HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 4, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

ENROLLMENT UPDATE – NOVEMBER 2014 MEDICAID AND PRELIMINARY 2015 EXCHANGE

This week, our *In Focus* section reviews updated end-of-November 2014 reports issued by the Department of Health and Human Services (HHS) on Medicaid expansion enrollment from *"Medicaid & CHIP: November 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report."* CMS has provided updated Medicaid enrollment totals in 50 states and the District of Columbia, and corrected previous inaccuracies in both current and baseline Medicaid enrollment figures from earlier reports. Additionally, we review preliminary 2015 Exchange enrollment from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief, *"Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report,"* with enrollment data for November 15, 2014 through January 16, 2015. Combined, these reports present an initial picture of Medicaid and Exchange enrollment as we enter 2015.

Key Takeaways from Medicaid Enrollment Report

- Across 50 states and DC reporting Medicaid and CHIP monthly enrollment data, nearly 69 million individuals were enrolled as of November 2014 (point-in-time count on November 30).
- Medicaid participation continues to grow, with more than 1 million net new enrollees since HHS' August 2014 report. Enrollment is up nearly 10.3 million from last year's "Pre-Open Enrollment" period, defined as July 2013 through September 2013. (As a note, HHS continues to revise the baseline "Pre-Open Enrollment" period enrollments in each report).
- The top five states in percentage growth of Medicaid and CHIP enrollment under the Medicaid expansion are Kentucky (72.2 percent), Vermont (68.8 percent), Nevada (65.4 percent), Oregon (57.4 percent), and Arkansas (48.2 percent).
- The top five states in percentage growth of Medicaid and CHIP among states that did not expand Medicaid are Idaho (13.3 percent), Georgia (12.9 percent), Tennessee (12.7 percent), North Carolina (12.2 percent), and South Carolina (11.4 percent).
- Overall, four states saw enrollment increases of greater than 50 percent, with another eleven states showing enrollment increases of more than 25 percent.
- The top five states in total enrollment growth of Medicaid and CHIP are California (2.63 million), Ohio (526,378), New York (517,846), Washington (482,485), and Kentucky (438,148); combined, they represent 45 percent of enrollment growth across all states. California alone accounts for more than 25 percent of this enrollment growth.

Table 1 – Medicaid/CHIP Enrollment Growth Overview – November 2014

	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Nov. 2014)	Nov. 2014 % Change	Nov. 2014 # Change
Expanded Medicaid				
State-Based Exchange	21,829,752	27,369,013	*25.4%*	*5,539,261*
Federally Facilitated	12,722,377	15,965,226	*25.5%*	*3,242,849*
Has Not Expanded Medicaid				
State-Based Exchange	251,926	285,438	*13.3%*	*33,512*
Federally Facilitated	23,870,416	25,354,223	*6.2%*	*1,483,807*
Total	**58,674,471**	**68,973,900**	***17.6%***	***10,299,429***

Key Takeaways from Preliminary Exchange Enrollment Report

- Through the special enrollment period, which extended through April 19, 2014, nearly 8.02 million individuals enrolled in a qualified health plan (QHP) for plan year 2014 through the Exchanges.
- Through January 15, 2015, more than 7.15 million individuals have newly enrolled or reenrolled in a QHP for plan year 2015 in the 37 states utilizing the federally facilitated enrollment portal. This represents a 30% increase in enrollments across these 37 states, and a net 1.67 million new QHP enrollments so far.

- Additionally, the ASPE report indicates that more than 40%, or 2.8 million of these enrollments are new consumers, defined as those individuals enrolling in a QHP who did not make a QHP selection as of November 2014 when open enrollment began.
- If enrollment trends in state-based Exchanges mirror those in federally facilitated states, final enrollment totals in the Exchanges across all states should easily surpass 10 million.

Table 2 – Prelim. 2015 Exchange Enrollment (Federally Facilitated States Only)

	Selected Exchange QHP (2014)	Selected Exchange QHP (2015)	QHP % Change	QHP # Change
Expanded Medicaid				
State-Based Exchange	2,459,887	N/A	N/A	N/A
Federally Facilitated	1,229,716	1,551,345	*26.2%*	*321,629*
Has Not Expanded Medicaid				
State-Based Exchange	76,061	N/A	N/A	N/A
Federally Facilitated	4,254,099	5,605,346	*31.8%*	*1,351,247*
Total	**8,019,763**	**7,156,691**	***30.5%***	***1,672,876***

The table on the following page (Table 3) provides state-level data on Medicaid and Exchange enrollment.

Medicaid and Exchange Enrollment Data Sources:

Link to CMS Medicaid Expansion Enrollment Report:

"Medicaid & CHIP: November 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report" (February 2, 2015)

Link to ASPE Health Insurance Marketplace Enrollment Report:

"Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report" (January 27, 2015)

Table 3 – Medicaid/CHIP Enrollment Growth Across All States (November 2014) and Preliminary 2015 Exchange Enrollment (Federally Facilitated States Only)

State	Expanded Medicaid	State-Based/ FFM	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Nov. 2014)	Nov. 2014 % Change	Nov. 2014 # Change	Selected Exchange QHP (2014)	Selected Exchange QHP (2015 FFM only)	QHP % Change	QHP # Change
US Total			**58,674,471**	**68,973,900**	***17.6%***	***10,299,429***	**8,019,763**		***30.5%***	***1,672,876***
Alabama	No	FFM	799,176	862,690	*7.9%*	*63,514*	97,870	134,205	*37.1%*	*36,335*
Alaska	No	FFM	122,334	125,270	*2.4%*	*2,936*	12,890	16,724	*29.7%*	*3,834*
Arizona	Yes	FFM	1,201,770	1,500,272	*24.8%*	*298,502*	120,071	169,178	*40.9%*	*49,107*
Arkansas	Yes	FFM	556,851	825,246	*48.2%*	*268,395*	43,446	54,885	*26.3%*	*11,439*
California	Yes	State-Based	9,157,000	11,790,244	*28.8%*	*2,633,244*	1,405,102			
Colorado	Yes	State-Based	783,420	1,147,566	*46.5%*	*364,146*	125,402			
Connecticut*	Yes	State-Based	618,700	763,836	*23.5%*	*145,136*	79,192			
Delaware	Yes	FFM	223,324	232,532	*4.1%*	*9,208*	14,087	20,449	*45.2%*	*6,362*
District of Columbia	Yes	State-Based	235,786	255,585	*8.4%*	*19,799*	10,714			
Florida	No	FFM	3,104,996	3,355,628	*8.1%*	*250,632*	983,775	1,270,995	*29.2%*	*287,220*
Georgia	No	FFM	1,535,090	1,732,424	*12.9%*	*197,334*	316,543	425,927	*34.6%*	*109,384*
Hawaii	Yes	State-Based	288,357	298,015	*3.3%*	*9,658*	8,592			
Idaho	No	State-Based	251,926	285,438	*13.3%*	*33,512*	76,061			
Illinois	Yes	FFM	2,626,943	3,064,265	*16.6%*	*437,322*	217,492	286,888	*31.9%*	*69,396*
Indiana	No	FFM	1,120,674	1,199,351	*7.0%*	*78,677*	132,423	185,730	*40.3%*	*53,307*
Iowa	Yes	FFM	493,515	570,048	*15.5%*	*76,533*	29,163	36,718	*25.9%*	*7,555*
Kansas	No	FFM	378,160	400,586	*5.9%*	*22,426*	57,013	80,064	*40.4%*	*23,051*
Kentucky	Yes	State-Based	606,805	1,044,953	*72.2%*	*438,148*	82,747			
Louisiana	No	FFM	1,019,787	1,050,038	*3.0%*	*30,251*	101,778	137,142	*34.7%*	*35,364*
Maine*	No	FFM	266,900	289,051	*8.3%*	*22,151*	44,258	61,964	*40.0%*	*17,706*
Maryland	Yes	State-Based	856,297	1,085,723	*26.8%*	*229,426*	67,757			
Massachusetts	Yes	State-Based	1,296,359	1,536,421	*18.5%*	*240,062*	31,695			
Michigan	Yes	FFM	1,912,009	2,201,137	*15.1%*	*289,128*	272,539	299,750	*10.0%*	*27,211*
Minnesota	Yes	State-Based	873,040	1,174,133	*34.5%*	*301,093*	48,495			
Mississippi	No	FFM	637,229	701,685	*10.1%*	*64,456*	61,494	81,251	*32.1%*	*19,757*
Missouri	No	FFM	846,084	852,435	*0.8%*	*6,351*	152,335	209,336	*37.4%*	*57,001*
Montana	No	FFM	148,974	161,575	*8.5%*	*12,601*	36,584	47,206	*29.0%*	*10,622*
Nebraska	No	FFM	244,600	234,857	*-4.0%*	*(9,743)*	42,975	61,474	*43.0%*	*18,499*
Nevada	Yes	FFM	332,560	550,209	*65.4%*	*217,649*	45,390	52,498	*15.7%*	*7,108*
New Hampshire	Yes	FFM	127,082	160,867	*26.6%*	*33,785*	40,262	46,642	*15.8%*	*6,380*
New Jersey	Yes	FFM	1,283,851	1,658,117	*29.2%*	*374,266*	161,775	211,788	*30.9%*	*50,013*
New Mexico	Yes	FFM	572,111	743,058	*29.9%*	*170,947*	32,062	43,054	*34.3%*	*10,992*
New York	Yes	State-Based	5,678,417	6,196,263	*9.1%*	*517,846*	370,451			
North Carolina	No	FFM	1,595,952	1,791,054	*12.2%*	*195,102*	357,584	458,676	*28.3%*	*101,092*
North Dakota	Yes	FFM	69,980	82,253	*17.5%*	*12,273*	10,597	15,606	*47.3%*	*5,009*
Ohio	Yes	FFM	2,341,481	2,867,859	*22.5%*	*526,378*	154,668	196,073	*26.8%*	*41,405*
Oklahoma	No	FFM	790,051	808,973	*2.4%*	*18,922*	69,221	101,026	*45.9%*	*31,805*
Oregon	Yes	FFM	626,356	986,109	*57.4%*	*359,753*	68,308	90,345	*32.3%*	*22,037*
Pennsylvania	No	FFM	2,386,046	2,388,054	*0.1%*	*2,008*	318,077	422,284	*32.8%*	*104,207*
Rhode Island	Yes	State-Based	190,833	261,559	*37.1%*	*70,726*	28,485			
South Carolina	No	FFM	790,229	880,610	*11.4%*	*90,381*	118,324	161,941	*36.9%*	*43,617*
South Dakota	No	FFM	115,501	116,333	*0.7%*	*832*	13,104	18,040	*37.7%*	*4,936*
Tennessee	No	FFM	1,244,516	1,402,357	*12.7%*	*157,841*	151,352	184,486	*21.9%*	*33,134*
Texas	No	FFM	4,441,605	4,669,995	*5.1%*	*228,390*	733,757	918,890	*25.2%*	*185,133*
Utah	No	FFM	294,029	291,763	*-0.8%*	*(2,266)*	84,601	116,423	*37.6%*	*31,822*
Vermont	Yes	State-Based	127,162	214,654	*68.8%*	*87,492*	38,048			
Virginia	No	FFM	935,434	937,818	*0.3%*	*2,384*	216,356	316,584	*46.3%*	*100,228*
Washington	Yes	State-Based	1,117,576	1,600,061	*43.2%*	*482,485*	163,207			
West Virginia	Yes	FFM	354,544	523,254	*47.6%*	*168,710*	19,856	27,471	*38.4%*	*7,615*
Wisconsin	No	FFM	985,531	1,031,888	*4.7%*	*46,357*	139,815	177,157	*26.7%*	*37,342*
Wyoming	No	FFM	67,518	69,788	*3.4%*	*2,270*	11,970	17,821	*48.9%*	*5,851*

Note: Several states use the FFM marketplace for enrollment, despite being a state-based exchange, these states are Nevada, New Mexico, and Oregon.

**Connecticut and Maine did not report Pre-Open Enrollment Period enrollment data to HHS for the report. HMA has substituted the December 2013 Medicaid enrollment total from the Kaiser Family Foundation, compiled by Health Management Associates (HMA) from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured (KCMU). Data available at: http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands-december/*

HMA Medicaid Roundup

Arizona

Lawsuit Filed Over Lack of Adequate Health Care for 17,000 Foster Kids. On February 3, 2015, *The Wall Street Journal* reported that child health advocates filed a lawsuit against Arizona for failing to provide sufficient health-care services and an adequate number of foster homes for foster children. The number of children in Arizona's foster care program rose 80 percent from 2012 to 2013, while the national total decreased 22%. According to the lawsuit, as a result of this rapid increase, some children slept in offices because they did not have homes. Arizona was already under fire in 2013 by child protective services for failing to investigate thousands of reports of abuse and neglect beginning in 2009. Read More

California

Warren Lyons (Email Warren)

Nearly All Exchange Enrollees Remain on Same Plan. On January 29, 2015, *Kaiser Health News* reported that 94 percent of the 944,000 people enrolled in California's exchange did not switch plans for 2015. Approximately one third looked around for different plans but did not choose a new plan while the remaining two thirds took no action and were automatically re-enrolled. Kaiser Permanente plans retained 99 percent of customers. Read More

New Regulations On Narrow Networks. On February 3, 2015, *California Healthline* reported that new regulations requiring stricter guidelines on narrow networks were approved. The regulations cover provider network adequacy, out-of-network notifications, and accuracy of provider lists and will go into effect immediately following OAL approval. Insurers will be required to:

- Adhere to new standards for appointment wait times;
- Offer an adequate number of physicians, clinics and hospitals to patients who live in certain areas;
- Provide an accurate list of in-network providers;
- Provide out-of-network care options for the same price as in-network care when the number of in-network providers is insufficient; and
- Report to DOI information about their networks and any changes.

Read more

Florida

Elaine Peters (Email Elaine)

Telemedicine Deal Likely to Pass This Year. On February 3, 2015, *News4Jax* reported that Florida House and Senate leaders are confident they will reach an agreement this year to increase telemedicine in rural areas of the state. In the past years, the House and Senate had been unable to reach any sort of agreement regarding a proposal for telehealth. One area of debate has been out-of-state physicians. However, lawmakers have agreed this year to license those physicians in the state of Florida while preventing them from practicing outside of their specialties. Read More

Florida Leads Nation in Highest Exchange Enrollment Due to Mapping Strategy, High Competition, and No Expansion. On February 2, 2015, *Kaiser Health News* reported that Florida has the highest exchange enrollment in the nation, with 1.27 million members. One strategy that the state has been using is a heat map that allows it to target areas with low enrollment. Florida also has a large number of insurers competing, specifically in large counties, while nonprofits and community groups receive federal funding to enroll people. In addition, Florida's choice to not expand Medicaid has forced low income people to sign up through the exchange to receive subsidies. Read More

Governor Scott Proposes to Repeal "Hospital Tiering" Law. On February 2, 2015, *Tampa Bay Times* reported that Governor Rick Scott's budget seeks to repeal a law that requires counties that use local dollars to obtain federal matching funds to share with counties that do not. Gov. Scott also recommended using trust fund money when Florida's Low Income Pool program terminates, if the state is unable to renew it for another year. Read More

Florida Stands Firm on No Expansion. On February 1, 2015, *The Tampa Tribune* reported that even with Indiana's recent approval for an expansion waiver, Florida House Speaker Steve Crisafulli continues to oppose the use of federal funding to expand Medicaid. Read More

Georgia

Kathy Ryland (Email Kathy)

Tenet Health May Look for Hospital Deal. On January 29, 2015, *Georgia Health News* reported that industry officials said Tenet is starting to look for a sale or a partnership for its five Georgia hospitals. Tenet declined to comment on their corporate development activities. Read More

Idaho

Lawmakers Say There Are Still Issues Regarding State's Behavioral Services. On January 28, 2015, *The Sacramento Bee* reported that although Optum, Idaho's administrator of mental health services, has said that it received a 95 percent satisfaction rating from Medicaid beneficiaries, lawmakers claim there are still delays and cuts to services. In rural areas, access to therapists for certain required services can be nonexistent. Optum is looking to expand the state's telehealth network to help serve these rural areas. Read More

Iowa

Mental Health Institute Closures Met with Opposition. On January 31, 2015, *The Des Moines Register* reported that Iowa is planning to close the Clarinda and Mount Pleasant mental health institutes by June 30. As a result, patients would either need to shift to private agencies or to institutions in Independence or Cherokee, Iowa, hundreds of miles away. This was met with great opposition from patients and mental health advocates. Rural police departments who don't have the resources to drive patients on such lengthy trips also oppose the closures. However, Department of Human Services Director Charles Palmer said they are looking into new treatment options to redesign the whole system. This includes short term crisis centers or step-down units.

Kansas

KDADS Attempts to Reduce Opposition on Regulating Behavioral Health Drugs; Providers Still Wary. On January 29, 2015, *Kansas Health Institute* reported that the Kansas Department for Aging and Disability Services, KDADS, said they are open to discussion to reduce opposition to a bill that would allow the state to regulate the use of prescription behavioral drugs. However, coalition members said they will continue to oppose the bill. The bill would repeal a 2002 law that prohibits policies and regulations, such as preferred lists, that restrict a physician's ability to prescribe mental health medication. KDADS claim that repealing the law will save the state $8.3 million this year. Coalition members fear that this is a "straight route to pharmacy management by MCOs." Read More

Maine

Maine Hospitals See Rise in Uninsured Patients and Increased Costs. On January 30, 2015, *MPBN News* reported that Maine's hospitals are seeing increased costs and higher debt due to the state's decision not to expand Medicaid. St. Mary's Hospital in Lewiston saw costs rise by $2 million. As a result, the hospital closed a behavioral intensive care unit and began to charge patients a down payment to enroll in its outpatient substance abuse program. Across the state, the total charity care costs have risen by $130 million. Read More

Massachusetts

Rob Buchanan (Email Rob)

Partners HealthCare Denied Deal to Acquire Hospitals. On January 29, 2015, *WBUR* reported that Judge Janet Sanders rejected Partner HealthCare's deal to acquire three hospitals. She stated that the deal would decrease competition and allow the hospital to increase prices. Studies conducted by the state's Health Policy Commission found that the acquisitions would have increased healthcare spending by $39 million to $49 million in a year. Sanders also said the deal would be too difficult to enforce. Read More

Providers and Insurers Push to Change Payment Model. On January 28, 2015, *The Boston Globe* reported that The Health Care Transformation Task Force,

which includes Partners HealthCare, Blue Cross Blue Shield of Massachusetts, and Atrius Health, is pushing to change the payment model from fee for service to performance-based. The task force hopes to move 75 percent of its patients to value-based arrangements, which reward providers for keeping patients healthy and out of hospital beds, by 2020. Read More

Michigan

HMA Roundup – Esther Reagan (Email Esther)

MI Health Link Dual Demo Begins Enrollment. On February 3, 2015, The Michigan Department of Community Health announced MI Health Link began enrollment. The program, serving dual eligibles, will begin March 5, 2015, with passive enrollment through May 1, 2015. Macomb and Wayne counties will be able to enroll in April and services will begin May 1, 2015. Read More

Excerpts from HMA's Michigan Update, published January 30, 2015. Below are excerpts from HMA's monthly Michigan Update. Read more.

Medicaid Managed Care Enrollment Activity. As of January 1, 2015, there were 1,528,379 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled in 13 Medicaid Health Plans (HMOs); this is an increase of 32,644 since December. The enrollment total reflects an increase of 30,009 HMP enrollees since December and an increase of 2,635 non-HMP Medicaid enrollees. Even with this increase, the total number of non-HMP Medicaid managed care enrollees in January - 1,140,886 - is still well below the June 2014 enrollment figure of 1,330,638.

Healthy Michigan Plan. Enrollment in the Healthy Michigan Plan (HMP) continues to grow. The Michigan Department of Community Health (DCH) reports that since launching the program on April 1, 2014, enrollment has grown to **533,110 as of January 26, 2015**. The MDCH updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the newly approved HMP beneficiaries reside in the state's five largest counties:

January 26, 2015 Healthy Michigan Plan Enrollment	
Wayne	143,570
Macomb	42,089
Oakland	41,063
Genesee	32,453
Kent	27,595
Five-County Total	**286,770**
Statewide Total	**533,110**

The vast majority of these enrollees (about 440,000) have income below poverty and almost 52 percent of the enrollees are women. About 46.5 percent of the enrollees are between the ages of 19 and 34; 39.5 percent are between the ages of 35 and 54; and 13.9 percent are between the ages of 55 and 64. Virtually all of these enrollees are already or soon will be enrolled in the state's Medicaid managed care organizations for their health care services. Since program implementation on April 1, 2014, MDCH reports that enrollees have received more than 350,000 primary and preventive care visits.

With few exceptions, new HMP beneficiaries are required to enroll in the Medicaid Health Plans (HMOs) to receive their health care benefits. As of January 1, 2015, there were a total of 387,493 HMP beneficiaries enrolled in the HMOs. HMP enrollment totals by health plan are expected to increase again in January as individuals continue to choose an HMO or are assigned to an HMO if they do not select a plan.

January 2015 Healthy Michigan Plan Enrollment			
Medicaid Health Plan	Voluntary Enrollees	Auto-Assigned Enrollees	Total Enrollees
Blue Cross Complete of MI	26,779	4,461	31,240
CoventryCares of MI	3,458	4,266	7,724
HAP Midwest Health Plan	14,434	10,380	24,814
Harbor Health Plan, Inc.	779	2,217	2,996
HealthPlus Partners	19,861	3,075	22,936
McLaren Health Plan	36,198	10,001	46,199
Meridian Health Plan of MI	66,793	30,962	97,755
Molina Healthcare of MI	31,998	14,633	46,631
Priority Health Choice, Inc.	22,502	4,258	26,760
Sparrow PHP	2,791	1,263	4,054
Total Health Care	9,180	5,155	14,335
UnitedHealthcare Comm. Plan	36,299	14,091	50,390
Upper Peninsula Health Plan	11,651	8	11,659
Total	**282,723**	**104,770**	**387,493**

Mississippi

Mississippi Issues CHIP Managed Care Rebid RFP. On January 30, 2015, the Mississippi Division of Medicaid (DOM) issued a request for proposals (RFP) to rebid contracts for the state's Children's Health Insurance Program (CHIP) managed care program. As of December 31, 2014, Mississippi's CHIP program served 50,300 children under statewide managed care contracts held by United Healthcare and Magnolia Health Plan, a subsidiary of Centene. Proposals are due to the DOM on March 27, 2015, with award expected by April 24, 2015. New contracts will be implemented on July 1, 2015. The DOM again intends to award two contracts. Read more

New Jersey

Karen Brodsky (Email Karen)

Medicaid and Marketplace enrollments exceed projections in New Jersey. On February 4, 2015 NJSpotlight reported that the latest enrollment figures in NJFamilyCare, the state's Medicaid program, and in the Marketplace showed tremendous gains over 2014. NJFamilyCare now has 1.67 million enrollees, an increase of 390,000 since last year at this time. While many of these enrollments may be attributed to Medicaid expansion under the Affordable Care Act, some have occurred as individuals signed up for Marketplace coverage, only to discover that they qualify for Medicaid. Original projections put Medicaid enrollment gains under Medicaid expansion at 234,000. The New Jersey Marketplace has had 80,000 newly enrolled participants and 130,000 renewals,

for a total of 210,000 enrollees in 2015. This number is likely to increase as individuals continue to sign up through February 15th. Read more.

New York

Denise Soffel (Email Denise)

Transition of Nursing Home Benefit and Population into Mainstream Medicaid Managed Care. Beginning February 1, 2015, managed care plans will cover the full range of nursing home services to current managed care enrollees new to nursing home care. Effective February 1, 2015, in New York City, all eligible beneficiaries age 21 and over in need of long term placement in a nursing facility will be required to join a Medicaid Managed Care Plan or a Managed Long Term Care Plan. On April 1, 2015, the counties of Nassau, Suffolk, and Westchester will be phased in, and the rest of the state is scheduled to transition beginning in July 2015 for both dual and non-dual eligible populations.

All current long-term placed beneficiaries in a Medicaid certified skilled nursing facility prior to the phase-in will remain in fee-for-service Medicaid and will not be required to enroll in a plan. No individual will be required to change nursing homes resulting from this transition; however, new placements will be based upon the MCO's contractual arrangements and the needs of the individual. Effective October 1, 2015, voluntary enrollment into managed care becomes available to individuals residing in nursing homes who are in FFS Medicaid.

The nursing home benefit will not include a lock-in; members are free to change plans at any time in order to access a nursing facility that they want.

Plans are required to meet a state-determined minimum number of nursing home network providers, which ranges from 2 to 8, depending on the county. Nursing facilities must be paid at the fee-for-service rate for a period of 3 years unless the home has negotiated an alternative rate or reimbursement methodology. If a managed care plan enrollee selects an out-of-network facility, and an in-network facility can meet the needs of the enrollee, they will be required to use the in-network facility. If no other appropriate provider is available within the plan network, the plan must enter into an out-of-network arrangement, which includes paying the fee-for-service rate.

The managed care plan is responsible for care plan development, arranging periodic assessments and coordinating with the nursing home. The plan is also responsible for monitoring quality of care.

Information about the nursing home transition, including a policy guidance, FAQs, and links to a webinar, can be found on the MRT web site.

New York State of Health Enrollment. With less than 2 weeks remaining in this year's open enrollment period, New York State of Health, the state-run health insurance marketplace, has enrolled more than 2 million individuals. A press release provides the following breakdown of enrollment:

- Total cumulative enrollment: 2,004,827
- Total Medicaid enrollment: 1,491,859
- Total private coverage: 512,968
- Total new 2015 enrollment: 429,972
- Total new 2015 Medicaid enrollment: 297,423

- Total new private coverage: 132,549
- Renewal rate in private coverage: 85 percent

New enrollment during the 2015 open enrollment period represents an increase of 27 percent over last year's enrollment; a 25 percent increase for individuals enrolled in Medicaid and a 35% increase for individuals enrolled in private coverage.

E-Prescribing Mandate. The Medical Society of the State of NY, along with 17 other professional organizations, wrote a letter to Acting Commissioner of Health Howard Zucker raising concerns about an e-prescribing mandate that was enacted into law in 2012 as part of the I-Stop (Internet System for Tracking Over-Prescribing) legislation. I-Stop requires that, effective March 2015, all prescriptions for controlled substances must be submitted electronically, in an effort to eliminate the problem of forged or stolen prescriptions. The Medical Society's concern is that many EHR vendors are not yet certified for e-prescribing controlled substances, and necessary system testing has not yet occurred. Software used in e-prescribing must be certified by the DEA. The letter points out that at least half of the state's nursing facilities do not yet have an EHR system, and assisted living facilities are even less likely to have systems that allow for communication with the pharmacy and prescriber. Senate Health Committee Chair Kemp Hannon is proposing legislation that would delay implementation for one year.

HHC Community Based Health Centers Reorganize into One Organization with Federal Health Center Designation. The New York City Health and Hospitals Corporation announced the reorganization of 39 HHC health centers and clinics into one new community health center. The new organization, Gotham Health, Inc. was approved by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) for Federally-Qualified Health Center Look-Alike designation. The new Gotham Health organization will include HHC's six large diagnostic and treatment centers and 33 smaller primary care community and school based clinics. The new designation will qualify HHC for nearly $30 million in additional Medicaid and Medicare reimbursement annually. Gotham Health has an independent Board of Directors made up of consumers and representatives of the communities served.

Behavioral Health Merger Being Considered. A possible merger between the Office of Mental Health and Office of Alcoholism and Substance Abuse Services is being studied by the two state agencies. The Albany Times Union reports that 2015 will be devoted to studying a possible merger. Merging the offices under a behavioral health umbrella has been contemplated for several years, but officials involved in mental health services were told last week that the state is planning hearings for later in the year. An OMH spokesperson is quoted as saying "This year, both agencies will continue to assess whether creating a new integrated behavioral health services agency would enhance New York State's ability to improve service delivery; transition to Medicaid Managed Care and more easily operate within the overall health care system; and improve treatment outcomes for the nearly 1 million people we collectively serve each year."

Families Feeling the Effects of State Institution Closures. On January 29, 2015, *The New York Times* reported on how certain families are struggling with the state's move towards deinstitutionalization. State officials say it is more humane for those with intellectual and developmental disabilities to live in communities

that are less restrictive. According to the federally funded research center University of Minnesota's Institute on Community Integration, institutions also cost three times as much per individual compared to group homes. However, as institutions close throughout New York, families with severely disabled adults are fighting against deinstitutionalization. Read More

North Carolina

State Proposes Changes to Medicaid Waiver Services in 2019. On February 2, 2015, *Autism Votes* reported that North Carolina has proposed changes to the Medicaid waiver program for home and community-based services. The proposal will comply with a federal directive that prohibits services that isolate patients from the general community, but rather focuses on a person-centered process. Read More

Ohio

Mel Borkan (Email Mel)

Medicaid Highlights from Governor's Budget Proposal. On Monday, Ohio's Governor John Kasich unveiled his 2016-2017 "Blueprint for a New Ohio Budget." Budget language isn't available, but information released by the Governor's office describes details of the initiatives that comprise the Blueprint.

Eligibility:

- Continuation of eligibility previously expanded under the ACA. The Department will seek to charge monthly premiums for individuals above 100% FPL (estimated to be $15 - $22 per month).
- Ohio would change its status from that of a '209 b' state to a '1634' state and in the process would raise the threshold for full eligibility for individuals who are Aged, Blind or Disabled from 64% FPL to 75% FPL; it would raise the asset limit from $1,500 to $2,000.
- Transitional benefits would be available for 6 months instead of 12. Eligibility for non-aged or disabled adults above 138% FPL would be eliminated, with some grandfathering for individuals currently eligible in those categories.
- Ohio also proposes to do a 1915i amendment.
- More programs (beyond Medicaid) will be moved into the State's new consolidated eligibility system.

Benefits:

- The Governor's budget proposes moving behavioral health services in Managed Care; incorporating additional benefits under 1915i amendment, and, including Intensive Behavioral Services and specialized transportation in Ohio's Medicaid in the Schools program

Long-Term Supports and Services (LTSS):

- The budget proposes that Ohio Medicaid eliminate the "independent service provider" option as a strategy to improve the administrative oversight of the program, decrease programmatic fraud and abuse, and

improve health outcomes for individuals. Ohio Medicaid would not take any new independent service providers after July 1, 2016 and by July 1, 2019 only accept claims submitted through home health agencies. This change will impact over 13,000 service contractors within seven HCBS waivers

- The State will implement standardized assessments and 'no wrong door' entry into long term care.
- The State will also negotiate and implement its HCBS transition plan to comply with new federal regulations.
- The State would make a significant new investment ($316 million over two years) to create more choices for Ohioans with developmental disabilities to live and work in the community.
- The State proposes to rebuild community behavioral health system capacity. It adds services to the Medicaid behavioral health services benefit package, enhances care coordination through managed care and strengthens housing and other community services.
- Delegated nursing authority, which currently exists in waivers operated by the Ohio Department of Developmental Disabilities will be granted in waivers administered by the Department of Medicaid and by the Department of Aging.
- Housing increases are sustained and the budget establishes an Ohio Housing Trust Fund.

Nursing Facilities:

- Rebase nursing facilities with new Grouper update (cost expected to be about $84.1 million) and roll all new costs into nursing facility quality payments.
- Remove nursing facility reimbursement methodology from Ohio's statute.
- Reduce rates for low acuity nursing facility residents.
- Change Franchise Permit Fee to permit Department of Medicaid to use electronic alternatives to mail when issuing assessments and close loophole about permanently surrendered beds.

Health Plan Payments:

- Gives individuals with developmental disabilities an option to enroll in managed care.
- Enrolls adopted and foster care kids in managed care.
- Changes process to begin managed care enrollment with the Medicaid eligibility determination.
- Requires plans to identify and work with community workers for outreach, especially for pregnant women.
- Beginning Jan 1, 2016, set managed care plan rates at the lower boundary of the actuarially established range.

- The state proposes to use one time unused managed care quality incentive funds to pay for enrolling new fee-for-service populations who will shift into managed care.

Physician Payment Changes:

- Primary care rates would increase over two years as would dental rates. Medicaid would move to reimburse only up to the Medicaid max for all Part B categories of service, including physician services. Savings would be used to support primary care rate increases. Subsidies for medical education would be converted to support the primary care rate increase. Enhanced payments to the Holzer Clinic, established in 1992, would be eliminated and used instead to support primary care rate increases. Physician claims associated with a technical denial received by a hospital would now be subject to recoupment.

Pennsylvania

Matt McGeorge (Email Matt)

Philadelphia Councilman Releases Autism Report. Councilman Dennis O'Brien announced the release of an autism report from the Philadelphia Autism Project. The report is based on more than two years of information gathering and stakeholder meetings according to the Philadelphia Tribune. The report was initiated to assess the services and supports that are available to individuals and families who are living with autism. Almost 140 initiatives were identified which if implemented will improve the quality of life for those living with autism. Read More

Medicare and Medicaid Underpayments Far Outpace Charity Care at Hospitals. According to a report by *WITF* free care or uncollected payments are less than the underpayments Pennsylvania Hospitals and Health systems receive from Medicare and Medicaid. The Hospital and Healthsystem Association of Pennsylvania explains that Medicare pays about 91% of the "true cost of providing care" and Medicaid pays 82%. The implication of the underpayments as explained by Lancaster General Hospital representative is that they will have to charge more to the commercial managed care patients. Read More

Pennsylvania Governor Tom Wolf Announces Resolution of Maternity Care Issue Between Highmark and UPMC. Governor Tom Wolf announced that Highmark will continue to cover pregnancy and related care at UPMC's Magee-Women's Hospital even though it is no longer in Highmark's provider network. According to the press release found at PR Newswire, the Pennsylvania Department of Insurance and Department of Health will continue to work with both Highmark and UPMC to enforce the consent decree. Read More

Tennessee

Governor Haslam's Medicaid Expansion Bill Dies in Senate Committee. On February 4, 2015, The Hill reported that Governor Bill Haslam's Medicaid expansion bill has died after it was voted down in the Senate's Health and Welfare Committee. Republican Speaker Beth Harwell predicted the bill lacks the necessary votes to pass out of the House committee as well. Read more

Texas

Diane Longley (Email Diane)

Sovaldi and Olysio Off the PDL. Late last week the P&T committee decided to make both Sovaldi and Olysio non-preferred. Viekira Pak has preferred status on the PDL. The table below is a summary of the HEP C coverage decisions made the Texas Health and Human Services P&T committee:

Brand Name	Current PDL Status	PDL Recommendations
Harvoni	NR	NPD
Olysio	NR	NPD
Sovaldi	NR	NPD
Victrelis	PDL	NPD
Viekira Pak	NR	PDL

(Blue = change made today, not preferred; green = change made today to preferred; white = no change).

In addition to the above decision, the committee recommended HHSC continue efforts to refine clinical criteria and develop "centers for excellence."

Gov. Abbott directs state agencies to comply with newly proposed state contracting changes immediately. In response to recent problems with questionable contracting practices and apparent conflicts of interest at the Texas Health and Human Services Commission, Governor Abbot has directed all state agencies to immediately begin complying with new rules to increase oversight of all contracting and procurement activities and restrict no-bid contracts. The directive from Abbott requires state agency heads to implement provisions of legislation introduced last week by Senator Jane Nelson, currently Committee Chair of Senate Finance and the Texas Sunset Commission, and former Chair of Senate Health and Human Services (see SB 353 here)

The proposed legislation includes the following provisions with which agencies must comply as of February 1:

- Require public disclosure of all no-bid contracts and a public justification for using such method;
- Require that all agency employees involved in procurement or contract management disclose any possible conflicts of interest;
- Prohibit contracts with business entities with which high-level agency leadership or staff have a financial interest;
- Require that the agency's board chair sign any contract valued at more than $1 million or delegate signature authority to the agency head;
- For procurements of more than $5 million, require the agency's central contracting office or procurement director to sign off on the procurement method and to indicate, in writing, to the Board and agency head any potential issue that could arise in the contract solicitation.

The legislative proposal has been referred to Senate Business and Commerce Committee, where it will proceed through the normal legislative process and will likely be revised over the next few months. Read more

Texas Legislative Update. Committee appointments for the Texas Senate have been released. As expected, newly elected Lt. Governor Dan Patrick made

significant changes in assignments. The Texas House committee appointments have not been published but are expected this week. The Texas Constitution prohibits House Committees from meeting during the first 30 days of the legislative session, but the restriction does not apply to the Senate. Senator Jane Nelson retained her chairmanship of Senate Finance, and Senator Charles Schwertner will remain Chair of the Health and Human Services Committee, an appointment he received late last year when former Chair Nelson took over Senate Finance. Vice Chair of Health and Human Services is newly elected Senator Lois Kolkhorst, previously a Representative and chair of the House Human Services Committee. For a list of all Senate assignments, link

Recently introduced legislation that may be of interest includes the following:

Bill No.	Description	Link
HB 116	Relating to expanding eligibility for benefits under the Medicaid program	Link
HB 334	Relating to a defense to prosecution of the offense of Medicaid fraud.	Link
HB 761	Relating to the payment for services provided by certain types of health care practitioners under contracts between the practitioners and managed care health benefit plans.	Link
HB 817	Relating to the contingent establishment of a health benefit exchange tailored to the needs of the state.	Link
HB 818	Relating to the establishment of a health benefit exchange tailored to the needs of the state.	Link
HB 881	Relating to outsourcing a service performed by a health and human services agency to a private commercial contractor.	Link
SB 55	Relating to the creation of a grant program to support community mental health programs for veterans with mental illness.	Link
SB 353	Relating to state agency contracting	Link
SB 889	Relating to the creation of a grant program to support community mental health programs for veterans with mental illness.	Link

New Insurance Commissioner is Announced. David Mattax has been named the new Commissioner of Insurance, effective January 20th. Mattax served as a deputy attorney general for defense litigation, past director of defense litigation, and past chief of the financial litigation division for the Texas Attorney General's Office. In his prior role, he has defended the Texas Department of Insurance since 1992 in rule promulgation and defense of agency actions. Mattax replaces former Insurance Commissioner Julia Rathgeber who has temporarily left the Department of Insurance to serve as Governor Abbott's Deputy Chief of Staff. However, Rathgeber has publicly announced she intends to return to the Department as Commissioner following the conclusion of the legislative session, which is scheduled to end June 1st.

New Interim Commissioner of the Department of State Health Services is Appointed. Kirk Cole, associate commissioner of the Texas Department of State Health Services (DSHS) has been named interim commissioner of the agency effective February 1st. Cole replaces Dr. David Lakey, who left the agency to accept a joint position with the University of Texas System and University of Texas Health Science Center in Tyler. Texas Health and Human Services Executive Commissioner Kyle Janek announced the launch of a national search to find a permanent replacement for Lakey. Cole, who is not a physician, previously served as a DSHS associate commissioner and was Lakey's second in command. Janek also announced their intent to name a chief medical executive licensed to practice medicine to advise Cole on health issues and medical aspects of the agency's programs and services. The Department of Health Services has

12,000 employees and an annual budget of $3.2 billion. The agency oversees disease prevention and bioterrorism preparedness, family and community health services, environmental and consumer safety, regulatory programs and mental health and substance abuse prevention and treatment programs.

Wyoming

State Legislators to Draft Expansion Compromise. On January 28, 2015, *The Washington Post* reported that Wyoming is moving towards expansion as lawmakers set out to draft a compromise between two Republican proposals. The first proposal, backed by Governor Matt Mead and the state health department, requires Medicaid recipients to pay low monthly premiums. Beneficiaries would also be provided with employment assistance programs and vocational rehabilitation programs. The second proposal, backed by Senator Charles Scott, sets up a state-funded health savings fund, similar to one recently approved in Indiana. Mead hopes to combine the two proposals. Read More

National

Obama Calls for Government to Negotiate for Specialty Drug Prices. On February 2, 2015, *TwinCities.com* reported that Obama's health care budget proposal seeks to allow Medicare to negotiate with drug companies for lower prices on specialty drugs that require large copayments from patients. Health insurers have been highlighting the high cost of drugs, like Hepatitis C medications. The head of the Pharmaceutical Research and Manufacturers of America, John Catellani, said that Obama's new plan, however, would alter the structure of the Medicare prescription program and drive premiums up. Read More

State Medicaid Programs Look for Hepatitis C Deals. On January 29, 2015, *The Wall Street Journal* reported that Medicaid programs are negotiating deals and discounts with pharmaceutical companies. Missouri and Connecticut are currently slated to receive discounts on hepatitis C medication in exchange for preferred status. Missouri's arrangement with AbbVie's Viekira Pak will replace Gilead's Sovaldi as the preferred drug for Medicaid recipients. AbbVie will provide rebates in exchange for preferred drug status, cutting the state's costs 30 to 40 percent and saving $4.2 million this year. Previously in the week, UnitedHealth Group entered into a preferred deal with Gilead's Harvoni drug while Blue Shield of California entered into a preferred deal with AbbVie's Viekira Pak. Read More

Legislation Would Provide Access to Out of State Care for Children with Complex Conditions. On February 3, 2015, *Modern Healthcare* reported that the Advancing Care for Exceptional Kids Act of 2015, which provides access to out of state managed care options for children with complex conditions, has received bipartisan support among lawmakers. If the legislation is enacted, it could save Medicaid $13 billion over the first 10 years. However, the bill may run into a deadlock over healthcare reform. Read More

Obama's Budget Would Extend CHIP Through 2019. On February 2, 2015, *The Hill* reported that the health care budget proposal would extend funding for CHIP, set to end September 30 of this year, through 2019. The program covers over 8 million children. Read More

Industry News

Kindred Completes Acquisition of Gentiva Health Services. On February 2, 2015, Kindred Healthcare, a Louisville, KY-based company, announced that it has completed its acquisition of Gentiva Health Services. Including net debt, the deal is valued at $1.8 billion. The combined company will serve over 1.1 million patients and will have approximately $7.2 billion in revenues and $1.0 billion in operating income. Read More

IASIS Files for IPO. IASIS Healthcare Corp., a Franklin, Tenn.-based healthcare services company owned by TPG Capital, has filed for a $100 million IPO (likely a placeholder figure). The company plans to trade on the NYSE under ticker symbol IAS, with J.P. Morgan, BofA Merrill Lynch and Barclays serving as lead underwriters. It reports $9.3 million in net income on $2.5 billion in revenue for the year ending Sept. 30, 2014. Read More

LifePoint Completes Acquisition of Nason Hospital. On February 2, 2015, LifePoint Hospitals, a Brentwood, TN-based company, announced that it has finalized its acquisition of Nason Hospital, which will now be part of its Conemaugh Health System. Over the next 10 years, LifePoint will invest $8.5 million in capital improvements under the terms of the acquisition. Healthcare veteran Richard Grogan will act as interim CEO for Nason Hospital. Read More

Community Health Systems Sells Harris Hospital. On February 2, 2015, Community Health Systems, a Franklin, TN-based company, announced that the divestiture of its Newport, Arkansas based Harris Hospital was completed, effective February 1, 2015. CHS still operates nine hospitals in Arkansas. Read More

Community Health Systems to Pay $75 Million in Fraud Settlement. On February 2, 2015, *Reuters* reported that Community Health will pay $75 million as part of a settlement for illegally donating to county governments in New Mexico for Medicaid federal funding. According to the lawsuit, filed by Robert Baker in 2005, three of Community Health's hospitals donated money to secure a rural area Medicaid program funds. Through the program, for every dollar the state spent, the federal government provided three dollars. Read More

HCA Projects 2015 Revenues $38.5 Billion to $39.5 Billion; Earnings Forecast Weaker. On February 3, 2015, *The Wall Street Journal* reported that although HCA Holdings reported better than expected results for its fourth quarter, the company's projections of earnings per share fell below expectations. HCA predicted EPS would be $4.55 to $4.95, compared to the expected $5.15. The revenue forecast was in line with analyst projections at $38.5 billion to $39.5 billion. Read More

Centene Net Income Rises 64 Percent in 2014. On February 3, 2015, *Modern Healthcare* reported that Centene Corp. recorded net income of $271 million in 2014, up 64 percent from 2013, on $16.6 billion revenue, up 52 percent. This was largely in part due to reimbursements received for the health insurer premium tax from Texas. Additionally, revenue from exchanges, carrier health business growth, and new business in California and New Hampshire increased revenues this year. Centene has over four million members. Read More

Sovaldi Sales Reach $10.3 Billion in 2014. On February 3, 2015, *The New York Times* reported that sales of Gilead Sciences' Hepatitis C medication, Sovaldi, reached $10.3 billion in 2014. The company's other Hepatitis C medication, Harvoni, had $2.1 billion in sales. However, at $1,000 a pill, Sovaldi has put a lot of strain on health insurers, Medicaid programs, and prison systems. Read More

United in Preferred Deal with Gilead. On January 28, 2015, *Reuters* reported that UnitedHealth Group entered a deal with Gilead for preferred status on Harvoni hepatitis C medication, effective February 1, 2015. This applies to all commercial, fully insured customers through Optum RX in addition to self-insured customers. Other companies who made deals with Gilead include Aetna, Anthem, Humana, and CVS Health. Meanwhile, Express Scripts and the state of Missouri's Medicaid program made agreements with AbbVie for its Viekira Pak. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
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
March 27, 2015	Mississippi CHIP	Proposals Due	50,300
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 24, 2015	Mississippi CHIP	Contract Awards	50,300
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 1, 2015	Mississippi CHIP	Implementation	50,300
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 Welcomes: Karen Batia, Principal – Chicago, Illinois

Karen Batia comes to HMA most recently from Together4Health, LLC (T4H) where she served as the Chief Executive Officer. In this role, Karen was responsible for founding and implementing the start-up Care Coordination Entity comprised of more than 34 organizations serving vulnerable Medicaid-insured populations in Cook County. Some of her accomplishments include: obtaining funding through IL Healthcare and Family Services foundation gifts to create T4H model and business; establishing a for-profit LLC and securing initial capital investment for start-up of the company; developing care models; establishing a network of more than 100 provider organizations; participating in the national PRIDE Consortium formed to develop effective health plan models for expanding service and support networks to vulnerable populations; and achieving recognition for the T4H model in several publications including DHHS ASPE Medicaid Primer. During her tenure with Together4Health, Karen served in a dual role as the Executive Director of Heartland Health Outreach and Vice President of Heartland Alliance for Human Needs and Human Rights. This two-fold role allowed Karen to provide leadership to a workforce of 230 staff with an annual budget of $24M across integrated health care services including primary care, oral health care, behavioral health, and a continuum of housing options. Additionally, Karen spearheaded strategic and operational functions relative to health reform activities, integrated service delivery, and state/national advocacy efforts.

Prior to her work with Together4Health and Heartland Health Outreach/Heartland Alliance for Human Needs and Human Rights, Karen served as the Chief Clinical Officer for Heartland Alliance for Human Needs and Human Rights where she developed and implemented Heartland's Philosophy of Care and Fidelity Scale as well as established Philosophy of Care In Action, a Heartland University monthly series, and secured continuing education units needed for state professional license maintenance for attendees.

Additional positions that Karen has held include Senior Director, Mental Health and Addiction Services, Heartland Health Outreach/Mental Health and Addiction Services; Director, Mental Health Services, Chicago Health Outreach; Director, Homeless Mental Health Programs, Chicago Health Outreach; Practitioner, private psychotherapy practice; and Clinical Coordinator, Emergency Housing Program, Northwestern Memorial Hospital.

Karen received her Ph.D. in Clinical Psychology and her Master of Arts degree from The Gordon F. Derner Institute of Advanced Psychological Studies of Adelphi University. She received her Bachelor of Arts degree from The University of Michigan.

HMA Community Strategies Launches Blog

HMA Community Strategies (HMACS) has launched a blog, where HMACS team members will write about topics relevant to ongoing and past projects related to creating healthy, equitable and sustainable communities. Monthly blog posts will provide thoughtful analysis of an issue or strategy that HMACS is exploring. Some posts will dive deeper into recent events and the potential

impacts on the communities in which we live. Other posts will showcase where the HMACS team is in the community, services we are providing, and the local perspectives we are learning.

Visit the HMACS blog: http://hmacs.healthmanagement.com/blog/

For more information about the blog or HMACS, please contact Jackie Laundon at jlaundon@healthmanagement.com.