Act 2014-132 into law on September 24, 2014. Read more

PA Supreme Courts Orders Governor Corbett to Halt all Closing of Health Centers. On November 21, 2014, the *Philadelphia Inquirer* reported that the Pennsylvania Supreme Court has ordered Governor Corbett to stop the closure of health centers and layoff of dozens of nurses. The majority concluded that the legislature never changed a 1996 mandate requiring the state to maintain the same level of health centers (60) it had in 1995. Kevin Hefty, of the SEIU Healthcare PA, noted that he expects that the Corbett Administration will reopen closed health centers and restore all levels of service; however, a health department spokeswoman said it was not clear how the administration would respond. Read more

Texas

HMA Roundup – Lisa Duchon (Email Lisa)

Evaluation Finds Room for Improvement among MCOs Providing Service Coordination for STAR+PLUS Members. On December 2, 2014, the Health and Human Services Commission (HHSC), which administers the Texas Medicaid program, released an evaluation report on the "patient-centeredness" of the Home- and Community-Based Services (HCBS) Program, which allows individuals on Medicaid who have a disability, chronic illness, or are elderly (called STAR+PLUS members) to receive services in their homes. The study examined perceptions of STAR+PLUS service coordinators and members about the extent to which individual service plans (ISPs) address the needs and desired outcomes of members enrolled in the HCBS Program. The state's External Quality Review Organization (EQRO) for managed care, the Institute for Child Health Policy, University of Florida, conducted the study.

Member Perspective. The evaluation found a mixed record on the effectiveness of managed care organizations' service coordinators in meeting members' needs. The report noted that although the legal standard for in-home follow-up is an annual reassessment, the need for covered services often arises during the course of a year. Additionally, STAR+PLUS members often do not know who to call to get help; many could not name someone at their health plan who coordinates their care. Even for members who do not have a nurse who visits them regularly, because their conditions are relatively less severe, low levels of contact with service coordinators translated to unmet care needs.

Service Coordinator Perspective. Service coordinators perceived their most common challenges to developing a member's ISPs as: getting health care providers to sign documentation of medical conditions to verify medical necessity; conducting in-home assessments in a timely manner; issues with health plan software; and making follow-up contact with members. The

report also noted high service coordinator caseloads as a barrier to improving communication with members.

Recommendations. The EQRO recommended that the state adopt more stringent standards on the frequency and means of contact between service coordinators and members and also offered recommendations to health plans, as follows:

- In-home visits by service coordinators
- Proactive telephone contact with members by service coordinators on a regular schedule (quarterly or monthly)
- Use of telehealth technology to ensure that service coordination is patient-centered and tailored to members' needs
- Protocols for improving communication that involve all stakeholders – service coordinators, nurses, providers, members, and their families
- During points of contact, service coordinators should actively assess members' preferences and needs and inform them of available programs offered by the MCO, including disease management, exercise programs, and value-added services.
- Health plans should explore strategies for reducing the caseloads of service coordinators, which would allow more frequent contact with members.

The study, which covered a period from September 2010 through October 2012, was based on a mixed-methods approach that included analysis of paper and electronic individual service plans; a structured telephone survey with STAR+PLUS members or their caregivers; in-depth face-to-face interviews with STAR+PLUS members or their caregivers living in the Harris County (Houston) service area; and semi-structured telephone interviews with STAR+PLUS service coordinators.

Vermont

HMA Roundup – Rob Buchanan (Email Rob)

Centurion Selected to Provide Comprehensive Correctional Healthcare in Vermont. On November 21, 2014, *CNN Money/PRNewswire* reported that the State of Vermont has announced its intent to award Centurion Managed Care, LLC (a joint venture between Centene and MHM Services Inc.) a contract for comprehensive correctional healthcare services. Centurion will provide medical and behavioral health services to inmates and detainees housed at eight facilities in the state. The award is expected to commence operations in Q1 2015. Read more

Washington

HMA Roundup – Doug Porter (Email Doug)

CMS Cites Spokane Nursing Home Facility for More Than 40,000 Violations. On November 25, 2014, *AP*/the *Idaho Statesman* reported that CMS inspectors have cited the Lakeland Village Nursing Facility in Spokane County for more than 40,000 violations, including strapping residents to chairs in front of TVs

and forcing them to face a wall for hours at a time. The state Residential Care Services agency also cited the facility this year. Lakeland Village has responded to each citation with a plan of correction, but advocates for the disabled believe the facility should be closed for good. Read more

Wyoming

State Releases RFP for Care Management Entities for Youth with Complex Behavioral Health Conditions. On November 20, 2014, the Wyoming Department of Health (WDH), Division of Healthcare Financing released a Request for Proposals (RFP 0111-Z) to identify vendors that would serve as a statewide Care Management Entity (CME) for youth with complex behavioral health conditions. The CME is expected to support WDH's efforts to better serve youth in their homes and communities by providing the necessary high-fidelity wraparound (HFWA) services and supports for enrolled youth. HFWA services provide structured, personal treatment planning for children and their families. The CME will serve as an entry point for Wyoming's Medicaid-eligible youth with behavioral health conditions, ensuring the appropriate provision of required services and enabling the youth and their family to achieve well-being in their communities using HFWA. Questions are due by December 3, 2014, and proposals are due on February 2, 2015.

National

What Would Happen if the Supreme Court Banned Federal Tax Credits for Health Insurance Plans? On December 2, 2014, *Kaiser Health News* discussed what would happen to the ACA if the Supreme Court were to invalidate tax credits for individuals living in the three dozen states which operate federally-facilitated healthcare marketplaces. A recent lawsuit (King v. Burwell) argues that the federal tax credits were meant for residents of states running their own exchanges, and not for those in states with federally-facilitated exchanges. If the Court rules in favor of King, millions of Americans would lose their subsidies for health insurance; many would likely be unable to afford their premiums. America's Health Insurance Plans, an insurance trade group, predicts that such an action would prompt many healthy people to abandon their coverage, creating a sicker pool of insured consumers that would thus drive up premiums further. Eliminating subsidies for individuals would also effectively eliminate the "employer mandate" requiring large companies to provide coverage. The Supreme Court will likely rule on the case in late June of 2015. Read more

State Finances and Healthcare Coverage Could Be Seriously Affected If Congress Does Not Reauthorize CHIP. In its December 2014 issue, *Governing* magazine reported on the potential consequences to state budgets if Congress does not reauthorize the Children's Health Insurance Program (CHIP) next year. About 4 million children are currently enrolled in CHIP, which is funded jointly by states and the federal government. The Georgetown Health Policy Institute estimates that if the federal government decided not to reauthorize CHIP, the eight states that currently cover all CHIP kids through Medicaid would lose about $1 billion collectively, since their federal assistance would drop to Medicaid levels. The 14 states that operate CHIP programs totally separate from Medicaid would lose all federal assistance for CHIP kids, costing the states

upwards of $5 billion collectively. Such financial pressures could cause some states to stop the program altogether. Read more

ACA Regulation Can Put Subsidies Out of Reach for Many Families. On December 2, 2014, *NPR* reported that ACA regulations can prevent families seeking employer-based health insurance from accessing federal subsidies. While the ACA is expected to provide $10 billion in subsidies this year, the law determines whether employer-based coverage is affordable based on the cost of worker-only coverage, rather than the cost of family coverage. This means that some employees wishing to cover their family members are deemed ineligible for federal subsidies. Without the subsidies, the increased cost of family coverage is often unaffordable. Read more

Competition from New Entrants Restrain Premium Increases. On December 1, 2014, *Kaiser Health News* (KHN) reported that counties adding at least one insurer next year will see an average one percent increase to premiums, versus a seven percent increase on premiums in counties where the number of insurers is not changing. KHN estimated that the number of insurers offering silver plans will increase in two-thirds of counties. Carriers were originally cautious about entering a marketplace, unsure how expensive it would be to provide medical services; some carriers used 2014 as a time to study what their competitors offered and charged. Having avoided the rough first year, many insurers are now recognizing opportunities to undercut overpriced plans from 2014 and offer more affordable options to consumers. Read more

Pre-ACA Medicaid and CHIP Enrollees at Risk for Losing Coverage. On November 25, 2015, *Modern Healthcare* reported that many states are struggling to re-enroll adults and children in Medicaid and CHIP, putting hundreds of thousands of current beneficiaries at risk of losing coverage. Individuals who were beneficiaries prior to ACA Medicaid expansion must provide their state with additional information to redetermine their eligibility under a new formula to define household income under the Modified Gross Income (MAGI) standard, but consumers do not always understand their states' requests for additional information. Advocates say that the requests are sometimes confusing and not always presented in the consumers' primary language. As a result, many consumers have not responded to redetermination notices and have lost their coverage. Read more

Lawmakers Seek Relief from Rising Price of Generic Drugs. On November 24, 2014, the *New York Times* reported that state and federal lawmakers are investigating ways to address the soaring price of generic drugs. One half of generics went up in price between last summer and this summer, and about 10 percent more than doubled in cost in that time. Several lawmakers have proposed importing drugs from other countries or extending drug rebates to insurers; however there is no universal consensus about how to cope with increased drug prices. Read more

Managed Care Prepares for Influx of Ex-Inmates. In its November 2014 issue, *Managed Care Magazine* reported that managed care plans are preparing to offer coverage to recently-released inmates, a group that has historically had little or nothing to do with the Medicaid system. According to the Council of State Governments, at least 70 percent of the roughly 10 million people released from prison or jail each year are uninsured. Transitioning recently-released inmates into Medicaid coverage can lessen the financial burden on state-funded health care programs and could help reduce the likelihood of recidivism. However,

extending Medicaid to these individuals will involve careful planning, and the process will differ from state to state. Read more

Forty-Five Critical Access Hospitals to Lose Their "Rural" Status Due to Changes in Demographic Classifications. On November 21, 2014, *Healthcare Finance* reported that 45 critical access hospitals in 21 states will lose their "rural" status because of changes in federal demographic classifications and must reapply by September 2016 to keep their critical access designation. The U.S. Census Bureau and Office of Management and Budget changed their urban and rural classification in several dozen regions around the country. Facilities can keep their designation by showing that they lie in a rural-urban commuting area with a population density of less than 50,000, or can work with their states to take legislative action that defines a hospital as rural. Read more

INDUSTRY NEWS

Molina Healthcare of Florida Completes Acquisition of Florida Medicaid Assets from First Coast Advantage. On December 1, 2014, *Business Wire* reported that Molina Healthcare of Florida, a wholly owned subsidiary of Molina Healthcare, Inc., closed on its acquisition with First Coast Advantage, LLC. The acquisition will transition First Coast's 63,000 enrollees to Molina's respective Medicaid programs. First Coast was awarded a contract in 2013 to participate in the Managed Medical Assistance (MMA) program for Region 4. Read more

Karen Rohan Named President of Aetna Inc. On December 1, 2014, Aetna announced the appointment of Karen S. Rohan as president of Aetna Inc. Rohan joined Aetna in 2012 as executive vice president and head of Specialty Products. In 2013, she assumed management of Aetna's Local and Regional businesses. In addition to her current responsibilities managing Local and Regional businesses, Rohan will oversee National, Government and Specialty businesses. Read more

HealthSouth Enters into Definitive Agreement to Acquire Encompass Home Health and Hospice. On November 24, 2014, HealthSouth Corporation announced it has entered into a definitive agreement to acquire privately held EHHI Holdings, Inc., which owns Encompass Home Health and Hospice, for approximately $750 million. HealthSouth is the nation's largest owner and operator of inpatient rehabilitation hospitals. Encompass is the fifth largest provider of Medicare-focused skilled home health services in the United States, operating 140 locations across 13 states. Read more

RFP Calendar

Date	State	Event	Beneficiaries
December 19, 2014	Missouri	Proposals Due	398,000
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
March 1, 2015	Michigan Duals	Implementation	70,000
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	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	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; 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 Webinar Replays Available:

"Veterans - Benefits and V.A. System Access" **– Replay Link**

"Medicaid in an Era of Health & Delivery System Reform" **– Replay Link**

"Managed Care and Individuals with Intellectual and Developmental Disabilities: Innovative Approaches to Care Coordination" **– Replay Link**