HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 10, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

Sam Stockstill
Email

THIS WEEK

- IN FOCUS: FLORIDA, UTAH MEDICAID EXPANSION PROPOSALS
- MINNESOTA APPOINTS ZIMMERMAN AS NEW MEDICAID DIRECTOR
- ROBERTS NOMINATED FOR RHODE ISLAND EOHHS SECRETARY
- TENNESSEE GOVERNOR CLOSE TO DECIDING ON MEDICAID EXPANSION
- NEW MEXICO ATTORNEY GENERAL SUES NURSING HOME PROVIDER
- OREGON TO ADAPT KENTUCKY MEDICAID ENROLLMENT SYSTEM
- MACPAC HOLDS NEXT PUBLIC MEETING ON DECEMBER 11-12
- BLUE SHIELD OF CALIFORNIA ENTERS MEDI-CAL MARKET THROUGH ACQUISITION OF CARE1ST
- MOLINA AWARDED PUERTO RICO MEDICAID CONTRACT
- CARECORE AND MEDSOLUTIONS COMPLETE MERGER AGREEMENT

IN FOCUS

FLORIDA, UTAH MEDICAID EXPANSION PROPOSALS REVIEWED

This week our *In Focus* section reviews Medicaid expansion proposals released last week in Florida and Utah. The two states join Wyoming as Republican-led states that have largely opposed Medicaid expansion up until now. Utah's proposal – Healthy Utah – comes directly from the office of Governor Gary Herbert, while Florida's proposal – A Healthy Florida Works – comes from a statewide coalition of business leaders, including Chambers of Commerce.

Florida – "A Healthy Florida Works"

Covered Population. The A Healthy Florida Works proposal estimates that more tha 800,000 eligible beneficiaries would enroll in the 2015-2016 fiscal year, with nearly 1,000,000 by 2020. Those eligible include:

- parents and individuals aged 19 and 20 with income between 22 percent and 138 percent of the federal poverty level (FPL);

- SSI and aged, blind, and disabled (ABD) individuals with income between 74 percent and 138 percent of FPL; and
- childless adults up to 138 percent of FPL.

Enrollee Requirements. Much like the Wyoming proposal, A Healthy Florida Works would require many enrollees to pay a monthly premium and participate in workforce/job training activities.

- Premiums would be required, as permitted by federal law, from nearly all enrollees, with monthly premium contributions ranging from a proposed $3 to $25 per month, depending on income.
- Enrollees (excluding individuals with disabilities) would be required to participate in job and education training activities, including on-the-job training, job placement, and education. Parents would be required to complete 20 hours of weekly job and education training, while childless adults would be required to complete 35 hours per week.

Health Plan Coverage. A Healthy Florida Works would initially leverage the state's existing Medicaid managed care contracts. However, the proposal indicates the intention that a self-sufficient, state-run private insurance marketplace facilitating enrollment in years two and beyond of the program.

- In year one of the expansion, existing Medicaid health plans serving the statewide Medicaid managed care program would be available for enrollment. 800,000 new enrollees would represent a 30 percent increase in non-specialty, non-LTC managed care enrollment.

MMA Non-Specialty Health Plans	November Enrollment	Mkt. Share
Staywell Health Plan (WellCare)	627,775	23.8%
Sunshine State Health Plan (Centene)	383,297	14.6%
Amerigroup Florida (Anthem)	308,930	11.7%
Preferred Medical Plan	282,286	10.7%
Humana Medical Plan	267,984	10.2%
United Healthcare of Florida	246,235	9.4%
Molina Healthcare of Florida	155,689	5.9%
Better Health	86,440	3.3%
Integral Quality Care	85,335	3.2%
Simply Healthcare Plans	78,252	3.0%
Coventry Health Care (Aetna)	42,269	1.6%
South Florida Community Care Network	41,085	1.6%
Prestige Health Choice	27,261	1.0%
Total Non-Specialty Enrollment (November 2014)	**2,632,838**	

- In subsequent years, additional plans would be allowed to apply to serve the expansion population. Interested plans would need to meet all Florida health plan requirements and submit an acceptable rate bid by January 1, 2016.

Link to A Healthy Florida Works proposal: http://ahealthyfloridaworks.com/

Utah – "Healthy Utah"

Covered Population. The Governor's proposal estimates that roughly 95,000 individuals would receive coverage through Healthy Utah in the first year of the program, with a potential 140,000 enrolled by fiscal year 2019. Enrollment estimates include 63,000 adults under 100 percent of FPL and 32,000 adults between 100 percent and 138 percent of FPL in year one (fiscal year 2016).

Healthy Utah coverage is limited to those ages 19 through 64. Of those eligible, the Governor's proposal estimates that:

- 52 percent are female;
- 58 percent are under age 35; and
- 56 percent have a job or are self-employed.

Enrollee Requirements. As in Wyoming's and Florida's proposal, enrollees may be subject to monthly premiums and copayments based on their income, and they will also be enrolled in workforce development programs.

- Those with incomes below 100 percent of FPL will have minimal cost sharing. Those with incomes between 100 percent and 138 percent of FPL will pay approximately 2 percent of their income toward premiums and pay coinsurance of roughly 10 percent on many services.
- Additionally, most enrollees without disabilities would be automatically enrolled in an integrated work program intended to provide enrollees with opportunities to improve their employment situation.

Health Plan Coverage. How Healthy Utah enrollees will receive coverage depends on their situation, with the Governor's proposal outlining the three scenarios of coverage for individuals ages 19 to 64, below 138 percent of FPL.

- Enrollees without access to affordable coverage through an employer would receive premium assistance to purchase coverage from a Qualified Health Plan on the insurance marketplace. Healthy Utah coverage will be provided through Silver-level plans available in the Marketplace. In 2015, the six plans below will be participating in the Marketplace. Plans are encouraged but not required to participate in the Healthy Utah expansion.

Utah Marketplace Qualified Health Plans (QHPs)	Average Premium (Age 30)	Counties Served
Humana (HMO)	$186	2/29
Molina (HMO)	$207	4/29
Arches Health Plan (HMO)	$238	29/29
Altius (HMO)	$239	9/29
BridgeSpan Health Company (PPO)	$250	29/29
Arches Health Plan (POS)	$255	29/29
SelectHealth (HMO)	$258	29/29
Altius (POS)	$299	20/29

Source: Healthcare.gov

- Enrollees deemed to be medically frail, due to serious medical or behavioral health issues, will have the option to receive coverage in the state's current Medicaid system, through a Medicaid ACO, local behavioral health authority, or coordinated through a primary care physician.

Utah Medicaid ACOs	Ownership/Affiliation
Health Choice Utah	IASIS Healthcare
Healthy U	University of Utah Health Plans
Molina Healthcare	Molina Healthcare
SelectHealth Community Care	Intermountain Healthcare

- Enrollees with access to affordable coverage through an employer will receive Medicaid assistance to purchase employer coverage. Additionally, children on Medicaid will have the option of enrolling in their parents' plan, with wrap-around coverage provided.

Link to Healthy Utah Proposal: http://healthy.utah.gov/

HMA Medicaid Roundup

Alaska

Existing Problems with Medicaid System Need Fixing Before Medicaid Expansion Moves Forward. On December 7, 2014, the *Alaska Dispatch News* reported that two systems in Alaska's Medicaid program contain major defects that must be addressed before newly-elected Governor Bill Walker moves forward with his goals for Medicaid expansion in the state. According to newly appointed Department of Health and Social Services Commissioner Valerie Davidson, the Medicaid eligibility system has a backlog of applicants that must be addressed first before an estimated 40,000 Medicaid expansion enrollees join the rolls. Davidson also explained that the state's Medicaid payment system has had a backlog in payments since it began last year. Read more

California

HMA Roundup – Pat Dennehy (Email Pat)

Cedars Sinai Finds Computers Better Then Doctors at Recording Patient Symptoms. On December 9, 2014, the *Los Angeles Times* reported on a new study by Cedars Sinai Medical Center that found that computers are more effective than physicians at recording patient symptoms. The study, which evaluated the treatment of 75 patients at gastrointestinal clinics in Los Angeles found that computer generated summaries were more complete, succinct, comprehensive and useful than physician-recorded summaries. Read more

Medi-Cal Reimbursement Rates to Primary Care Providers to Be Cut Twice on January 1. On December 8, 2014, the *California Healthline* reported that primary care providers (PCPs) will have their Medi-Cal reimbursement rates lowered two times on January 1. The two-year Medicaid federal rate increase for PCPs is set to expire on January 1, and the state Department of Health Care Services plans to implement its state-ordered 10 percent reduction in reimbursement rates for fee-for-services Medi-Cal PCPs (per AB 97) that same day. The cuts might prompt some PCPs in the state to stop accepting new Medi-Cal patients. Read more

Walgreens to Test Mobile Application for Virtual Doctor Visits in California and Michigan. On December 8, 2014, the *AP*/the *San Francisco Chronicle* reported that Walgreens is testing a mobile app in California and Michigan that will allow patients to access a virtual physician consultations at home or at one of its retail clinics. The virtual visits will cost $49 and providers will be able to prescribe for certain conditions. Read more

Understanding the Reasons for L.A. County's High Opt-Out Rate Among Dual Eligibles. On December 4, 2014, the *California Healthline* reported that in recent months the opt-out rate for enrollment in L.A. County's dual eligible program was as high as 50 percent. This news comes as health officials are in the process of enrolling a large number of dual eligibles in the state's pilot project, Cal MediConnect. As more people are automatically enrolled in the program, health officials expect that the opt-out rate may continue to grow. Resistance to the program could be due to an organized effort to urge dual eligibles to back out, a lack of clear communication among officials, providers, and patients, or because of disapproval by participants for being automatically enrolled into an unfamiliar program. Read more

Governor Jerry Brown Shows Interest in Including Immigrants in Medi-Cal. On December 3, 2014, the *Los Angeles Times* reported that Governor Jerry Brown is considering expanding the state funded Medi-Cal to undocumented immigrants following President Obama's new policies shielding these individuals from deportation. Undocumented residents cannot currently sign up for ACA subsidized health insurance or Medicaid. If the Brown Administration expands coverage, more than a million immigrants in California could benefit. Read more

Colorado

Technical Glitches in Colorado Health Exchange. On December 2, 2014, the *Denver Post* reported that at least 88 prospective customers experienced a technical issue when completing an online application within the state's health insurance exchange. Connect for Health Colorado is working with those who start their application before December 15 to ensure January coverage. Read more

Connecticut

HMA Roundup – Rob Buchanan (Email Rob)

Contractor Alleges DSS Continued Providing Medicaid Coverage to 12,000 People Without Checking Their Coverage Eligibility. On December 8, 2014, the *CT Mirror* reported that the Connecticut Department of Social Services (DSS) continued providing Medicaid coverage to about 12,000 people for more than a year without checking whether they remained eligible. According to Stanley Stewart, who was contracted to head the effort to replace DSS' outdated eligibility system, the Department's failure to confirm eligibility violates federal rules. Stewart argues that covering medical care for these 12,000 individuals could have cost the state and federal governments millions of dollars. DSS spokesperson David Dearborn explained that the Department was overwhelmed by a significant caseload growth and that it did not have the capacity to handle all renewal forms. However, Dearborn also countered that most of the beneficiaries in this group are either seniors or adults with disabilities, whose income and household size tend to be stable and allow them to remain eligible for Medicaid each year. Read more

Florida

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

HHS Secretary Burwell Expresses Interest in Discussing Medicaid Expansion with State Lawmakers. On December 10, 2014, *Health News Florida* reported that HHS Secretary Sylvia Burwell wants to discuss the prospect of Medicaid expansion in Florida with the state Legislature. Burwell said she wants to understand why the Legislature opted out of ACA expansion, and that she is open to talking about expansion with lawmakers and Governor Rick Scott. Read more

Republican-Backed Medicaid Expansion Plan Would Cover 1 Million People. On December 5, 2014, the *Naples Daily News* reported on "A Healthy Family Works," a new program being proposed by Florida Republicans that would increase the number of low-income Floridians who receive health coverage by nearly 1 million. The program would provide private health insurance coverage to individuals earning up to 138 percent of the federal poverty level; it would use $50 billion in federal dollars over 10 years and $410 million in state funds each year. Those state funds would come from the elimination of the state-run Medically Needy Program. The proposal is supported by some of the state's most influential organizations, including Associated Industries of Florida and the Florida Hospital Association. The proposal requires that enrollees actively look for employment, take job training courses and pay annual premium payments between $36 and $300 into private health savings accounts. Read more

Iowa

Governor Branstad Suggests Consolidating Mental Health Facilities. On December 8, 2014, the *Des Moines Register* reported that Governor Terry Branstad suggested the state should consider consolidating services among its six institutions for people with mental illnesses or disabilities. The state Department of Human Services runs four mental health institutions and two resource centers for people with mental disabilities. The Governor argues that some of these facilities are obsolete and inefficient, and that this results in a high cost per bed. Branstad acknowledged that the facilities are a source of jobs in the state and expressed interest in starting a discussion of how Iowans could be protected from economic downturn. Read more

Kansas

Voluntary Admissions to Osawatomie State Hospital Suspended. On December 3, 2014, the *Kansas Health Institute* reported that the Kansas Department for Aging and Disability Services (KDADS) suspended voluntary admissions to one of the state's two inpatient facilities for people with serious mental illnesses. Voluntary admissions refer to patients with a diagnosis of anti-social personality syndrome, substance use disorder, or an organic mental disorder. Over-admittance of patients prompted federal health officials to declare that Osawatomie's services were not sufficient to meet the needs of its patients. KDADS threatened to take away Medicare funding if the hospital's deficiencies were not addressed. Read more

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Manatt Health Solutions Report Identifies Top Priorities for New Governor to Ensure Strength of the MassHealth Medicaid Program. On December 9, 2014, Manatt Health Solutions published a report titled "The Future of MassHealth: Five Priority Issues for the New Administration." The report identifies five priorities on which the next Governor of the Commonwealth must focus to ensure the long-term stability of MassHealth. The Executive Summary of the report can be found here.

BMC HealthNet Cuts Ties with Children's Hospital. On December 4, 2014, the *Boston Globe* reported that BMC HealthNet Plan will end its contract with Boston Children's Hospital on January 1. BMC HealthNet is a subsidiary of the teaching hospital Boston Medical Center and manages care for 270,000 Medicaid beneficiaries, including 12,000 who use Children's Hospital. The insurer explains that it cannot afford to pay the hospital's high rates; BMC HealthNet finished the fiscal year ending September 30 with $43 million in losses. The hospital still has contracts with Neighborhood Health and Network Health; BMC HealthNet members who want to continue using Children's Hospital could move their coverage to one of these plans. The insurer also reported it has cut Springfield-based Baystate Health from its network. Read more

New Report from HMA and the Massachusetts Association of Health Plans Outlines Cost Control Strategies for MassHealth. On December 3, 2014, the *Lowell Sun* discussed a report prepared by Health Management Associates (HMA) for the Massachusetts Association of Health Plans (MAHP) outlining strategies for Medicaid reform in the state. An HMA team led by Tom Dehner reviewed how the state's MassHealth Medicaid program compared to Medicaid programs and cost control initiatives in other states to determine appropriate cost control methods for Massachusetts. MassHealth managed care organizations experienced $137 million in losses between October 2013 and July 2014, largely due to less favorable risk in the covered population than expected, the high price of hepatitis C drugs, and low capitation payment rates. The report recommends granting enrollees eligibility for MassHealth 12 months at a time in order to avoid disruptions in coverage. The report explains that continuity of coverage can reduce average medical expenses, offsetting the expense of carrying members whose financial situations may change during a year and jeopardize their eligibility. MAHP will present the report to Governor-elect Charlie Baker's transition team on December 11. Read more

Minnesota

Minnesota Appoints Marie Zimmerman as New Medicaid Director. On December 9, 2014, the National Association of Medicaid Directors welcomed Marie Zimmerman as the new Minnesota Medicaid Director. She will oversee federal relations, legislative staff, the policy and implementation division and the purchasing and service delivery division. Zimmerman was previously the Policy Director for the Health Care Administration and started her new role on December 4.

New Hampshire

HMA Roundup – Rob Buchanan (Email Rob)

New Hampshire Medicaid Expansion Enrollment Reaches 25,000, Exceeding Expectations. On December 7, 2014, *AP*/the *Concord Monitor* reported that New Hampshire is close to meeting its first-year enrollment target for the state's newly-expanded Medicaid program. Less than six months ago, the state expanded Medicaid to cover individuals under age 65 who earn up to 138 percent of the federal poverty line. Officials expected between 30,000 and 40,000 of the estimated 50,000 eligible adults would sign up in the first year, either through the state's Medicaid managed care program or a program that subsidizes existing employer coverage. As of last week, the state had signed up 25,300 people. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Division of Developmental Disabilities Will Amend Supports Program Terms and Conditions. The Department of Human Services, Division of Developmental Disabilities (DDD) plans to implement the Supports Program in 2015 as of part of the Comprehensive Medicaid Waiver. The Supports Progam is intended to increase service capacity for people with developmental disabilities served by DDD. While full implementation has not yet taken place, DDD is planning to put forth amendments to the Supports Program terms and conditions and is inviting stakeholder input. Self-advocates, families, providers and other DDD stakeholders are invited to a webinar on December 15, 2014, at 3:00 p.m. to receive an overview of DDD's proposed amendments to the original Supports Program terms. The information shared in the webinar will help stakeholders interested in drafting input to those amendments prior to their submission to CMS. Presenters are Elizabeth Shea, Assistant Commissioner and Jennifer Joyce, Director of Employment, Transition and Day Services. Click here to pre-register.

Home Care Bill Would Require Medicaid Managed Care Organizations to Meet with Providers and Discuss Alternatives Before Reducing Reimbursement Levels. On December 8, 2014, *NJ Spotlight* reported on a controversial bill that attempts to resolve a long-standing disagreement between home care provider agencies and the Medicaid program regarding reductions in their reimbursement rates. The origins of A-3549 (and S-2284) began in July 2011 when state plan personal care attendant (PCA) services were carved from Medicaid fee-for-service into Medicaid managed care. The following summer Horizon NJ Health decided to reduce reimbursement rates to PCA providers by 10 percent with short notice to providers. The latest bill introduces a notification period and opportunity for home care providers to meet with the Medicaid managed care organization (MCO), and for the Division of Medical Assistance and Health Services that oversees the managed care program to receive advance notice following a meeting between the MCO and providers. The New Jersey Association of Health Plans has expressed concerns with the latest bill. Read more

Seton Hall Law School, Center for Health & Pharmaceutical Law & Policy Releases a 2015 Guide for New Jersey Residents Selecting Marketplace Health Plans. Under a grant from the Robert Wood Johnson Foundation, the School is collaborating with the New Jersey Appleseed Public Interest Law Center on The Sentinel Project, which is dedicated to assuring that consumers gain meaningful access to the broad range of health care services required by the Affordable Care Act. The guide will help navigators, community assisters and consumers with health plan selection. It includes information about, for example, plan cost, provider networks, and covered services. "A Guide to Assist Consumer Selection of Health Insurance Plans for 2015" is available online here.

New Mexico

New Mexico Attorney General Sues Preferred Care Partners Management Group for Understaffing and Substandard Care. On December 5, 2014, *AP*/the *Kansas City Star* reported that New Mexico Attorney General Gary King sued Preferred Care Partners Management Group, one of the nation's largest nursing home chains, for understaffing seven of its nursing homes, such that they could not provide adequate care. King's case includes confidential witnesses from the nursing homes' own staff alleging that managers know nursing assistants were too overwhelmed to provide necessary care to all residents. Four of the seven New Mexico facilities run by Preferred Care were given the worst grades for quality on Nursing Home Compare, a federal website that evaluates nursing homes. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Insurers and Providers Prepare for January 1 Launch of FIDA. On December 8, 2014, *Crain's Healthpulse* reported that health plans and providers are preparing for the January 1 launch of the Fully Integrated Dual Advantage (FIDA) program for dual eligibles. The $15 billion pilot program aims to better coordinate health care services for 138,000 duals via 22 managed care plans. However, the state has not yet set rates it will pay insurers; plans therefore do not know if state reimbursement rates will be adequate to cover the duals, many of whom have complex care needs. While providers support FIDA in theory, they worry that payment glitches could limit patients' access to care. Read more

Northern Westchester Hospital to Join North Shore-LIJ Health System. On December 8, 2014, the *Stamford Advocate* reported that Northern Westchester Hospital has signed a contract to become part of the North Shore-LIJ Health System. The hospital has 233 beds and employs 1,200. Under the agreement, Northern Westchester's board will remain the hospital's governing body for several years. Northern Westchester is North Shore-LIJ's nineteenth hospital. North Shore-LIJ expects to secure all necessary approvals to finalize the relationship by early 2015. Read more

DOH Announces Awards for the Population Health Improvement Program. On December 5, 2014, the New York State Department of Health (DOH) announced the selection of regional contractors for the Population Health Improvement Program (PHIP). The goal of PHIP is to promote the "Triple-Aim" of better health care, better population health, and lower health care costs. The selected contractors will be responsible for identifying best practices and

strategies to promote better health outcomes and reduce disparities across the population in each region. The PHIP contractors are listed below, along with the recommended award that is to be paid out over two years.

Region	Contractor	Award Recommendation
Capital District	Healthy Capital District Initiative	$2,440,000
Central New York	Health Advancement Collaborative of Central New York, Inc.	$2,439,993
Long Island	Nassau-Suffolk Hospital Council, Inc.	$2,400,000
Mid-Hudson	Taconic Health Information Network and Community Inc.	$2,434,685
Mohawk Valley	The Mary Imogene Bassett Hospital	$2,438,819
New York City	Fund for Public Health in New York Inc.	$5,000,000
North Country	Adirondack Health Institute Inc.	$2,440,000
Southern Tier	STHL, Inc.	$2,070,848
Tug Hill Seaway	Fort Drum Regional Health Planning	$2,438,616
Western New York	P2 Collaborative of Western New York, Inc.	$2,440,000

The Finger Lakes Health Systems Agency will serve as the PHIP contractor in the Finger Lakes region and will provide technical assistance to DOH that will help it support the other contractors. Read more

North Carolina

Legislative Differences on State Medicaid Program Persist. On December 9, 2014, the *Charlotte Observer* reported that lawmakers continue to disagree over the structure of the state's Medicaid program and whether insurance companies should be allowed to manage patient care. On December 9, a legislative committee on health and human services voted to strip language from a proposal that envisioned insurance companies and provider-led care networks in regional competition for Medicaid patients. Without agreement on how providers should be paid and who should oversee patient care, the legislature again faces a stalemate on the Medicaid program. Read more

Oregon

Oregon to Adapt Kentucky Medicaid Enrollment System. On December 9, 2014, the *Statesman Journal* reported that the Oregon Health Authority (OHA) will import Kentucky's online Medicaid enrollment system. OHA Medicaid Director Judy Mohr Peterson told lawmakers that Kentucky's system has been successful in that state and that it would likely work well in Oregon, since the state has a similar Medicaid population. The decision comes after the Oregon's botched rollout of its own Cover Oregon Medicaid system. Mohr Peterson said that Kentucky's technology should be fully adapted by Oregon's Medicaid system by fall of 2015. Read more

Pennsylvania

HMA Roundup – Ashley Derr (Email Ashley)

Corbett Administration Doubles Staffing for Health PA Enrollment. On December 04, 2014, the *Patriot-News* reported that the Corbett Administration doubled their call center staff for Healthy PA enrollment to accommodate the high volume of calls. During the first three days of enrollment, 55 staff members were receiving calls; on Thursday that number rose to 130. While capacity issues have arisen at the call center, according to the state, the online enrollment process has been working well. During the first two days of enrollment the state received 11,500 applications. Read more

Rhode Island

HMA Roundup – Rob Buchanan (Email Rob)

Governor-Elect Raimondo Nominates Elizabeth Roberts for EOHHS Secretary. On December 7, 2014, the *Providence Journal* reported that Governor-elect Gina Raimondo announced that she will nominate two-term Lt. Governor Elizabeth H. Roberts as Secretary of the Executive Office of Health and Human Services (EOHHS). Roberts is a former state senator and the state's first female lieutenant governor. She is also Chair of the state's Healthcare Reform Commission. If confirmed by the Senate in January, Robert will succeed Steven M. Constantino, who has served as EOHHS Secretary since 2011 under Governor Chafee. Read more

Tennessee

Governor Haslam to Reveal Decision on Medicaid Expansion by End of December. On December 5, 2014, the *AP/Leaf-Chronicle* reported that Governor Bill Haslam plans to announce his decision on whether to move forward with Medicaid expansion by the end of the month. The Governor was heavily criticized for refusing Medicaid expansion last year, which would have brought in $1.4 billion in federal dollars to cover about 180,000 uninsured residents. Haslam recently met with HHS Secretary Burwell; he aims to get federal officials to approve an alternative expansion plan in order to gain the approval of Tennessee lawmakers who oppose ACA expansion. Nine Republican governors have already expanded Medicaid, and three more are currently in discussions with federal officials. Read more

National

MACPAC Holds Next Public Meeting on December 11-12. On Thursday, December 11 and Friday, December 12, 2014, the Medicaid and CHIP Payment and Access Commission (MACPAC) will hold its next public meeting at the National Guard Association of the United States, One Massachusetts Avenue NW, Washington DC. The Commission will resume its examination of the future of the State Children's Health Insurance Program (CHIP) in preparation for its March 2015 report to Congress. Commissioners will also discuss the expanding connection between Medicaid and the private insurance market as they review a draft March chapter on premium assistance programs. The Commission will

also discuss policy options to improve access and reduce cost of care for Medicare and Medicaid beneficiaries. Click here for the full agenda and meeting information.

HHS Awards $36.3 Million in ACA Funding to Reward Quality and Expand Improvement in Health Centers. On December 9, 2014, the US Department of Health and Human Services announced $36.3 million in ACA funding to 1,113 health centers in all 50 states, the District of Columbia, and seven US Territories to recognize health center quality improvement achievements and invest in ongoing quality improvement activities. The facilities receiving the awards demonstrated a proven record in clinical quality improvement through chronic disease management, preventive care and the use of Electronic Health records to report quality data. Click here for the full list of 2015 Quality Improvement Awards recipients.

DHHS Report Finds Many Providers Listed in Medicaid Provider Networks Are Unavailable to Treat New Patients. On December 9, 2014, the *New York Times* reported that many doctors who are listed as available to treat Medicaid enrollees are in fact not able to treat these individuals. According to a study by the inspector general of the Department of Health and Human Services, half of providers who are listed in enrollees' networks could not offer appointments to new Medicaid patients, either because they were not accepting new Medicaid patients or because they could not be found at their last known address. Other providers reported that they did not participate in the Medicaid health plan with which they were supposedly affiliated. These findings suggest that the actual size of provider networks for new Medicaid enrollees may not be adequate. Read more ***HMA's Weekly Roundup covered the OIG's commentary Medicaid Managed Care access standards on October 29, 2014. Link to Roundup***

Study Finds Nearly 9 Percent of Medicaid Births are Elective Early Deliveries. On December 8, 2014, *Kaiser Health News* reported that nearly 9 percent of births covered by Medicaid (or about 160,000 each year) were elective deliveries before 39 weeks of gestation. A study by AcademyHealth looked at early elective delivery rate for 22 states using data from 2010 to 2012 and found that the average rate of early elective delivery rate was 8.9 percent. The results are concerning because babies born earlier than 39 weeks have higher mortality rates than babies born at 39 weeks or later, and they are more likely to have feeding, breathing and developmental problems. Furthermore, women who induce labor are twice as likely to need a cesarean section, which carries many surgical risks. The AcademyHealth study is the first large-scale study specifically looking at Medicaid births. Read more

Health Care Needs of Newly Insured Challenge Primary Care Workforce. On December 7, 2014, *AP/Yahoo News* reported that the 6.7 million Americans who have gained health care coverage through the Affordable Care Act are overwhelming primary care provider networks in some areas of the country. A survey this year by the Physicians Foundation found that 81 percent of doctors describe themselves as either over-extended or at full capacity, and 44 percent said they planned to cut back on the number of patients they see, retire, work part-time or close their practice to new patients. Concurrently, insurance companies are limiting the number of doctors in their provider networks as a means of cutting costs. While many patients are able to access care, often for the first time, many are reporting difficulty finding doctors who are in their health plan network and willing to take on new patients. Read more

ACA Co-Ops Lower Premiums for 2015, Stirring Competition. On December 6, 2014, *Kaiser Health News/USA Today* reported that many health insurance co-ops are offering relatively low premiums in 2015, making them strong competition for well-established commercial insurance plans that traditionally dominate the insurance market. At least half a dozen co-ops created through the ACA have lowered 2015 premiums in an attempt to boost membership in their second year of operation. Last year, the ACA created about two dozen co-ops, which received $1.9 billion in federal loans to start up. In 2015, co-ops will be offering the lowest-cost silver plans in all or large parts of Arizona, Connecticut, Colorado, Idaho, Illinois, Maine, Maryland, New Mexico and New Jersey. Read more

Future of CHIP is Uncertain as Congress Mulls on Decision to Continue Funding. On December 4, 2014, *Stateline* reported that the likelihood of future funding for the Children's Health Insurance Program (CHIP) is uncertain as Congress' lame-duck session comes to a close. Funding for CHIP is set to expire on September 30, 2015; lawmakers are trying to determine whether the subsidized health plans offered on the state and federal insurance exchanges are an adequate alternative to CHIP. States, advocates and the Medicaid and CHIP Payment Access Commission (MACPAC) are asking Congress to renew funding for two to four more years of CHIP. If Congress chooses to stop funding, states are not likely to pay for it on their own. About 4 million of the 8 million children currently enrolled in CHIP would be at risk of losing CHIP coverage in the first year if Congress fails to renew funding. Read more

INDUSTRY NEWS

Blue Shield of California Enters Medi-Cal Market Through Acquisition of Care1st. On December 9, 2014, the *Los Angeles Times* reported that Blue Shield of California has agreed to acquire Care1st, a health plan that serves as a subcontractor to L.A. Care Health Plan and covers over 500,000 patients enrolled in Medi-Cal. The deal would give Blue Shield 473,000 people in Medicaid managed care plans and 46,000 Medicare patients, mostly in Los Angeles and San Diego counties. This marks the first time the Blue Shield has participated in Medi-Cal. Neither Care1st nor Blue Shield has disclosed the acquisition price or other terms of the deal. Howard Kahn, chief executive of L.A. Care, says the company will review the Blue Shield deal over the next few months before signing off on it. Read more

ACA's Expanded Coverage of Addiction Treatment Services Increases Demand for Assets by Private Equity Firms. On December 8, 2014 *Reuters* reported that private equity firms and healthcare companies are putting more money into the operators of U.S. rehabilitation centers as an increasing number of Americans get health care coverage for addiction treatment. The increased utilization in addiction treatment services is largely the result of the ACA requirement that health plans cover substance abuse and mental health disorders (along with nine other "core health benefit areas"). Experts say the market for addiction services has increased from $21 billion in 2003 to $35 billion a year now, driving up the value and demand for related assets. Read more

Molina Healthcare Awarded Contract to Administer Puerto Rico's Medicaid Program. On December 8, 2014, Molina Healthcare, Inc., announced that its wholly owned subsidiary, Molina Healthcare of Puerto Rico, Inc., has executed a contract with the Puerto Rico Health Insurance Administration (ASES by its Spanish acronym) to operate the Commonwealth's Medicaid-funded Government Health Plan (GHP) program in the East and Southwest regions. Molina Healthcare of Puerto Rico's total expected enrollment in the two regions is approximately 350,000 members. The GHP program will integrate physical and behavioral health care services under a single managed care organization in each region. The program is scheduled to begin in April 2015. Read more

CareCore and MedSolutions Complete Merger Agreement. On December 4, 2014, CareCore National, LLC, and MedSolutions, Inc., announced the completion of a merger that will help advance the companies' collective commitment to containing healthcare costs and achieving quality medical outcomes. CareCore and MedSolutions are leading providers of Specialty Benefits Management (SBM) services to managed care organizations and risk-bearing provider organizations. The merger allows the companies to jointly develop a broader range of solutions and to invest even more heavily in the information and analytics technologies they have each been developing. The

merged company is continuing to operate under both the CareCore and MedSolutions brands for the time being. Read more

LHC Group Names Dionne E. Viator Executive VP, CFO and Treasurer. On December 4, 2014, home health, hospice and post-acute healthcare services provider LHC Group, Inc., announced it has selected Dionne E. Viator as its Executive Vice President, Chief Financial Officer and Treasurer, effective February 1, 2015. Mrs. Viator has spent the last 21 years at the General Health System, a $500 million net patient revenue healthcare system with 527 licensed beds. Viator was responsible for developing the General Health System's accountable care strategy and infrastructure and positioning the organization for payment reform. Viator will succeed Jeffrey M. Kreger, who will become the company's Senior Vice President of Finance. 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:

"Public Health Departments in the Era of Delivery System Reform" – **Replay Link**

"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**

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

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.