HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 28, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

REVIEWING OREGON'S MEDICAID MANAGED CARE PROGRAM

This week, our *In Focus* section reviews Oregon's Medicaid managed care environment which has been administered by risk-based provider networks, known as Coordinated Care Organizations (CCOs) since 2012. As of December 15, 2014, more than 907,000 Medicaid beneficiaries were enrolled in a CCO. On

Monday, January 26, 2015, Centene Corporation announced an agreement to acquire Agate Resources, Inc., a health insurer based in Oregon that operates one of the 16 CCOs under its subsidiary, Trillium Community Health Plan. In light of that announcement, and since we haven't written much on Oregon recently, we review the structure and current status of the CCO market in Oregon.

Background of CCO Program

In July 2012, the Oregon Health Authority received approval from the Centers for Medicare and Medicaid Services (CMS) to establish CCOs under Section 1115 waiver authority to replace the existing Medicaid managed care program. At that time, most Medicaid beneficiaries were mandatorily enrolled in fully-capitated managed care organizations (MCOs) under the Oregon Health Plan Plus program. Under the new CCO delivery systems, MCOs were replaced by risk-based, locally governed provider networks responsible for integrating benefits such as behavioral, dental, and transportation services that were previously carved-out from the MCO capitation structure. Under the 1115 waiver, the Oregon Health Authority agreed to reduce the per capita trend in medical expenditures by 2 percentage points by the end of the second year of the waiver.

The state released a Request for Applications (RFA) in March 2012, with applications due in May 2012. Prospective CCOs were approved for selected service areas and began serving clients August 1, 2012, with all 16 CCOs operational by November of that year. CCO contracts must be renewed on an annual basis, and all contracts must be rebid under a new RFA after six years. We anticipate that the CCO rebid RFA would be released in early 2018.

CCO Market – Enrollment and Financial Overview

There are 16 CCOs currently operating under contract with the Oregon Health Authority; two are owned by PacificSource, a regional, multistate health plan. The table below details recent CCO enrollment and market share data as well as average 2015 per-member-per-month capitation rates for illustrative purposes. Four CCOs – Health Share of Oregon, FamilyCare CCO, Willamette Valley Community Health, and Trillium Community Health Plan – account for roughly 60 percent of the market with the other 10 CCOs covering the remaining 40 percent. Depending on location, CCO eligible enrollees may only have one CCO serving their geography or may have a choice among multiple CCO options.

CCO	Service Area	Enrollment (Dec. 2014)	Market Share	2015 Avg. PMPM[1]	Change from 2014 Avg. PMPM
Allcare Health Plan, Inc.	All of Curry, Josephine, Jackson and part of Douglas counties	48,568	5.4%	$383.84 $422.78	-1.3% 0.1%
Cascade Health Alliance	Parts of Klamath County	17,002	1.9%	$372.93	3.1%
Columbia Pacific CCO	All of Clatsop, Columbia and Tillamook counties. Parts of Coos and Douglas counties	28,068	3.1%	$383.86 $418.84	2.1% 3.1%
Eastern Oregon CCO *(partially owned by Moda Health)*	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler	44,801	4.9%	$361.67	6.4%
FamilyCare CCO	Clackamas, Multnomah, Washington, and part of Marion County	114,893	12.7%	$328.98	2.0%
Health Share of Oregon	Clackamas, Multnomah and Washington Counties	233,802	25.8%	$368.98	4.1%
Intercommunity Health Network	All of Benton, Lincoln and Linn Counties	55,498	6.1%	$386.62 $409.36	0.7% 2.1%
Jackson Care Connect	Jackson County	30,022	3.3%	$373.07	-1.7%

CCO	Service Area	Enrollment (Dec. 2014)	Market Share	2015 Avg. PMPM[1]	Change from 2014 Avg. PMPM
PacificSource Community Solutions - Central OR	All of Deschutes, Crook and Jefferson and part of Klamath County	50,876	5.6%	$374.57 $550.91	3.7% 5.7%
PacificSource Community Solutions - Columbia Gorge	Hood River and Wasco Counties	12,244	1.3%	$366.50	7.6%
PrimaryHealth Josephine Co.	Josephine County and parts Douglas and Jackson Counties	11,054	1.2%	$386.53	2.9%
Trillium Community Health Plan *(pending acqusition by Centene)*	All of Lane County	89,237	9.8%	$390.02	-3.2%
Umpqua Health Alliance	Most of Douglas County	25,195	2.8%	$417.15	1.7%
Western Oregon Advanced Health	All of Coos and Curry County	20,606	2.3%	$435.23	3.3%
Wilamette Valley Community Health	Marion County and most of Polk County	101,726	11.2%	$304.83	1.2%
Yamhill Comm Care	Yamhill County, parts of Marion, Clackamas and Polk Counties	23,950	2.6%	$312.73	2.1%
Total CCO Enrollment		**907,542**			

[1] Stated 2015 Avg. PMPM rates are a blended average based on historical case-mix for the CCO-A benefit (includes physical, mental health, and dental), which accounts for more than 75% of all CCO enrollments. For illustrative purposes only.

For more information on the CCO program:
http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx

HMA Medicaid Roundup

Arkansas

Arkansas Pushes to Continue Private Option Medicaid Expansion Through 2016. On January 22, 2015, *Arkansas Business* reported that Governor Asa Hutchinson announced he will push for the continuation of Arkansas' Medicaid expansion waiver through 2016. The waiver allows the state to use federal Medicaid funds to purchase private insurance for the poor and cover 213,000 people. Hutchinson also proposed a task force to come up with recommendations for the future of health care and hopes to pursue Medicaid changes that will encourage participants to look for work and seek preventative care. The private option expansion has been beneficial for hospitals but the governor worries about state cost increases in 2017 and 2020 as written in the law. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Jennifer Kent Appointed Director of California Department of Health Care Services. Jennifer Kent, Executive Director of Local Health Plans of California and a former Principal of Health Management Associates was appointed Director of the California Department of Health Care Services.

Judge Orders Timely Determinations on Medicaid Eligibility and Temporary Coverage to Applicants. On January 23, 2015, *Kaiser Health News* reported that Judge M. Grillo ordered California to make timely determination on Medi-Cal applicants and to provide temporary coverage to those waiting 45 days or longer. Last year, California hit a backlog of 900,000 applicants leaving them without access to care. The lawsuit, filed by health advocates and legal services groups, cited one case in which a man died two months prior to receiving his approval for Medi-Cal. Read More

Narrow Networks at a Flash Point in California. With healthcare payers increasingly relying on narrow provider networks to contain costs and achieve quality, California regulators are pressing health plans to blunt out-of-network costs and maintain accurate provider directories. California insurance officials are drawing the line on health plans with narrow provider networks. Emergency regulations announced on January 5, 2015, by Insurance Commissioner Dave Jones "are meant to address the deficiencies in the market we have been seeing," says Janice Rocco, Deputy Commissioner for Health Policy and Reform at the State Department of Insurance. Read More

Judge orders Medi-Cal to meet 45-day eligibility deadline. With thousands of low-income Californians waiting for health care, a judge has ordered the state's Medi-Cal system to meet its 45-day legal deadline for determining eligibility and, if that is not possible, enroll applicants immediately if they are likely to be found eligible. The ruling Tuesday by Alameda County Superior Court Judge Evelio Grillo follows strenuous efforts by state officials to eliminate a huge backlog of applications for Medi-Cal, the government-funded health care program for the poor that was expanded last year as part of the new federal health care law. Read More

Department of Healthcare Services (DHCS) to Host Meeting to Discuss Drug Medi-Cal (DMC) Emergency Regulations. The proposed emergency regulations support California's Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver amendment that was submitted to CMS on November 21, 2014. The DMC-ODS Section 1115 waiver provides a continuum of care modeled after the American Society of Addiction Medicine criteria for substance use disorder treatment services. The waiver amendment makes improvements to the Drug Medi-Cal (DMC) service delivery system, adds more local control and accountability in selection of high quality providers, improves local coordination of case management services, implements evidenced based practices in substance abuse treatment, and increases coordination with other systems of care including physical health. The waiver amendment would also allow the state to extend the DMC Residential Treatment Service as an integral aspect of the continuum of care to additional beneficiaries by removing the 16-bed limit on Residential Treatment Service facilities.

The DMC-Organized Delivery System is a Medi-Cal benefit for residents in counties that choose to opt into the waiver; eight to 12 counties are expected to initially opt-in to waiver participation. Upon approval of an implementation plan and execution of a contract with the state, a participating county can subcontract with DMC certified providers, provide county-operated DMC-ODS services or contract with a managed care plan to provide services. With state approval, participating counties may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may also act jointly in order to deliver these services.

Standard DMC services approved under the State Plan will be available to all beneficiaries in all counties. Only beneficiaries that reside in a waiver county, however, will receive waiver benefits.

DMC Services	State Plan Benefit	Opt-In Waiver
Outpatient/Intensive Outpatient	X	X
Narcotic Treatment Programs (NTP)	X	X
Residential Services	Perinatal Only	X (one level)
Withdrawal Management		X (one level)
Additional Medication Assisted		X
Recovery Services		X
Case Management		X
Physician Consultation		X

Kaiser Health News: California Takes Different Path On Insuring Immigrants Living In U.S. Illegally. Kaiser Health News staff writer Anna Gorman reports: "The push to offer health insurance to all Californians regardless of immigration status is the latest in a series of immigrant-friendly state policies over the past few years. Already, immigrants here illegally can obtain licenses to practice medicine, law or other professions, and as of this month, they can apply for driver's licenses. There is no guarantee that other states will follow California's lead, but the size and demographic makeup of the state ensure it a prominent role in the national debate over coverage of people living in the country illegally." Read more

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Rick Scott Unveils 2015-2016 "Keep Florida Working Budget." On Wednesday, January 28, 2015, Governor Rick Scott released his "Keep Florida Working" recommended budget for FY 2015-16. The total budget is $77 billion of which $28.3 billion is the general revenue portion. The general revenue amount represents a $1.1 billion increase, or a 4 percent increase over the prior year. The increase is mostly attributable to increased sales tax collections and is an indication that Florida's economy continues to improve. Link to budget documents

The budget is focused on four main components:

- $673 million in tax cuts for Florida families and businesses
- The highest per-student K-12 funding in Florida history
- Making Florida a global destination for jobs
- Strengthening Florida's communities by enhancing workforce training, protecting the environment and keeping families and communities safe and healthy

Medicaid and KidCare highlights

- Fully funds Medicaid enrollment of 3.7 million based on the latest estimating conference.
- Fully funds KidCare enrollment of 244,000 based on the latest estimating conference.
- Continues $2.167 billion for the Low Income Pool program and authorizes the Agency to request additional trust fund budget authority during the state fiscal year in the event the federal government makes any adjustments in program funding.
- Saves $30.3 million through a Managed Care Quality-Based payment by tying a portion of MCO payments to performance based on reducing potentially preventable readmissions and complications in hospitals.
- Provides $8 million to enroll 400 individuals from the wait list into the Developmental Disabilities HCBS waiver.
- Provides $7.6 million for Graduate Medical Education rural primary care residency slots.

- Provides $500,000 for a consultant to develop an Outpatient prospective payment system using Ambulatory Patient Groups (APGs).
- Provides $500,000 for a consultant to develop a Nursing Home prospective payment system using Resource Utilization Groups (RUGs).
- Provides $3 million for Advanced Data Analytics and Detection Services to identify fraud, waste and abuse in the Medicaid Program.
- Saves $2.4 million and eliminates 52 FTEs for Management and Efficiencies due to implementation of Statewide Medicaid Managed Care (SMMC), streamlined processes and consolidated duties, and administrative efficiencies.
- Saves $1.1 million and eliminates 26 FTE as a result of the closure of two Medicaid field offices due to the restructuring of resources to support the implementation of the SMMC.

Other Issues

- Provides $15 million for Child Welfare Services.
- Provides $14 million to enhance the Child Welfare Workforce.
- Provides $22 million for Mental Health and Substance Abuse services.
- Provides $7.4 million for three State Veterans Nursing Homes (next phase of construction for the seventh nursing home in St. Lucie County and initial funding for the eighth and ninth nursing homes)

Florida's AHCA Issues RFI for MMIS Replacement. Florida's Agency for Health Care Administration (AHCA) has issued a request for information regarding a planned reprocurement and replacement of the state's existing Medicaid Management Information System (MMIS) and Decision Support System (DSS) with the goal of a more interconnected data system to support Florida's Medicaid program. AHCA's RFI indicates that the state intends to receive federal approval of the planning phase in February of this year, with a targeted RFP release of July 2015, based on input from this RFI. AHCA intends to award contracts by the end of 2015 and begin a two-year implementation phase in mid-2016. The current MMIS and DSS contractor is Hewlett Packard Enterprises Services (HPES), whose 10-year contract will expire at the end of June 2018.

Georgia

Georgia Bills Achieve First Reader. In response to the Governor's plan to create a task force that will create a plan to continue supporting the poor and uninsured once the Disproportionate Share Hospital funds will be reduced, a number of bills have achieved first reader and have been assigned to committees. Bill HB 14 would prevent any local government or local authority from accepting federal funds unless approved by an Act of the General Assembly. Bill HB 47 authorizes refills of topical ophthalmic products under certain conditions. Bill HB 53 allows patients to withdraw consent for an HIV test. Bill SB 1, related to autism coverage, calls to provide definitions, limitations, and a premium cap.

Indiana

Indiana Receives Federal Approval for Medicaid Expansion Waiver. On January 27, 2015, the *IndyStar* reported that Indiana was approved for a waiver expanding Medicaid. Governor Mike Pence's alternative program, called Healthy Indiana Plan 2.0, requires individuals to contribute to the cost of care, ranging from $1 to $27 a month. Enrollee payments help fund a $2500 Personal Wellness and Responsibility account ("Power Account"), which resembles a Health Savings Account. Pence stated Medicaid is not a "long-term entitlement program" but is a "safety net." Indiana is the fifth state to receive a waiver. Read More

Iowa

CoOportunity Seeks Liquidation. On January 24, 2015, *The Des Moines Register* reported that the state's insurance commissioner announced the liquidation of CoOportunity, Iowa's consumer-owned cooperative, effective February 28, 2015. CoOportunity covered 120,000 people in Iowa and Nebraska. It is the first of the 23 health insurance cooperatives in the country to fail. The co-ops were formed under the ACA to increase competition and prevent monopolies in states with a small number of insurers on the marketplace. CoOportunity was unable to make enough premiums to cover the costs of healthcare. Read More

Kansas

Kansas House Committee to Draft Bill to Expand Medicaid. On January 26, 2015, *wibw.com* reported that a House Committee is working on a bill to expand Medicaid after hearing testimony from the Kansas Hospital Association and from Via Christi, the state's largest health system. Committee Chairman, Tom Sloan, said a bill should be drafted within a few weeks. Read More

Maryland

Governor Hogan's Budget Plan Cuts Rates for Medicaid Providers. On January 22, 2015, *The Washington Post* reported that Governor Larry Hogan's budget proposal would cut reimbursements to Medicaid providers, returning them to fiscal year 2014 levels and saving the state an estimated $160 million. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

New Heads of MassHealth and Health Connector. On January 22, 2015, *Boston.com* reported that Governor Charlie Baker appointed Daniel Tsai, a private healthcare systems and services consultant, as head of MassHealth. Baker also appointed Louis Gutierrez, a private sector IT consultant, as Executive Director of Health Connector. Read More

Attorney General Maura Healey Opposes Partners HealthCare Deal. On January 26, 2015, *The Boston Globe* reported that Attorney General Maura Healey is trying to prevent Partners HealthCare from merging with three community

hospitals. Healey claimed she would sue the company if it acquired South Shore Hospital and two Hallmark Health System hospitals, saying that the deal would raise costs and give Partners HealthCare too much market power. Read More

MassHealth $230 Million Over Budget. On January 20, 2015, *Nashoba Publishing* reported that due to increased enrollment, high cost drugs, and increased rates and fees, the state's Medicaid program, MassHealth, is $230 million over budget. Approximately $109 million is attributable to excess Medicaid signups in the temporary Medicaid program. Massachusetts Taxpayers Foundation research director Andrew Bagley said the problem may even be worse since full enrollment and utilization may not be known for months. Read More

Small Health Insurers Challenge Risk Adjustment. On January 25, 2015, *The Boston Globe* reported that insurers from the Massachusetts Association of Health Plans object to the risk adjustment provision under the ACA, which they say will cause them to pay significant amounts to Blue Cross Blue Shield (BCBS), the state's largest insurer. The risk adjustment provision requires insurers with healthy members to put money into a state-run pool that redistributes the funds to plans with expensive, sick patients. The Association claims the state is using flawed data and a bad methodology that will only benefit BCBS. Risk adjustment is intended to prevent insurers from designing plans that only appeal to healthy individuals. However, plans, like Minuteman Health with 9,000 members, claim this hurts small, new insurers that attract the young and healthy population through new approaches and innovative designs. Read More

Missouri

Missouri Medicaid Program Makes Exclusive Deal with AbbVie for Hepatitis C Medication. On January 27, 2015, *St. Louis Post-Dispatch* reported that the state's Medicaid program has entered into a deal with AbbVie for a 20 percent to 30 percent rebate on the Viekira Pak Hepatitis C medication. The state will no longer provide Sovaldi and expects to save $4.2 million next year. Missouri currently has 300 patients receiving treatment. Read More

New Hampshire

HMA Roundup – Rob Buchanan (Email Rob)

Nursing Homes May Lose $7 Million in Medicaid Reimbursement Cuts. On January 23, 2015, *CharlotteObserver.com* reported that as part of the state's Department of Health and Human Services' plan to try to fill a $58 million budget gap, nursing homes could face a cut of $7 million in Medicaid reimbursements. The budget shortfall resulted from "an increase in the number of children eligible for Medicaid, administrative costs from implementing New Hampshire's Medicaid expansion plan, and the state's settlement of a lawsuit over mental health services." Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid increases in primary care payments improved PCP appointment availability in New Jersey. On January 21, 2015, the New England Journal of Medicine published a study funded by the Robert Wood Johnson Foundation

that examined the experience of Medicaid enrollees in 10 states (including New Jersey) in accessing primary care services following a two year increase in Medicaid reimbursement rates. The payment increase was the result of ACA Section 1202, a provision that raised Medicaid reimbursement to Medicare levels in 2013 and 2014 and provided 100 percent federal funding for the increased cost. The study assessed "whether willingness to provide appointments for new Medicaid enrollees was related to the size of increases in Medicaid reimbursements in each state." According to the study, New Jersey's Medicaid program experienced one of the largest increases in primary care appointment availability. Just 15 states have elected to continue the increased primary care reimbursements beyond 2014 when federal funding for the increase ended. New Jersey is not one of them. *NJSpotlight* covered the study in depth in a January 22, 2015 release. Read more.

New York

HMA Roundup - Denise Soffel (Email Denise)

Governor Cuomo's Health Budget Proposal. Governor Cuomo presented his executive budget proposal to the legislature last week in a joint state of the state and budget presentation. Total budget spending for the next state fiscal year, which begins April 1, 2015, is projected to be $141 billion. The Governor framed his budget as the "Opportunity Agenda." With over 6 million New Yorkers covered by Medicaid, total spending (federal, state and local shares) is expected to be $62 million in SFY 2016. This represents a 5.6 percent increase over last year's spending on Medicaid. The Governor's budget presentation highlighted the success of the work of the Medicaid Redesign Team, which has brought per capita spending down, and changed the trajectory of the cost curve for the Medicaid program. In fact, few significant health initiatives are presented in this year's budget as most policy developments have already been initiated through the work of the MRT, and with the implementation of the Delivery System Reform Incentive Program (DSRIP).

Initiatives Highlighted by the Governor:

- A new capital pool of $1.4 billion to make health infrastructure improvements intended to stabilize safety net providers. This includes $700 million for Brooklyn communities, and $700 million for upstate communities including bed reduction/primary care expansion in Oneida County ($300 million) and debt restructuring in rural communities ($400 million).
- Implementation of a Basic Health Plan, as authorized under the ACA. This is in addition to the $1.2 billion allocated in last year's budget to support safety net institutions as they implement projects under DSRIP.
- A process for determining whether to establish an Office for Community Living whose goal would be to further the goals of the Olmstead plan, strengthen the No Wrong Door approach, and reinforce the initiatives of the Balancing Incentives Program.
- $5 million in grants to enhance coordination between health homes and the criminal justice system.
- Leveraging an assessment on health insurance plans meant to finance on-going operations of New York State of Health, the NY health

insurance marketplace. The assessment would be determined by calculating the cost of operating NYSOH and dividing those costs proportionately across health insurance plans based on their gross direct premiums.

- Funding to support the "Ending the AIDS Epidemic" initiative, an effort to identify individuals at risk for HIV and linking them to Pre-Exposure Prophylaxis Program.

Other Initiatives:

- Language codifying a process for distributing any shared savings under the annual Medicaid Global Cap targets.
- Changes in reimbursement within the Medicaid managed care program that would allow the state to utilize reimbursement methodologies that are value-based.
- New regulations for retail clinics operated by corporate entities such as in-pharmacy clinics; additional oversight for urgent care providers; and additional regulations and restrictions on surgical procedures performed in outpatient settings.
- Pilot program that would allow up to five business affiliations to increase capital investment. The pilot program is limited to business corporations that are not traded in the public or over-the-counter stock market. The business entity must commit to maintaining or enhancing the hospital's existing levels of service, charity care and core community benefits. It must also commit to retaining the workforce, either in existing jobs or through retraining, and create a foundation to address the public health needs of the community. Finally, the business entity must identify how public distributions will be made in ways that ensure that the community's access to care and core community benefits are not compromised.

Materials related to the Governor's budget proposal can be found on the website of the Division of the Budget. An overview of the budget is here.

Oregon

Medicaid Backlog of 43,000 Individuals. On January 27, 2015, the *Idaho Statesman* reported that 43,000 Oregonians are still waiting for their Medicaid applications to be processed due to the state switching to a federal portal from Cover Oregon. Of the 43,000, about 30,000 came through healthcare.gov, which has a weeklong lag until the state receives the application. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Aetna Drops Keystone Health Center. On January 24, 2015, *insurancenewsnet.com* reported that Aetna is ending its agreement with Keystone Health Center, effective February 1, 2015. About 11,000 Medical Assistance patients will need to switch either providers or plans by February 14th. Last year, these same individuals were moved to Aetna after UPMC dropped Keystone. Keystone Health serves medically underserved populations and is the sole

provider of pediatric, crisis intervention and infectious disease services. Read More

New Governor's First Day Agenda Includes Backing-Out of Healthy PA. Governor Wolf's administration has started to have discussions with the Obama administration about undoing Healthy PA according to the *Philadelphia Inquirer*. One of the Governor's campaign pledges was to expand Medicaid without using the Healthy PA model but the timeline for that change is unclear. The article notes that the governor does not need legislative approval to move toward a traditional Medicaid expansion but he will need the legislature to approve his cabinet nominations including the Secretary for the Department of Human Services, who will lead the transition. Read More

Healthy PA Program Glitch Causing Problems for Addiction and Alcohol Treatment Providers. The *Philadelphia Inquirer* reports that since the middle of December Medicaid recipients who transitioned to the private coverage option have not received coverage for their substance abuse treatment from their new insurance. Many providers are continuing to see these individuals despite the coverage issue, but some note that they have seen a decline in the number of people seeking services this December. Estelle Richman, who is heading up the human service transition team for Governor Wolf, states that fixing the drug and alcohol coverage issue is a top priority for the incoming Secretary of Human Services. Read More

Geisinger Connects to Statewide Research and Education Network. The Pennsylvania Research and Education Network (PennREN) that fosters collaboration between members has its first health care organization affiliate, Geisinger Health System. A press release posted on the Keystone Initiative for Network Based Education and Research (KINBER) explains that PennREN provides broadband connectivity and promotes the use of innovative technologies. By participating in PennREN, Geisinger believes it will be able to share a significant amount of data with research partners in the Commonwealth and deliver enhanced access to reliable broadband connections to its healthcare providers. Read More

Texas

Texas Legislature Facing Enrollment, Cost Issues in Medicaid Program. On January 27, 2015, *The Texas Tribune* reported on health care items lawmakers are grappling with as the state health care budget is to be released. Rising incomes in the state are causing the share of Medicaid paid by the federal government to decrease. Meanwhile, Medicaid enrollment is increasing. The state predicts the ACA could add 560,000 more Medicaid enrollees in 2015. Conservatives also fear health care spending will surpass education. Finally, lawmakers are looking into consolidating the state's five health agencies into one to save money over the next two years.

Vermont

Healthfirst Withdraws from Medicare ACO Offering. On January 19, 2015, *VTDigger* reported that Healthfirst will withdraw from the shared-savings accountable care organization program due to difficult to attain incentive payments. Under the ACA, the program was designed to split savings between

the federal government and provider if an ACO was able to meet quality standards and treat patients for less. However, none of the ACOs in Vermont were able to achieve this. Read More

National

CBO Report Estimates ACA will Cost 7 Percent Less than Projected. On January 26, 2015, *Reuters* reported that a Congressional Budget Office (CBO) report estimates the ACA will cost 7 percent ($68 billion) less than an April 2014 projection for coverage between 2015 and 2024. The CBO reported that because of lower than expected Marketplace enrollment, insurance subsidies will cost approximately $964 billion over the next decade. The CBO estimates 12 million individuals will enroll in private coverage this year, 21 million in 2016, and between 24 and 25 million each year beginning in 2017. Medicaid, however, is predicted to cost $59 billion more than expected over the next decade due to higher enrollment. Read More

HHS Announces Goal to Move Toward Quality-Based Medicare. On January 26, 2015, *Kaiser Health News* reported that Health and Human Services Secretary Sylvia Burwell announced her goal that within four years, half of Medicare spending will go to hospitals, doctors and providers that coordinate patient care and stress quality in an effort to move away from the fee-for-service model. In 2014, 20 percent of traditional Medicare spending went to accountable care organizations. Burwell hopes to increase this to 30 percent for 2016 and 50 percent by the end of 2018. Read More

Higher Medicaid Reimbursements Increase Physician Access for Patients. On January 21, 2015, *Kaiser Health New* reported that according to a recently published study, the federally funded physician pay raise increased availability of primary care appointments for Medicaid patients. Under the ACA, the higher reimbursements, which lasted for two years, ending December 31, 2014, increased the availability by 8 percent, compared to 1 percent among privately insured patients. The study examined 10 states. Read More

Federal Exchange Enrollment Surges as Deadline Approaches. During the week ending January 16, marketplace enrollment in 37 federally funded states was 400,253, up 145% from the previous week. So far, nearly 7.2 million have enrolled. The Congressional Budget Office estimated 12 million people would enroll this year through both the state and federal exchanges and HHS Secretary Sylvia Burwell estimated 9.1 million. Florida has the highest numbers of sign-ups at 1.3 million, with Texas following second at 918,890.

Share of Young Adult Sign-Ups Stagnant in Exchanges. Young adult sign-ups under the health law have not met expectations. Currently this year, individuals aged 18 to 34 make up 26 percent of the newly-insured, compared to 25 percent last year. However, officials say this may change in the last few weeks when enrollment is expected to surge. On January 29th, more than 200 events will be held encouraging young people to sign up. So far, 9.5 million have signed up through the 37 federally facilitated Exchange states. About 87 percent are receiving subsidies, compared to 83 percent last year.

Industry News

Centene to Acquire Agate Resources. On January 26, 2015, Centene announced it will acquire Agate Resources, a holding company that offers healthcare products and services in Oregon. This includes Trillium Community Health plan, a subsidiary of Agate that delivers coverage to Medicaid and dual enrollees through Oregon's Coordinated Care Organization program. Trillium currently serves 87,000 members. Read More

Revelstoke Capital Partners Completes Investment in Encore Rehabilitation Services. On January 23 2015, *Reuters PE Hub* announced Revelstoke Capital Partners completed their investment in Encore Rehabilitation Services. Encore is a Michigan-based provider of rehabilitative therapy services and associated compliance and revenue cycle support services to skilled nursing facilities, assisted living facilities, and home health agencies. Financial terms were not announced. Read More

Community Health Systems to Purchase 80 Percent Equity Interest in Metro Health. On January 23, 2015, Community Health Systems announced that it has entered a definitive agreement to purchase an 80 percent equity interest in Metro Health. The purchase will include Metro Health Hospital, outpatient centers, and related assets. Metro Health is based in Wyoming, Michigan. Read More

MDwise President and CEO Charlotte MacBeth Steps Down. On January 23, 2015, MDwise announced that Charlotte MacBeth is stepping down as President and CEO to relocate to Illinois. Chief Operations Officer Katherine Wentworth will serve as interim CEO. Read More

Affinity Health Plan Announces Glenn A. MacFarlane President and CEO. On January 7, 2015, Affinity Health Plan announced that Glenn A. MacFarlane replaced Bertram L. Scott as the new President and CEO, effective January 1, 2015. MacFarlane became Affinity's SVP of strategy, business, and product development in 2012 before being promoted to CFO in 2014. Read More

Advance Health Raises $40 Million in Minority Growth Equity Funding. Advance Health, a Virginia based provider of managed care prospective health assessments and care management solutions, has raised $40 million in minority growth equity funding. Summit Partners led the round, and was joined by Noro-Moseley Partners. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
January 30, 2015	Florida Healthy Kids	RFP Release	185,000
January, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
February 1, 2015	South Carolina Duals	Implementation	68,000
February 1, 2015	Louisiana	Implementation	900,000
February, 2015	Georgia	RFP Release	1,300,000
March 1, 2015	Michigan Duals	Implementation	70,000
March 2, 2015	Florida Healthy Kids	Proposals Due	185,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
July 1, 2015	Washington Duals	Implementation	48,500
July 1, 2015	Missouri	Implementation	398,000
July, 2015	Georgia	Contract Awards	1,300,000
August, 2015	Michigan	Contract Awards	1,500,000
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
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
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. *Please note revised enrollment totals in Illinois; previous version of the table overstated duals demonstration enrollment for December 2014.*

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	455	2,831	19,461	37,248	48,114	46,870	49,060	49,253	57,967
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 Fully Integrated	**17,091**	**31,427**	**50,716**	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**N/A**

Source: State enrollment reporting compiled by HMA

HMA News

HMA Q&A Looks at Section 1332 Waivers

Link to Q&A

Section 1332 waivers are designed to give states additional flexibility in how they implement key elements of the Affordable Care Act. In this Q&A, Health Management Associates Principal, Tony Rodgers, outlines how states can utilize 1332 waivers – ranging from simple fixes that address specific unintended consequences caused by ACA requirements to the potential for creative experiments designed to expand healthcare access.