HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 17, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

The HMA Weekly Roundup will not publish for the next two weeks. We will resume weekly publication on Wednesday, January 7, 2015 with a preview of key Medicaid and legislative issues to watch for in our states in 2015. HMA and the Weekly Roundup team wish all our readers a happy and safe holiday season.

IN FOCUS

TENNESSEE GOVERNOR UNVEILS MEDICAID EXPANSION PROPOSAL

This week our *In Focus* section reviews Tennessee Governor Bill Haslam's alternative Medicaid expansion proposal unveiled on December 15, 2014. The proposal includes the option for premium assistance for individuals to purchase coverage through their employer, but also creates an alternative option through the existing TennCare Medicaid managed care program, providing health savings accounts and healthy behavior incentives to defray TennCare cost-sharing. Haslam's administration estimates that 200,000 residents between the ages of 21 and 64 would be eligible to enroll in one of these two options.

Healthy Incentives Plan – Medicaid MCO Health Savings Accounts

Under the *Healthy Incentives Plan*, a new component would be added to the existing TennCare Medicaid managed care program (organized under an 1115

Waiver). Individuals selecting this option would have a Healthy Incentives for Tennesseans (HIT) account, which are modeled after Health Reimbursement Accounts (HRAs), according to the Governor's proposal. According to *The Tennessean* (12/15/2014), members would be able to accumulate funds in their HIT account in three ways:

1. Participation in disease management programs and utilization of more preventive services.
2. Utilization of emergency room services only when medically necessary.
3. Filling out detailed health assessments with medical history and other health information.

The HIT account will be used to pay for TennCare copays for individuals with incomes below 100 percent FPL, while those with incomes between 100 and 138 percent FPL will be required to pay a monthly premium in addition to copay requirements. Premiums would be paid for by a combination of HIT funds and other income if necessary to cover the monthly required amount.

If all eligible individuals selected the *Healthy Incentives Plan* option, TennCare enrollment could increase 15 to 20 percent. United, Blue Cross Blue Shield of Tennessee, and Amerigroup (Anthem) are the three MCOs serving the TennCare program. The Insure Tennessee proposal does not appear to open the program up to new MCOs at this time.

Volunteer Plan – Employer-Sponsored Insurance Vouchers

In a similar design to one coverage option under Utah's *Healthy Utah* proposal unveiled last week, uninsured individuals in Tennessee with access to affordable health insurance through their employer would be eligible to receive a voucher through the *Volunteer Plan* to cover out-of-pocket costs associated with employer-sponsored coverage, including premiums and cost-sharing. The Governor's proposal states that the voucher would be valued at "slightly less" than the average TennCare per-enrollee cost. In this past year's TennCare reprocurement, HMA estimated the average statewide per-member-per-month (PMPM) at around $370, based on FY 2012 data in the RFP data book.

The Governor's proposal does not provide an estimate of those potential enrollees likely to have access to employer-sponsored coverage. Additionally, a potential enrollee may choose between either the *Volunteer Plan* or the *Healthy Incentives Plan*, regardless of the availability of employer-sponsored coverage.

Next Steps and Timing

The *Insure Tennessee* proposal must be approved by the Tennessee General Assembly and receive formal approval from CMS, which could push implementation to late 2015 or 2016. The proposal indicates that *Insure Tennessee* would operate as a two-year pilot program.

Additionally, Governor Haslam has reached an agreement with Tennessee's hospital community to fund the state costs of *Insure Tennessee* as federal Medicaid matching funds shift from 100 percent to 90 percent in the coming years. This would likely be achieved through a provider assessment program. Insure Tennessee would be set up to automatically terminate if either funding support from the hospitals or from CMS is reduced during the life of the program.

HMA Medicaid Roundup

Alabama

Governor Bentley Suggests Support of Medicaid Expansion. On December 12, 2014, the *Montgomery Advisor* reported that Governor Robert Bentley expressed support for expanding the state's Medicaid program. The expansion, similar to a program launched in Arkansas, would use a block grant with employment requirements. A Kaiser Family Foundation study estimates that 191,000 Alabamians would be eligible for Medicaid under the expansion. Read more

Arizona

State Publishes Responses Received for Regional Behavioral Health Authority RFP. On December 11, 2014, the Arizona Department of Health Services published the responses it received for its Request for Proposal (RFP No. ADHS15-00004276) for Regional Behavioral Health Authorities for Greater Arizona. The Department received responses from Magellan Health Services, Health Choice Integrated Care, and UnitedHealthcare Integrated Services for coverage in the Northern Arizona service area, which includes Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties, and a small portion of Graham County. Magellan Health Services, Cenpatico of Arizona (Centene), and UnitedHealthcare Integration Services submitted responses to provide coverage in the Southern Arizona service area, which includes Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma Counties.

California

Covered California Extends Deadline to Sign Up for Health Insurance Coverage. On December 15, 2014, the *Los Angeles Times* reported that the Covered California exchange has extended its deadline for consumers to sign up for health insurance coverage beginning January 1. Consumers who have started the application process by December 15 (the original enrollment deadline) will now have until December 21 to complete the process. Covered California's Executive Director Peter Lee explained that the extension will give consumers time to seek guidance from enrollment counselors for selecting the best plan to suit their needs. Read more

Computer Glitch Diverts Some Exchange Consumers to Medi-Cal. On December 12, 2014, *U-T San Diego* reported that the Covered California exchange experienced a system glitch which diverted some applicants to Medi-Cal coverage even though they qualified to purchase a commercial policy on the exchange. The exchange's Communications Director Amy Palmer said that exchange officials would work to make sure that consumers who were

mistakenly categorized in Medi-Cal are able to use their commercial insurance plans on the first day of the new year. Palmer did not have an estimate of the number of consumers affected by the glitch. Read more

Audit Finds Many Kids in Denti-Cal Program Are Not Receiving Adequate Care. On December 11, 2014, the *San Francisco Chronicle* reported on a state audit of Denti-Cal, the state's dental program for low-income children. According to the audit, Denti-Cal serves fewer than half of its enrollees, often because providers will not take on new Denti-Cal patients. Providers argue that the state's reimbursement rates for Denti-Cal services are too low. These rates have not increased since 2000, and they were cut by 10 percent last year. The audit also found that access to care was dependent on geography, with worse access in rural counties. The audit criticized the State Department of Health Care Services for failing to "adequately monitor the program." Read more

Medi-Cal, Obamacare Experience Strong Initial Enrollment. On December 10, 2014, the *Los Angeles Times* reported that in the first three weeks of open enrollment, 48,950 signed up for an qualified health plan and an additional 160,000 signed up for Medi-Cal, the state's Medicaid program. The state currently has 1.2 million people enrolled in ACA, with a goal of adding 500,000 enrollees by February 15. Details concerning renewals and healthcare plan changes will be released next month. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Audit Finds Connect for Health Colorado Exchange Lacks Adequate Financial Controls. On December 8, 2014, the *Denver Post* reported that a state audit of the Connect for Health Colorado finds that the exchange lacks adequate financial controls. The audit focused on the exchange finances for FY 2012-2014; it cites that the exchange allowed nearly $489,000 in "unallowable or unreasonable" payments to vendors and service providers. The audit also identified nearly $32 million in contract irregularities, including 13 contracts for more than $150,000 that were not approved by the exchange board. Exchange officials said they would implement the audit's recommendations for new policies and financial controls. Read more

Delaware

State Releases RFP for a Data System for Aging and Disability Services. On December 16, 2014, the Delaware Department of Health and Social Services, Division of Management Services released an RFP (RFP No. HSS-14-060) for the Data System for Aging and Disability Services. The state seeks a vendor to provide software to maintain, track, and report on client data in aging and disability-related programs, as well as provide an integrated service database for a public-facing Aging and Disability Resource Center website. Proposals are due by February 11, 2015.

District of Columbia

Technology Glitches on D.C. Health Link Exchange Delay Enrollment for Hundreds of Consumers. On December 16, 2014, the *Washington Post* reported that technology glitches on the D.C. Health Link health insurance exchange delayed up to 500 consumers trying to sign up for coverage. While over 2,600 consumers successfully completed enrollment by the December 15 deadline, some consumers reported completing the application process only to receive an error message at the end. Others were not even able to start the enrollment process. Exchange Director Mila Kofman said that exchange employees will spend the next several days contacting each delayed applicant to ensure they complete enrollment successfully. Read more

Florida

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

Sam Verghese Appointed As Head of Department of Elder Affairs. On December 11, 2014, Governor Rick Scott appointed Sam Verghese as the Secretary of the Department of Elder Affairs. Verghese served as External Affairs Director for the Governor's office in 2014. Prior to that, he served as chief of staff for the Florida Department of Business and Professional Regulation and as staff director for the Majority Office of the Florida House of Representatives. Read more

Georgia

HMA Roundup – Mark Trail (Email Mark)

Georgia Releases RFQC List. On December 15, 2014, the Georgia Department of Community Health (DCH) released a list of qualified suppliers for its Georgia Families Care Management Organization RFQC. DCH sought to identify qualified contractors interested in providing Medicaid risk-based managed care services as a care management organization. The qualified contractors are:

- Amerigroup Georgia
- AmeriHealth
- CareSource Georgia
- Gateway
- Humana
- Molina
- Peachstate (Centene)
- United Healthcare
- WellCare

The selected plans are now eligible to participate in future contracts issued by DCH. Read more

Department of Community Health Holds Monthly Board Meeting. On December 11, 2014, the Georgia Department of Community Health held its monthly Board meeting. Commissioner Reese reported on the following:

- The RFP to re-procure the care management organizations will be released by December 29, 2014. The RFQC responses are currently under evaluation, and those deemed successful will be the only care management organizations eligible to bid on the RFP. Winners should be announced by June 2015.

- DCH has decided that a separate procurement for a Credentials Verification Organization (CVO) will not be done. Instead, the Department will amend its contract with HP to include the CVO function, which HP may enact through a subcontract.
- Commissioner Reese himself will assume the role of Interim Medicaid Director as DCH performs a national search to replace former director Jerry Dubberly.

A summary of the Board meeting and accompanying documents can be found on the DCH website. The next Board meeting will be January 8, 2015.

Idaho

Medicaid Expansion Plan Would Cover 100,000 Low-Income Idahoans. On December 15, 2014, *KTVB* reported on a Medicaid expansion proposal that would extend coverage to 100,000 low-income Idahoans. The program is being proposed by the Governor's Medicaid Redesign Work Group; it would be paid for using a mix of federal and state dollars and would save the state an estimated $173 million over 10 years. Under the program, those making less than 100 percent of the federal poverty limit (FPL) will be eligible for Healthy Idaho, the state's Medicaid program. Those earning between 100 and 138 percent FPL will be able to get subsidies to purchase plans on the state's exchange. Read more

Illinois

Family Health Network Takes Legal Action to Stop Medicaid Sanctions. On December 11, 2014, *Crain's* reported that Family Health Network (FHN) is seeking a temporary restraining order against the Illinois Department of Healthcare and Family Services (HFS). FHN is seeking this court order since the state suspended automatic enrollment for FHN and Harmony Health Plan (WellCare) consistently low HEDIS scores. FHN alleges that its low scores on quality measures are not due to low-quality care, but rather because of incomplete data from doctors filing claims through an antiquated data system, which has since been overhauled. FHN claims it could lose up to 40,000 patients if the state does not remove its sanctions. Read more

Indiana

FSSA Holds Webinar on Hoosier Health Connect. On December 10, 2014, the Indiana Department of Family and Social Services Administration (FSSA) held a webinar to review the Hoosier Care Connect program and its implementation timeline. FSSA provided an overview of the program and outlined the selection process for the managed care entities (MCEs) selected to run the program. Three MCEs – Anthem, MDwise, and Managed Health Services (Centene) – were selected. The Department also outlined the Care Coordination, Care Management and Disease Management responsibilities for which the MCEs will be held accountable. Finally, the Department laid out the timeline for transitioning enrollees to an MCE. Click here to listen to a recording of the full webinar.

Kansas

Kansans With Disabilities Concerned About Proposed KanCare Changes. On December 15, 2014, the *Kansas Health Institute* reported that the state is proposing changes to some Medicaid programs that would change services for Kansans who are disabled, frail, or elderly. Services for this population are currently covered by KanCare, the state's privatized Medicaid program which is managed by three managed care companies. Groups that advocate for Kansans with disabilities argue that the proposed changes were designed without the input of stakeholders or advocacy groups. Advocates allege that the proposed changes will cut services for this population. Read more

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Medicaid Insurers Report Steep Financial Losses. On December 12, 2014, the *Boston Business Journal* reported managed care providers in the state are reporting hundreds of millions of dollars in losses this year. The managed care plans – including Neighborhood Health Plan, BMS HealthNet Plan, Tufts Health Plan, Fallon Health, and Health New England – have cited several reasons for these losses, including a lack of paying membership due to sign-up problems on the Health Connector website, the cost of the expensive hepatitis C drug, Sovaldi, and the high cost of treating the relatively sick population of new Medicaid enrollees. Read more

Boston Medical Center and Tufts Medical Center Considering a Merger. On December 11, 2014, the *Boston Globe* reported that Boston Medical Center (BMC) and Tufts confirmed that the two non-profit hospitals are in talks about a merger. The two centers, only a mile apart, have many issues to consider as they consider consolidation. BMC is the busiest trauma and emergency department in New England and Tufts performs many complex procedures. As of the first nine months this year, Tufts reported a deficit of $4.9 million while BMC generated a surplus of $4.9 million. Read more

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Health Michigan Plan Surpasses Total Enrollment Projection in Just Eight Months. On December 11, 2014, the Michigan Department of Community Health (DCH) announced that the Healthy Michigan Plan has surpassed its original two-year and total eligibility projection this week, reaching 481,863 enrollees. The Healthy Michigan Plan launched on April 1, 2014; DCH originally estimated that 477,000 people would enroll in the first two years of the program. There are already signs of enrollees taking charge of their health and wellbeing, as they have had 351,000 primary and preventive care visits in the first eight months of the program. DCH provides Healthy Michigan Plan enrollment by county on its website along with a progress report that provides demographic statistics.

Minnesota

State Delays Deadline to Sign Up for Health Insurance Coverage. On December 15, 2014, *The Hill* reported that officials from the MNsure marketplace have pushed back the deadline to sign up for healthcare coverage to December 20. The original deadline was December 15. MNsure officials explained that the delay was in response to requests from insurance companies, and not due to any technical issues with the marketplace. Minnesota is the second state to delay the deadline; New York pushed back its enrollment deadline last week. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Intensive Coordinated Care Model is Improving Health Outcomes Under Medicaid Managed Care. On December 15, 2014, the *NJ Spotlight* reported on efforts by UnitedHealthcare Community Plan, a Medicaid MCO in New Jersey, to improve the health of its most complex members in collaboration with the Camden Coalition of Healthcare Providers. The model relies on in-person care coordination to ensure members keep medical appointments and take their medications, compared to the standard telephone-based approach. The model has led to reductions in the number of patient readmissions and in number of emergency department visits. UnitedHealthcare is the second largest Medicaid MCO in New Jersey with over 460,000 members statewide. Read more

New York

HMA Roundup – Denise Soffel

New York State of Health Marketplace Enrollment. On December 12, 2014, the New York State of Health (NYSOH) announced that more than 154,562 people have newly enrolled through the Marketplace since the state's second open enrollment period began on November 15. This does not include people who were enrolled through the Marketplace in 2014 and are now in the process of renewing their coverage for next year. About two-thirds of the newly enrolled are eligible for Medicaid. The Department of Health also announced an extension of the December 15 deadline to apply for or renew coverage that takes effect January 1; the new deadline is December 20. The extension gives consumers more time to enroll, in light of November's extreme winter weather. Open enrollment ends February 15. Read more

Robert Hayes Moves to Community Healthcare Network. On December 11, 2014, Community Healthcare Network announced that Robert M. Hayes will join the organization as the new President and CEO. Hayes has spent the past five years at Universal American Corporation specializing in quality assurance for government-funded healthcare programs, including Medicare and Medicaid. Prior to that, Mr. Hayes served as President and General Counsel at the Medicare Rights Center. Community Healthcare Network is a not-for-profit organization providing access to affordable, culturally-competent, and comprehensive community-based primary care, dental, nutrition, mental health and social services for diverse populations in underserved communities throughout New York City. Read more

MMCARP Provides Updates on Medicaid Managed Care, FIDA. On December 11, 2014, the Medicaid Managed Care Advisory Review Panel (MMCARP) held a conference call to provide an update on Medicaid Managed Care (MMC) and related programs. Regarding MMC programs, MMCARP covered the following:

- HealthNow is not currently withdrawing from MMC, but all new enrollments are still frozen per DOH instruction. HealthNow had previously released a letter saying it was pulling out of MMC; DoH staff did not know the insurer's future plans.
- The nursing home transition is still set for January 1, 2015. The Behavioral Health transition is still set for April 1, 2015, despite the fact that CMS has not yet approved the Behavioral Health 1115 Amendment.
- Family Health Plus ends on December 31, 2014 as all enrollees will have been transitioned into Medicaid or a subsidized plan through the health exchange. Those who are still enrolled in the program (about 13,000 individuals) were sent notices telling them they need to choose a new plan on the exchange. Those who need help transferring to another plan are being offered help.

MMCARP also provided updates on the state's Fully-Integrated Duals Advantage (FIDA) program. Since September, 22 plans have executed contracts with CMS and DOH and have completed the readiness-review process. DOH has sent letters regarding eligibility to enrollees in Region 1, which includes the five boroughs of New York City and Nassau County. Opt-in enrollment in Region 1 begins on January 1, and passive enrollment begins on April 1. In Region 2 (which includes Suffolk and Westchester Counties), opt-in enrollment begins on April 1 and passive enrollment begins July 1. Individuals can dis-enroll from the FIDA program at any time. The earliest FIDA passive enrollment for nursing homes will begin in August 2015.

Virginia

McAuliffe to Include Medicaid Expansion in Budget. On December 13, 2014, *AP/Washington Post* reported that Governor Terry McAuliffe will include a Medicaid expansion proposal in the next two-year budget proposal, which he will reveal this week. Two state officials report that the plan will expand eligibility to about 400,000 low-income adults in the state, beginning in 2016. The GOP-controlled Legislature has previously rejected McAuliffe's efforts to expand Medicaid. Read more

Wyoming

Legislative Committee Recommends One Medicaid Expansion Proposal, Rejects Another. On December 16, 2014, the *Wyoming Public Media* reported that a state legislative committee has rejected the Wyoming Department of Health's proposed Medicaid expansion plan in favor of a bill crafted by the committee. The panel sought to determine whether it should recommend one, both, or neither of the proposals to be considered by the full Legislature in the 2015 session. The endorsed plan would provide 17,600 low-income residents with a Medicaid-funded health savings account they could use to purchase private insurance. Read more

National

Nearly 2.5 Million Consumers Select Health Plans on HealthCare.gov. On December 17, 2014, *Kaiser Health News* reported that over 2.5 million Americans have selected a health plan since the second open enrollment period began on November 15. Just over half of those who selected coverage are returning customers. CMS chief deputy administrator Andy Slavitt and HealthCare.gov CEO Kevin Counihan reported that federal officials have begun to automatically re-enroll 2014 customers who have not selected a new plan for 2015. Enrollment in states running their own exchanges is not yet available. Read more

Ratings Agencies Give Negative Outlook to Health Care and Hospital Sector. On December 16, 2014, *Reuters* reported that three major credit rating agencies gave the health care and hospital sector a negative outlook next year due to declining operating cash flows and continued uncertainties regarding implementation of the ACA. S&P, Moody's Investors Service, and Fitch Ratings explained that many hospitals have exhausted numerous opportunities for cost-cutting, and that the rising emphasis of preventive care and lowering utilization of healthcare services has affected hospitals' bottom line. Fitch Ratings also cited the shift to Republican control in Congress, which could cause parts of the ACA to be defunded or repealed, thus leading to more uncertainty about the healthcare and hospital sector. Read more

CMS Announces Model Design Awardees in State Innovation Models (SIM) Initiative. On December 16, 2014, CMS announced the State Innovation Models (SIM) Initiative Model Design Awards, which will provide financial and technical support to awardees for planning and designing their State Health Care Innovation Plans (SHCIPs). Applicants were required to develop multi-year payment and service delivery models and engage a broad range of stakeholders in order to develop their SHCIPs. CMS awarded nearly $43 million in Model Design awards to 21 awardees, including 17 states, three territories, and the District of Columbia. HMA assisted several states in the proposal process. Awardees will have twelve months to submit their SHCIPs to CMS. Read more

Small Businesses Dropping Group Health Plan Coverage. On December 15, 2014, *Kaiser Health News* reported that some small business owners have stopped offering a group health plan to their employees now that the ACA offers subsidies for workers to buy their own coverage through the health insurance marketplace. With this option, business owners do not have to pay premiums, meaning they can invest their money into higher wages or better equipment. Although the benefit of using subsidized marketplace plans to cover employees versus using group health plans is unclear, brokers expect more firms to drop their health plans in the next few years. Read more

ACA Provision Helps Blue Cross and Blue Shield. On December 11, 2014, the *Wall Street Journal* reported on a piece of the Affordable Care Act legislation that helps Blue Cross and Blue Shield qualify for tax breaks on their expenses and reserves. The law dictates that the insurer must spend at least 85 percent of its revenue from insurance premiums on medical claims to continue to qualify for the tax breaks. However, the ACA also includes a provision that allows Blue Cross and Blue Shield to count spending on improving healthcare quality towards the 85 percent threshold. Read more

Doctors Facing Steep Fee Cut as Temporary Medicaid Program Set to Expire. On December 10, 2014, the *Washington Post* reported that primary care doctors will face a steep fee cut, an estimated nationwide average of 40 percent, starting January 1 when a two year temporary Medicaid law is set to expire. The health law increased Medicaid fees for primary care doctors in order to encourage them to take on new Medicaid patients. It is unlikely the federal government will agree to continue paying the full Medicaid fee, forcing states to budget for the higher Medicaid fee. Fifteen states have committed to paying the fee while 12 other states are undecided. Read more

Industry News

WellCare Names Kenneth A. Burdick CEO and Board Member. On December 15, 2014, WellCare Health Plans, Inc. announced the appointment of Kenneth A. Burdick as the company's next president and Chief Executive Officer, effective January 1. Burdick will also now serve on the company's Board. Burdick joined WellCare in January 2014 as President, National Health Plans, before being promoted to President and Chief Operating Officer in June. Prior to joining WellCare, Burdick was CEO of Blue Cross and Blue Shield of Minnesota. Before that, he was CEO of the Medicaid Division of Coventry Health Care. He will replace David Gallitano, who has served as interim CEO since November 2013. Read more

Addus HomeCare Names Maxine Hochhauser COO. On December 15, 2014, Addus HomeCare Corporation announced the appointment of Maxine Hochhauser as Chief Operating Officer. Hochhauser has nearly 30 years of experience in home health and home care operations. She joins Addus from Amedisys, Inc., where she was Senior Vice President, Enterprise Operations. Read more

Amedisys Names Paul B. Kusserow as Next CEO. On December 16, 2014, home health and hospice company Amedisys, Inc. announced that its Board of Directors has named Paul B. Kusserow as President and Chief Executive Officer and member of the Board of Directors, effective December 16, 2014. Kusserow was most recently Vice Chairman of Alignment Healthcare, Inc., an integrated clinical care company focused on providing care to the Medicare population. Before that, he held senior positions at Humana Inc., Ziegler HealthVest Fund, and San Ysidro Capital Partners. Kusserow will succeed President and Interim CEO Ronald LaBorde, who will remain a member of senior management in the role of Vice Chairman. Read more

Trinity Health Announces Three-Hospital System Acquisition in Connecticut. On December 17, 2014, Trinity Health announced the acquisition of the three-hospital St. Francis Care health system, as reported by *Modern Healthcare*. Under the deal, Trinity will invest $275 million over the next five years into St. Francis, which includes St. Francis Hospital, Johnson Memorial Hospital, and Mount Sinai Rehabilitation Hospital. The deal is expected to close in late 2015. Read more

Tenet Healthcare Withdraws Hospital Acquisition Application in Connecticut. On December 11, 2014, Tenet Healthcare announced that it will withdraw its applications to acquire Waterbury Hospital, Saint Mary's Hospital, Bristol Hospital, and Eastern Connecticut Health Network. Tenet declared the acquisition is not beneficial to stakeholders, explaining that the state's approach to oversight would inhibit Tenet from operating the hospitals successfully. Read more

Centene Announces 2015 Guidance. On December 12, 2014, Centene announced its 2015 guidance and confirmed its 2014 guidance. Centene expects premiums and service revenues to increase from $20.3 billion to $20.8 billion, a 3.2 percent growth compared to 2014 guidance. Earnings per diluted share are expected to be $5.05 to $5.35, a 17 percent growth compared to 2014 guidance. Full year 2014 earnings will be announced on February 3, 2015. Read more

Express Scripts Initiates CFO Transition Process. On December 15, 2014, Express Scripts announced that it is initiating a Chief Financial Officer transition process. Cathy R. Smith will be leaving the company and no longer serves as executive vice president and CFO; however, she will continue her employment into Q1 2015 in order to facilitate a smooth transition. The company also announced that James M. Havel has been appointed to serve as Executive Vice President and Interim Chief Financial Officer, effective January 2, 2015. Havel joins Express Scripts from Major Brands Holdings, a beverage distribution company, where he has served as CFO since 2012. Read more

Centene Opens Service Center in Tucson. On December 11, 2014, Centene announced that it opened a new service center in Tucson, AZ. The facility will be a call center for Centene's Arizona-based Bridgeway Health Solutions, as well as Centene's other national health plans. Centene currently employs 40 people at this center and plans to grow to more than 100 people by the end of next year. Read more

RFP Calendar

Date	State	Event	Beneficiaries
December 19, 2014	Missouri	Proposals Due	398,000
December 29, 2014	Georgia	RFP Release	1,300,000
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
Early 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Early 2015	Louisiana MLTSS - DD	RFP Release	15,000
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
June, 2015	Georgia	Contract Awards	1,300,000
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
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Georgia	Implementation	1,300,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
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
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	
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
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
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	
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)
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
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	
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.*

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the four states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
California	3,445	15,322	17,846	39,731	42,473	44,804	48,976	51,527	58,945
Illinois	106	444	2,281	5,552	7,963	8,064	8,632	12,651	
Massachusetts	13,191	13,274	13,409	18,836	18,067	17,739	17,465	18,104	
Virginia				11,169	11,983	21,958	28,642	29,648	27,701
Total	**16,742**	**29,040**	**33,536**	**75,288**	**80,486**	**92,565**	**103,715**	**111,930**	**N/A**

Source: State enrollment reporting compiled by HMA

HMA News

Bloomberg Briefing on Supreme Court's Consideration of ACA Subsidies Features HMA's Greg Nersessian

Link to Replay of Briefing

Bloomberg Intelligence held a web briefing to discuss the ACA tax credit Supreme Court case and potential workarounds. The Supreme Court is considering whether the federal government has the right to give tax credits to buy health insurance under the Affordable Care Act in 35 states. Bloomberg Intelligence Healthcare analyst Jason McGorman and Litigation analyst Aude Gerspacher along with guest speakers Michael S. Kolber and Greg Nersessian examine the ramifications of the upcoming ruling. The speakers discuss and analyze:

- How the Supreme Court Justices may view the language issue in the case;
- What type of workarounds may exist if the Court strikes down tax credits;
- How states may work to compromise given Republican majorities; and
- Which companies are most exposed.

HMA Webinar Replays Available:

- ***"The Republican Midtern Victory and the Potential Impact on Health Care Reform"*** **– Replay Link**
- ***"Public Health Departments in the Era of Delivery System Reform"*** **– Replay Link**

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