HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

UPDATE ON CAPITATED DUALS DEMONSTRATION ENROLLMENT

This week, our *In Focus* section reviews publicly available data on enrollment in financial and administrative alignment demonstrations for dually eligible beneficiaries (duals) in seven states currently serving duals in a capitated financial alignment model. These seven states – California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia – have begun either voluntary or passive enrollment of duals for fully integrated Medicaid and Medicare benefits under a three-way contract with the Centers for Medicare & Medicaid Services (CMS) and health plans, known as Medicare-Medicaid Plans (MMPs). Three additional states – Michigan, Rhode Island and Texas – also have established a demonstration with CMS but have not begun enrollment, as described further, below. As of February 2015, more than 300,000 duals are enrolled in a MMP, based on state-based and CMS reporting.

Note on Enrollment Data

Three of the seven states – California, Illinois, and Massachusetts – are reporting monthly enrollment in their duals demonstration plans, while another – Ohio – is intermittently reporting enrollment. However, as with Medicaid managed care enrollment reporting, there is often a lag in published data. These four states have reported enrollment data through January 2015 (California through February 2015). Duals demonstration plan enrollment is also available through CMS Medicare Advantage monthly enrollment reports, which are published around the middle of each month. In the table below, we provide the most current state-reported data, with CMS data supplementing where needed. Historically, we have seen some inconsistencies between state-reported data and the CMS enrollment report, ranging from less than one percent in Massachusetts to more than 12 percent in California.

Duals Demonstration Enrollment Overview

In the past six months, enrollment in duals demonstrations has increased more than 150 percent, topping 300,000 at the beginning of 2015. California, Illinois, and Ohio have the largest enrollment in duals demonstration plans.

State	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
California	44,804	48,976	51,527	58,945	122,908	123,059
Illinois	46,870	49,060	49,253	57,967	63,731	66,223
Massachusetts	17,739	17,465	18,104	17,918	17,867	17,583
New York					17	406
Ohio					68,262	66,892
South Carolina						83
Virginia	21,958	28,642	29,648	27,701	27,527	26,877
Total Duals Demo Enrollment	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**301,123**

Sources: State Enrollment Data, CMS Enrollment Data

So far, enrollment in these seven states represents less than 25 percent of the potential enrollment of more than 1.3 million across all ten capitated demonstration states.

	Current Enrollment	Potential Enrollment	% Enrolled (Full Potential)
California	123,059	350,000	35.2%
Illinois	66,223	136,000	48.7%
Massachusetts	17,583	90,000	19.5%
Michigan		105,000	0.0%
New York	406	178,000	0.2%
Ohio	66,892	114,000	58.7%
Rhode Island		28,000	0.0%
South Carolina	83	53,600	0.2%
Texas		168,000	0.0%
Virginia	26,877	78,600	34.2%
Total (All States)	**301,123**	**1,301,200**	**23.1%**

Sources: State Enrollment Data, CMS Enrollment Data, HMA Estimates.

Enrollment should be expected to grow significantly in the coming months, with New York and South Carolina having just begun voluntary enrollment, and Michigan and Texas set to begin voluntary enrollment on March 1, 2015. By July 1, nine of the ten states pursuing a capitated duals demonstration should be in the passive enrollment phase, with Rhode Island the only state still finalizing an implementation timeline.

Duals Demonstration Enrollment by Health Plan

As of February 2015, a little over half of all duals in a demonstration are enrolled in a publicly-traded MCO, with Molina leading the pack, enrolling just under 34,000 duals, as listed in the table below. Health Net and Aetna are the second and third largest in terms of both publicly-traded and overall MMP enrollment, with close to 28,000 and just over 24,000 enrollees, respectively. Inland Empire Health Plan in California is the largest non-publicly traded MMP, and the fourth largest MMP overall.

Looking ahead, Molina, Anthem, and Centene are poised to potentially see the largest growth in duals enrollment, based on potential enrollment across all ten states and even distribution among plans within those states. WellCare is the only publicly-traded MCO not listed in the table below; WellCare should begin to see enrollment in the New York demonstration in the coming months.

Health Plan	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Molina	12,514	13,387	13,656	16,379	34,267	33,991
Health Net	8,783	11,555	13,299	16,089	29,093	27,735
Aetna	6,717	7,004	7,002	8,123	24,206	24,161
Humana	15,655	18,253	18,711	18,700	19,663	19,981
Anthem	11,626	14,291	15,025	14,704	18,147	18,316
United					14,350	14,072
Centene	847	895	953	1,209	12,420	12,277
CIGNA/HealthSpring	7,561	7,908	7,722	8,667	9,899	10,500
Total Publicly Traded Plans	**63,703**	**73,293**	**76,368**	**83,871**	**162,045**	**161,033**
Inland Empire	7,887	8,805	9,365	11,445	21,374	22,347
CareSource					16,271	16,065
LA Care	4,577	4,270	4,033	4,493	14,744	15,038
BCBS of Illinois	10,150	10,656	10,726	11,853	12,878	13,321
Care 1st	5,311	5,266	5,274	5,879	12,214	11,669
HP of San Mateo	2,673	2,673	2,682	2,694	10,226	10,157
Commonwealth Care Alliance	9,864	9,917	10,005	10,054	10,135	10,034
Meridian	6,308	6,562	6,663	7,739	8,641	9,342
Health Alliance	4,729	4,982	5,230	6,693	6,801	6,690
VaPremier	5,235	6,896	6,665	6,243	6,260	6,131
Santa Clara Family Health Plan					5,487	5,747
Community Health Group Partner	3,059	3,275	3,422	3,703	5,504	5,633
Fallon Total Care	6,415	6,110	5,930	5,796	5,740	5,606
Network Health	1,460	1,438	2,169	2,068	1,992	1,943
Guildnet						186
VNS Choice						80
AmeriHealth Caritas						34
Elderplan						31
Advicare						23
Independence Care System						13
Total Other/Local Plans	**67,668**	**70,850**	**72,164**	**78,660**	**138,267**	**140,090**
Total All Plans	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**301,123**

Sources: State Enrollment Data, CMS Enrollment Data

Note: *Health plans without enrollment data as of February 2015 are not included in the table above. For a full list of participating demonstration plans, see the Duals Calendar at the end of the HMA Weekly Roundup. A full list of the 22 participating plans in New York is available here.*

HMA Medicaid Roundup

Arizona

Judge Approves Settlement for Improved Inmate Health Care Coverage. On February 19, 2015, *AZCentral* reported that a federal judge approved a settlement to improve inmate health coverage after the American Civil Liberties Union filed a suit claiming the current health care system caused deaths and preventable injuries. The Arizona Department of Corrections denied the allegations. The settlement will affect 34,000 inmates and cost taxpayers $8 million a year. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Section 1115 "Bridge to Reform" Waiver. California's current section 1115 "Bridge to Reform" Medicaid waiver expires at the end of October. Over the last several months, the Department of Health Care Services (DHCS) has undergone a stakeholder engagement process to develop concepts for inclusion in the application to CMS to renew waiver authority for another five-year term. DHCS is seeking approval of the waiver by November 1. According to DCHS, "The new waiver will deliver quality, whole-person care to our members and contain rising health care costs that pave a path for sustainability of the Medi-Cal program." The new waiver will bring together federal, state, and local governments along with health plans, providers, and safety net programs to share accountability for members' health outcomes. DHCS intends to seek a waiver totaling between $15 billion to $20 billion to accomplish various system transformation initiatives. The new waiver design has three core components:

1) shared waiver savings with the federal government to be reinvested into Medi-Cal;
2) a redesign of Disproportionate Share Hospital (DSH) and Safety Net Care Pool funding under a global payment model to provide care to the remaining uninsured; and
3) a set of delivery system transformation and alignment incentives that lead to the achievement of waiver goals.

This set of delivery system transformation and alignment incentives includes incentives that foster partnerships and quality improvement among managed care plans, behavioral health systems, and providers; fee-for-service quality improvement incentives; a successor Delivery System Reform Incentive Payments (DSRIP) "2.0" at California's public hospital systems; incentives tied

to workforce development strategies; and incentives to promote access to housing and supportive services.

DHCS also plans to offer an opportunity for counties and associated Medi-Cal plans to partner in local pilots that include the aforementioned approaches across the spectrum of delivery system alignment and transformation. Additional information on the waiver renewal, including specific strategies under consideration, along with stakeholder input, is available on the waiver renewal website. A formal application for waiver renewal is anticipated to be submitted in late March to CMS. A draft application will be shared with the public for stakeholder input before submission, and DHCS will host a webinar to review the draft. DHCS has begun to engage CMS on the waiver design and to work toward agreement on terms and conditions of the five-year waiver. On February 20, 2015, *California Healthline* reported that the new 1115 Medicaid Waiver draft will be complete within a few weeks. Read More

1915b Mental Health Waiver Renewal. DHCS is preparing the 1915(b) Specialty Mental Health Services waiver renewal application that must be submitted to CMS by March 31. The existing waiver expires on June 30. As part of the waiver renewal development process, DHCS is convening a stakeholder webinar on March 2 from 9 a.m. to noon at the 1500 Capitol Avenue Auditorium in Sacramento. The purpose of the meeting is to provide stakeholders with an update on the current status of the waiver application and to provide information on the areas of focus being considered. Stakeholders will have an opportunity to provide comments/feedback at the meeting. The current 1915(b) waiver is available on the DHCS website. Please click here to view the agenda for this webinar. Any other materials will be provided prior to the webinar. No RSVP is required.

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Connect for Health Colorado Reports Enrollment at End of Second Open Enrollment Period. The marketplace performance in Colorado is getting mixed reviews now that the second open-enrollment period is over. According to the *Denver Post*, the state health insurance exchange signed up 139,652 Coloradans for commercial plans during the three-month open enrollment period. Almost 220,000 residents enrolled in a private or public plan, including 76,194 in Medicaid and 3,720 in Child Health Plan Plus.

Connecticut

Governor Malloy's Budget to Cut Health Care Services. On February 18, 2015, *The CT Mirror* reported that Governor Dannel P. Malloy will be making cuts to health care services and social services programs under his state budget. Malloy will cut Medicaid eligibility, shifting everyone who earns above 138 percent of the federal poverty line to the exchanges. This will save the state $44.6 million in the upcoming fiscal year and $82.1 million the following year. The state's Connecticut Home Care Program for Elders will stop taking new patients and raise cost sharing for existing patients from 7 percent to 15 percent. Non-primary care providers will face reimbursement cuts. A plan to better coordinate duals with disabilities will be eliminated. Hospitals will face higher taxes.

Mental health and substance abuse treatment providers will also face cuts worth $20 million. Additionally, Malloy will transfer the cost of public health initiatives to the insurance industry. Read More

Connecticut Exchange Enrolls Over 200,000. On February 23, 2015, *Hartford Courant* reported that Access Health CT has enrolled 204,358 people during open enrollment, 162,494 of which are Medicaid enrollees. The state will provide another month for a special enrollment period to those learning about the penalty tax for the first time. In total, the state's exchange has enrolled 552,603 people (442,508 through Medicaid) since October 2013. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Department of Corrections to Rebid Inmate Health Services Contracts. On February 23, 2015, *Health News Florida* reported that the Department of Corrections will rebid health care contracts for inmates after reports of abuse, unexplained deaths, and lawsuits from investigators who tried to expose the wrongdoings but were retaliated against. The contracts are worth approximately $1.4 billion. The department will add electronic health records requirements, liquidated damages provisions, and other enhancements to the contracts. The contracts will also address understaffing. The new contracts will ensure the presence of medical staff with proper skills and qualifications or companies will face high penalties. The new contracts are expected to drive up state costs. Read More

AHCA Will Authorize Over 3,100 New Nursing Home Beds. On February 19, 2015, *Health News Florida* reported that the Agency for Health Care Administration (ACHA) will authorize 3,115 new nursing home beds across the state at a cost of $350 million to $500 million. ACHA picked the beds from among 138 applications in seeking 18,000 beds across Florida. AHCA stated Florida will see the new surge of beds by 2017. Revenues from the new beds can bring in $285 million a year. Read More

Florida Approves 22 New Nursing Homes. On February 21, 2015, *Health News Florida* reported that the AHCA announced it will open 22 new nursing homes in addition to expanding beds in 11 facilities. Construction for the new homes is worth $430 million. However, the state will still be short 500 beds of its estimated need. News of the approval came the same day as the new nursing home scores were released. An analysis by *USA Today* found that 61 percent of homes received lower scores as a result of the tougher standards. Read More

Senate Majority Leader Galvano Calls for Expansion. On February 20, 2015, *Herald-Tribune* reported that Senate Majority Leader Bill Galvano (R) made a new call for the state to expand Medicaid. He stated that Florida is entering a crisis, with $2 billion in federal funding for safety net hospitals at stake. Expansion would also make 800,000 Floridians newly qualified for Medicaid. State Rep. Greg Steube (R) said there are no signs House leaders will act on this. Read More

Florida Leads Nation with Highest Exchange Enrollment. On February 18, 2015, *Associated Press* reported that Florida had 1.6 million people sign up for health coverage through the exchanges, the highest enrollment among all states. However, the state has been dealing with much opposition from Republicans,

who are fighting against Medicaid expansion. The high enrollment, despite opposition, points to Florida's high uninsured rate, at 19.5% percent, the third highest in the country. Read More

Florida Health Choices Struggling To Sell Amidst Obamacare Exchange. On February 19, 2015, *Jacksonville.com* reported that Florida Health Choices, the state's rival online marketplace to the federal exchange is struggling to sell coverage. It sold only 42 comprehensive plans during open enrollment. This will bring in roughly $253,000 in premiums. The website, however, cost millions to create. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Won't Meet Deadline to Move People with Developmental Disabilities Out of State-Run Psychiatric Hospitals. On February 20, 2015, *Georgia Health News* reported that the state has acknowledged that it will be unable to meet a June 30 deadline to transfer people with developmental disabilities out of state-run hospitals. The deadline was part of a five-year settlement with the Department of Justice to end all admissions of developmentally disabled people into psychiatric hospitals and remove those that remain. Additionally, the state was to establish community services for 9,000 people with mental illness, and provide community support to prevent hospitalization. However, problems arose with the state-provided community living situations, where 10 percent of the 480 people with developmental disabilities died after being transferred from a psychiatric hospital to the community. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Select Details of Governor's Budget Proposal for Medicaid Revealed. On February 23, 2015, the Illinois Department of Healthcare and Family Services (HFS) posted their overview slides on the impacts of Governor Rauner's proposed budget on the Medicaid program. Additional details were provided to the public at the state's Medicaid Advisory Committee (MAC) meeting held on Friday, February 20, 2015. Highlights from the slides (available here) and MAC meeting are detailed below.

- Rolling back of several optional services and rate increases to SMART Act levels. The SMART Act, implemented in 2012, cut many optional services and instituted rate cuts to providers. Recently many of these services were added back to the Medicaid benefit and rates to certain providers have increased. The Governor's budget would rescind these service additions and rate increases.
- Elimination of non-claims-based static payments to hospitals, including a portion of payments generated by the hospital assessment program.
- A reduction in funding to nursing facilities and elimination of funding for institutions for mental diseases (IMDs).
- Elimination of care coordination fees paid to non-risk provider-led Care Coordination Entities (CCEs) and Accountable Care Entities (ACEs).

- Reduction of 1.5 percent to Medicaid MCO rates. As a note, the elimination of several services and other rate reductions would further reduce MCO rates beyond the 1.5 percent cut as proposed.
- Increased efforts to verify Medicaid eligibility and reduce fraud and abuse.
- Reduction in pharmacy dispensing fee.

These proposed changes make up the bulk of the $1.47 billion in budget reductions for FY 2016. Many of these programmatic changes would require legislative action as well as federal approval. The Governor's budget proposal has drawn already criticism from many democratic legislators, who hold a veto-proof majority in both chambers of the Capitol. Several legislators have predicted the budget negotiations will extend beyond the legislative session's scheduled end of May 31, 2015.

Rauner's Medicaid Cuts May Ultimately Increase Costs, Critics Say. On February 24, 2015, *Kaiser Health News* reported that critics of republican Governor Rauner's proposed cuts say the targeted services were in place to save the state money. Rep. Greg Harris (D) stated that cutting services results in a more expensive higher level of care. For instance, if dental services are cut, people discontinue going to the dentist and end up in an emergency room, costing the state more money, said Senate President John Cullerton (D). Additionally, Rauner cut $735 million in hospital reimbursements at a time when 40 percent of the state's hospitals are operating in the red. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Dr. Monica Bharel Begins as Commissioner of the Department of Public Health. On February 24, 2015, *Boston.com* reported that Dr. Monica Bharel has been sworn in by Governor Charlie Baker to run the Department of Public Health. She was previously Chief Medical Officer of the Boston Health Care for the Homeless Program. As commissioner, her focus will be on opioid addiction, homelessness, and health care reform. Read More

Governor Baker Maintains Call for MassHealth Overhaul. On February 19, 2015, *The MetroWest Daily News* reported that Governor Charlie Baker is continuing a push to overhaul the MassHealth program. Baker hopes to implement reforms and initiatives to reduce spending in the program and bring the rate of growth to a level consistent with that of the budget. This year's budget for MassHealth is $13.7 billion, including state and federal revenues. Read More

New Jersey

Karen Brodsky (Email Karen)

New Jersey Experiences Steady Increase in Marketplace Enrollments. On February 23, 2015, *NJSpotlight* reported that the federal Marketplace open enrollment period ended on February 15, 2015 with 252,792 New Jersey residents signed up by the deadline. This represents 40 percent of all state residents who were eligible to enroll, which is comparable to the enrollment rate of other federal Marketplace states at 41 percent. Most enrollees will qualify for

federal tax credits to help with the cost of premium payments. As of January 2015, 83 percent of enrollees qualified for tax credits. New Jersey residents could lose these tax credits if the U.S. Supreme Court rules that the text of the ACA only allows for subsidies on state-run exchanges in the case of King v. Burwell, which will be decided in June or July of this year. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

New York State of Health Exchange Enrollment in 2015. New York State of Health, the state's health exchange, issued a press release announcing final enrollment tallies for the open enrollment period that ended February 15, 2015.

The breakdown of enrollees as of the February 15, 2015, is as follows:

- Total cumulative enrollment: 2,109,634
- Total Medicaid enrollment: 1,545,319
- Total private coverage: 564,315 (407,488 in Qualified Health Plans, or QHPs, and 156,827 in Child Health Plus, or CHP)
- Total new 2015 enrollment: 552,993
- Total new 2015 Medicaid enrollment: 373,518
- Total new private coverage: 179,475 (137,410 in QHP and 42,065 in CHP)
- Renewal rate in QHP coverage: 87 percent

Enrollment in private plans, both QHPs and CHP, grew more robustly than enrollment in Medicaid; individuals and families in QHPs and CHP now represent almost one-third of total enrollment. New Yorkers who have enrolled in coverage through the health exchange have reported that they are satisfied with their health insurance (92 percent) and are using their coverage to access care (84 percent).

New York State of Health Exchange Special Enrollment Period. Mirroring a decision made by CMS, on Friday, February 20, NYSOH announced that it would establish a special enrollment period for individuals and families who had to pay a federal penalty for 2014 and had not been aware or had not understood that they would have to pay a penalty for not having health insurance coverage. New York State is following the CMS lead in establishing a special enrollment period because the CMS decision only affects the federally-facilitated exchanges. The special enrollment period will start on March 1 and end on April 30, 2015. To be eligible, individuals must attest that when they filed their 2014 federal tax return, they paid a penalty for not having health insurance in 2014, and that they first became aware of or understood the implications of not having health insurance in 2014 when they filed their federal tax return.

New York-Presbyterian to Absorb New York Hospital – Queens. Crains HealthPulse reports that the New York-Presbyterian Hospital filed a certificate-of-need application to become the active parent of New York Hospital Medical Center-Queens. NYH-Queens has been an affiliate of the New York-Cornell Medical Center since 1992. In 1997 New York-Cornell merged with the Presbyterian Hospital, creating a system now known as the New York-Presbyterian Healthcare System. The proposed change would allow NY-

Presbyterian to gain oversight over the hospital's day-to-day operations. The hospital will be renamed New York-Presbyterian/Queens.

Home and Community Based Services Settings Transition Plan. Based on CMS guidance that was released in December 2014, the Office for People with Developmental Disabilities has made revisions to its Home and Community Based Services (HCBS) Settings Transition Plan and posted the revised plan for public comment. The plan now applies to all settings, including day habilitation and pre-vocational services, not just to residential settings. The federal regulations establish additional rights that must be honored for HCBS waiver participants. Modifications must be: supported by specific, assessed need; justified in the person-centered service plan; and documented in the person-centered service plan. Public comments on the revised transition plan will be accepted through March 18, 2015. The draft plan can be found on the OPWDD web site along with a description of the process for submitting public comment.

North Carolina

Group Home Transition Funding Ending. On February 23, 2015, *North Carolina Health News* reported that the "bridge" funding for people with mental health and developmental disabilities in group homes is ending. The funding was a temporary solution to help those who lost Medicaid-funded personal care services in 2012. Lawmakers failed to create a long-term solution for the affected people in 2013. Thus, temporary funding of $2 million was provided to tide the group homes over for fiscal 2014, ending July 1, 2015. Funding, however, ran out four months prior to the end of the year. Read More

Gov. McCrory to Wait for Subsidy Court Ruling to Make Recommendation on Expansion. On February 18, 2015, *fayobserver.com* reported that Governor Pat McCrory (R) will wait to make a recommendation on whether to expand Medicaid until a Supreme Court ruling regarding federal exchange subsidies. He claims the court case has too many ramifications. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Governor Kasich Presents State of the State. Ohio's Governor John Kasich (R) made his fifth State of the State address on February 24 in Wilmington, Ohio. The Governor compared the beginnings of today's economic turnaround in Wilmington to Ohio's economic recovery, pointing to the $8 billion deficit now replaced by a $1.5 billion surplus. The Governor talked about his plans for health care, though he did not mention the Medicaid expansion, which is continued through appropriations in his budget bill. He discussed his proposals on infant mortality and investments to help move individuals with developmental disabilities out of institutions and into homes, and to provide more services for individuals needing behavioral health services. The full text of the Governor's State of the State address can be found here.

Ohio's Efforts Continue toward Value-based Payment Models for Primary Care and High-cost Episodes of Care. Over the past year, the Governor's Office of Health Transformation has continued working with payers, plans, providers and patient advocates toward value-based payment models for primary care and high-cost episodes of care. In March 2015, Ohio's largest health insurance

plans will begin sending reports to providers who are principally accountable for six episodes of care. On February 20, the Governor's Office of Health Transformation hosted a webinar to describe the process that was used to develop the reports, what the reports contain, and how payments will relate to performance in the future.

Oregon

Oregon Suing Oracle for Terminating Medicaid System Contract Early. On February 18, 2015, *Katu.com* reported that the state is suing Oracle Inc. for planning to terminate its contract at the end of February 2015, after promising to renew it. Oregon's Medicaid system runs on Oracle technology, and terminating the contract will bring Medicaid to a halt. The state hopes a judge will force Oracle to continue to provide technology services. Oracle processes approximately 26,000 enrollments a week. Oracle claims it never made any promises to continue its services and blames the administration for not having a backup plan. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

PHC4 Research Brief Addresses Hospital "Superutilizers." A small number of patients hospitalized in Pennsylvania account for 11 percent of admissions and 14 percent of the bed days for fiscal year 2014. According to a research brief published by the Pennsylvania Health Care Cost Containment Council (PHC4), and as reported by the *Philadelphia Inquirer*, these patients, who are referred to as superutilizers, were admitted five or more times in the past year. The report noted that superutilizers are associated with 14 percent of Medicare payments and 17 percent of Medicaid payments from 2012. The break outs of the rate of superutilizers per 10,000 residents, by county, and by reasons for hospitalizations indicate that Philadelphia had a rate of 33.2 per 10,000; the top three reasons were for heart failure, blood infections and mental health disorders. Read more

UCLA's Dr. David Feinberg Named Geisinger CEO. Geisinger Health System has found a replacement for retiring president and CEO Dr. Glenn Steele, states *Modern Healthcare*. Dr. David Feinberg, who is currently the President of the University of California at Los Angeles Health System and Associate Vice Chancellor of UCLA Health Sciences in California, will start on May 1. Geisinger's Medical Assistance HealthChoices plan has over 130,000 enrollees as of December 2014. Read more

Many Children in Pennsylvania Have Dental Benefits but Don't Use Them. Katherine Mulligan, Pennsylvania Regional Director with DentaQuest, notes in an opinion piece published in the *Pittsburgh Post-Gazette*, that despite significant increases in people receiving preventive dental care there are still many who do not access these services. A November 2014 study by the Children's Hospital of Philadelphia highlights that efforts through the Pennsylvania Medical Assistance Program have increased the number of children receiving preventative dental care and highlights increases among minority populations in particular. The author believes that if outreach efforts were continued and

adopted by all health plans the benefits of proper dental care would be realized as a reduction in overall health care costs. Read more

Utah

Senate Approves Medicaid Expansion Plan. On February 25, 2015, *The Baltimore Sun* reported that Governor Gary Herbert's Medicaid expansion proposal was approved by the Senate to move to a final vote in the House. The proposal is an alternative plan to enroll low income residents in private health plans. If approved, it would run for two years, not three, until 2017. However, House speakers say they will not move forward with the legislation. Read More

Hospitals Offer to Pay Expansion Costs. *CQ Roll Call* recently reported that Utah's hospitals are offering to pay the state's costs for Medicaid expansion since they would benefit most. However, Governor Gary Herbert (R) said that this will not be necessary in the first two years of the program. Herbert is currently trying to convince the state legislature to approve his Healthy Utah proposal. He says the state would not raise taxes; if the program becomes unaffordable, he will withdraw from it. Beneficiaries would be required to sign a form acknowledging that benefits could be cut in the future.

Virginia

Agreement Reached on State Budget. On February 23, 2015, *The Washington Post* reported that the Senate and House have reached an agreement on the state budget. While expansion was rejected, the budget includes $132.9 million for the health care safety net, which will double the budget of free clinics, provide health care and prescription benefits to 22,000 mentally ill patients, and increase funding for children's psychiatry and crisis services. Read More

Washington

Southwest Washington Behavioral Health CEO Resigns. On February 19, 2015, *The Columbian* reported that Connie Mom-Chhing, CEO of Southwest Washington Behavioral Health, sent in her resignation last month. Her last day was February 20. Mom-Chhing will become chief behavioral health officer at Columbia United Providers in Vancouver, Washington. Southwest Washington Behavioral Health provides mental health services for Medicaid clients. It will cease to exist by April 2016, when a statewide Medicaid integration plan goes into effect and services are transferred to managed care companies. Read More

National

MACPAC to Hold Public Meeting. The Medicaid and CHIP Payment and Access Commission will hold a public meeting on February 26-27. The event will be held at the National Guard Association in Washington DC and cover the following topics: Extending CHIP: Short-Term Issues; Long-Term Policy Options for Children's Coverage; Update on Medicaid Expansions; Sites of Care Serving Medicaid Enrollees; Review of Medicaid Eligibility and Enrollment Issues; Improving Eligibility and Enrollment for the Medicare Savings Programs; Use of Psychotropic Medications by Medicaid Beneficiaries: Patterns

and Policy Issues; Medicaid Coverage of Dental Services for Adults; Medicaid Shared Savings: An Approach to Addressing Spending Growth; Themes from Administrative Capacity Roundtable.

Medicaid and CHIP Enrollment Up 19 Percent Since Expansion. On February 23, 2015, *The Hill* reported that Medicaid and CHIP enrollment grew to 10.75 million as of December 2014, a 19 percent increase since expansion began in 2013. The 28 expansion states had a 27 percent increase while states that did not expand had an increase of 7 percent. Read More

States Strive to Reduce Medicaid Emergency Room Visits to Cut Costs. On February 24, 2015, *The Pew Charitable Trusts* reported that states are attempting to cut costs by reducing emergency room admissions of Medicaid enrollees. Currently, almost half of all the states have put in place higher copayments to combat unnecessarily utilization. Other states, like Washington, enroll patients in primary care practices and schedule appointments. However, critics say dissuading emergency use can be dangerous for patients. Overall, emergency room spending accounted for only four percent of the national costs. Furthermore, only eight percent of emergency room visits were later deemed "not an emergency." Despite all this, states believe there are cost saving potential. Medicaid users visit emergency rooms twice as much as private plan enrollees and costs per visit are also on average four times as expensive. Read More

HHS Bans Plans with No Hospital Benefits. On February 23, 2015, *Kaiser Health News* reported that the Department of Health and Human Services released regulations that health plans lacking substantial hospital or physician services will not qualify as minimum value coverage and open up companies that offer them to fines. Large employers with low wage workers have been known to offer plans without any hospital benefits. The administration claimed such plans are "not a health plan in any meaningful sense," and released the new regulations February 20. Read More

Home Care Workers Join Movement to Increase Minimum Wages. On February 23, 2015, *USA Today* reported that home care aides will rally in 20 cities during the next two weeks seeking to raise the minimum wage to $15 an hour. Currently, home care aides make an average $9.60 an hour and an average annual salary of $18,600 because work is often part-time. Read More

Special Enrollment Period Extended. On February 20, 2015, *Kaiser Health News* reported that consumers who were previously unaware of the penalty tax on the uninsured will have a chance to sign up for coverage between March 15 and April 30 and only pay a portion of the fine next year. The special enrollment period will be available for federally run exchanges in 37 states. Some state exchanges may choose to grant the period as well. Read More

Industry News

Centene's Superior HealthPlan Awarded Contract for STAR Health Program. On February 20, 2015, the Texas Health and Human Services Commission announced a tentative award for Superior HealthPlan, Inc. to deliver managed care services for STAR Health, the statewide Medicaid managed care program for children in foster care. The STAR Health RFP was released April 16, 2014, with proposals due June 14, 2014. The operational start date is September 1, 2015. Read More

Prime Healthcare Approved for Purchase of Six Hospitals. On February 20, 2015, Prime Healthcare was approved to purchase six Catholic hospitals but under strict conditions. California Attorney General Kamala D. Harris ruled that Prime will need to keep all hospitals (four acute-care) open for the next 10 years. In addition, they must keep up the same amount of charity work for indigent patients as the Daughters of Charity Health System had. Prime will be reviewing the ruling for several days. The company had offered $843 million in cash and assumed debt for the hospitals in October. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February 16, 2015	Iowa	RFP Release	550,000
February/March, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
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
May 4, 2015	Georgia	Proposals Due	1,300,000
May 8, 2015	Iowa	Proposals Due	550,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
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
January 1, 2016	Iowa	Implementation	550,000
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; Anthem (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		11/1/2013	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	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

HMA News

HMA Webinar: *"Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards"*

Thursday, March 12, 2015
1:00pm Eastern
Link to Webinar Registration

HMA Information Services (HMAIS) will present the webinar, "Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards" at 1 p.m. EST Thursday, March 12.

The time for culturally responsive health care is now. Not only is it the right thing to do, but key elements are mandated by the federal CLAS (Culturally and Linguistically Appropriate Services) Standards. There is also a strong business case for culturally responsive health care; it drives patient satisfaction, helps improve outcomes, and brings a degree of economic viability to what is essentially an unfunded mandate. Unfortunately, many health care organizations find themselves either unfamiliar with the standards or lagging in the development and implementation of strategies for full compliance.

During this webinar, Health Management Associates Principal, Dr. Jeff Ring, will make the case for socially responsive health care and show your organization how to take the necessary steps to make it work for your patients and your organization.