

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... April 1, 2015



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THIS WEEK

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- ILLINOIS FY 2015 BUDGET FIX PASSES SENATE, SIGNED BY GOVERNOR
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- HMA WELCOMES: NORA LEIBOWITZ (PORTLAND, OR); JOHN O'CONNOR (COSTA MESA, CA); JIM PARKER (CHICAGO, IL)

IN FOCUS

MASSACHUSETTS DUALS DEMONSTRATION UPDATE

This week, our *In Focus* section reviews a presentation from MassHealth, the Massachusetts' Medicaid program, which provides an update, and solicits input, on One Care, the state's dual eligible financial alignment demonstration, which launched in October 2013. The update includes the status of enrollment by

rating category, the announcement of a new outreach campaign to encourage enrollment, preliminary results from an enrollee satisfaction survey, a breakdown of spending by category of service, and changes to the demonstration savings percentages and risk corridors. Below, we highlight key takeaways from the presentation.

One Care Savings, Risk Corridor Changes

The One Care presentation explains that in response to requests from the One Care plans, MassHealth and CMS have amended the financial methodology in the three-way contract to “provide additional financial protections and stability for the plans.” This includes a reduction in the applied savings percentages for Medicaid and for Medicare Parts A and B for demonstration Years 2 and 3. Savings percentages for Year 2 are to be reduced from 1.5 percent to 0.5 percent, while savings percentages for Year 3 are to be reduced from 4 percent to 2 percent. **Table 1** below details the Massachusetts changes as well as provides the savings percentages to be applied in other capitated financial alignment demonstration (FAD) states. The effect of these changes is essentially to increase One Care plans’ payment rates by 1 percent in Year 2 and 2 percent in Year 3 compared to what they previously would have been paid.

Table 1 – Aggregate Savings for Medicaid and Medicare Parts A and B, Percentages by Demonstration Year

	Demo Year 1	Demo Year 2	Demo Year 3
Massachusetts (Original)	0%/1.0%	1.5%	4.0%
Massachusetts (Revised)	N/A	0.5%	2.0%
California	1.0%	2.0%	4.0%
Illinois	1.0%	3.0%	5.0%
Michigan	1.0%	2.0%	4.0%
New York	1.0%	1.5%	3.0%
Ohio	1.0%	2.0%	4.0%
South Carolina	1.0%	2.0%	4.0%
Texas	1.25%/2.75%	3.75%	5.5%
Virginia	1.0%	2.0%	4.0%

Sources: MassHealth Update Presentation; State MOUs with CMS

Note: Demonstration years vary by state; some states’ Demonstration Year 1 is longer than a single calendar year.

It is interesting to consider whether or not plans in other states would be eligible for similar changes to the payment model. Massachusetts is the only state that has revised its aggregate savings percentages and risk corridor structure, although Massachusetts is the most mature demonstration program, having been implemented in late 2013. Most states, as detailed in **Table 1**, have aggregate savings percentages similar to Massachusetts’. One factor worth noting is that because of an existing integrated program in Massachusetts serving dual eligibles over the age of 65, the financial alignment demonstration only serves the under 65 dual eligibles, a predominantly disabled population. The costs associated with serving only this medically complex population may not be comparable to other states wherein the population being served under the dual eligible demonstration includes both elderly and disabled beneficiaries.

Additionally, the update states that the January 2015 contract addendum amends the risk corridor structure for Demonstration Year 1 and extends risk corridors into Years 2 and 3. The contract addendum shifts additional risk to the state and CMS, increasing the corridor in which MassHealth and CMS assume

90 percent of the gain/loss risk from 3 percent up to 10 percent, as detailed in **Table 2** below.

Table 2 – One Care Risk Corridors, Original and Amended

Original Risk Corridors		Amended Risk Corridors	
Gains/Losses 0% to 1.0%	No Sharing	Gains/Losses 0% to 1.0%	No Sharing
Gains/Losses 1.1% to 3.0%	90% MassHealth/CMS; 10% Health plan	Gains/Losses 1.1% to 10.0%	90% MassHealth/CMS; 10% Health plan
Gains/Losses 3.1% to 20.0%	50% MassHealth/CMS; 50% Health plan	Gains/Losses 10.1% to 20.0%	50% MassHealth/CMS; 50% Health plan
Gains/Losses >20.0%	No Sharing	Gains/Losses >20.0%	No Sharing

In terms of the possible implications of this change on other states, we note that not every state utilizes risk corridors. California has risk corridors in place for all three years, while Michigan intends to apply risk corridors in only the first demonstration year. Texas will utilize its gain-side experience rebate structure as currently exists in the STAR+PLUS program and functions similarly to a risk corridor, except only in sharing gains and not losses. The remaining states – Illinois, Ohio, South Carolina, and Virginia – have structures in place for reconciliation with plans based on medical loss ratios (MLRs).

One Care Enrollment Update

The One Care update also provides a breakdown of enrollment by health plan and by rating category for June 2014, with nearly 7,500 (55 percent) of enrollees across all plans in the “Community Other” rating category. The “Community High Behavioral Health (BH)” and “High Community Need” rating categories made up 22.4 percent and 16 percent of enrollment, respectively. As of March 2015, enrollment across all One Care plans has increased to nearly 17,800, per **Table 3** below.

Table 3 – One Care Enrollment (June 2014 and March 2015)

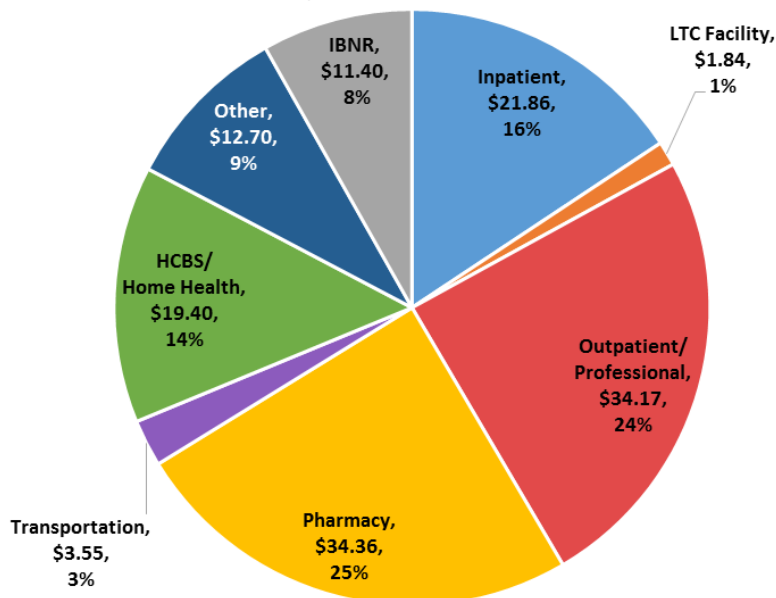
June 2014 Enrollment by Rating Category	Commonwealth Care Alliance	Fallon Total Care	Network Health (Tufts Health Plan)	Total	% of Total
C1 - Community Other	4,580	2,504	388	7,472	55.7%
C2A - Community High BH	1,375	1,253	373	3,001	22.4%
C2B - Community Very High BH	266	282	75	623	4.6%
C3A - High Community Need	1,491	596	63	2,150	16.0%
C3B - Very High Community Need	118	22	3	143	1.1%
F1 - Facility-Based Care	16	2	0	18	0.1%
Total	7,846	4,659	902	13,407	
% of Total	58.5%	34.8%	6.7%		
March 2015 Enrollment	10,287	5,615	1,895	17,797	
% of Total	57.8%	31.6%	10.6%		

Sources: MassHealth Update Presentation; March 2015 One Care Enrollment Report

One Care Financial Update

The One Care update also provides aggregate spending across all plans for the first nine months of the demonstration, October 1, 2013, through June 30, 2014, which totaled \$139.3 million and is detailed in the chart below. Pharmacy and Outpatient/Professional accounted for roughly half of all spending as reported by the One Care plans, with nearly identical levels of \$34.36 million (25 percent of total) and \$34.17 million (24 percent of total). Inpatient (\$21.86 million, 16 percent) and home and community based services (HCBS)/home health (\$19.4 million, 14 percent) making up the bulk of the remaining spending.

Chart 1 – One Care Spending (October 1, 2013 – June 30, 2014) (\$ Millions)



Source: MassHealth Update Presentation

The presentation also notes that spending over the first three quarters of the demonstration was impacted by the continuity of care period over the first three months of enrollment in a demonstration plan, during which time Members' prior services, provider relationships, and service authorizations are protected and must be paid for by the health plan. As of December 2013, 100 percent of enrollees would have still been in the continuity of care period, while only 35 percent were still in this continuity of care period by the end of June 2014.

Early Indicators Project (EIP)

Finally, the update included preliminary results from a survey the state conducted of enrollees approximately 120 days after enrollment. Overall, the preliminary survey responses were positive, including the following results:

- Over 80 percent had met with their PCP; most are satisfied with the PCP
- Over 70 percent had met with their Care Coordinator; 90 percent are satisfied
- Over 90 percent reported that the Care Team cared about their preferences and treated them with respect
- 90 percent of enrollees agree with services in their care plans
- Overall perceptions of One Care are positive
- 83 percent plan to stay in One Care

Links to Additional Information

[MassHealth One Care Update Presentation \(March 20, 2015\)](#)

[One Care Enrollment Update \(March, 2015\)](#)



HMA MEDICAID ROUNDUP

Arizona

Hospitals See Declining Operating Margins From Low Medicaid Rates. On March 29, 2015, *Arizona Daily Star* reported that despite a drop in uncompensated care, Arizona hospitals are experiencing declines in operating margins. The report cited lower revenue resulting from low reimbursement rates by Arizona's Medicaid program, according to the Arizona Hospital and Healthcare Association. Average hospital operating margins dropped from 3.3 percent in 2013 to 2.2 percent in 2014 according to the analysis. Governor Doug Ducey's FY 2016 budget will further lower rates by up to 5 percent. [Read More](#)

California

HMA Roundup – Warren Lyons ([Email Warren](#))

California Releases Proposed Section 1115 Waiver Application to CMS. On Friday, March 27, 2015, the Department of Health Care Services (DHCS) submitted a request to renew the state's section 1115 Medicaid Waiver for a new five-year term. The new waiver, "Medi-Cal 2020," seeks approximately \$17 billion in federal investment to further the achievements California has made in health care reform through a set of payment and delivery system transformation strategies. The application and concept paper are available at the [DHCS website](#). DHCS is seeking approval of the waiver from the Centers for Medicare & Medicaid Services (CMS) by November 1, 2015. Over the next few months, DHCS and CMS will collaborate on the terms and conditions of the new waiver. Concurrently, DHCS will continue to engage stakeholders, along with Administration and legislative partners, in the refinement of the waiver concepts. The California Medical Association and 17 other advocacy groups are urging CMS to require California to conduct an independent assessment of Medicaid provider reimbursement rates as a condition of approval of the state's 1115 Medicaid waiver. [Read More](#)

South LA Martin Luther King, Jr. Community Hospital to Reopen in June. On March 28, 2015, the *Los Angeles Times* reported that the Martin Luther King, Jr. Community Hospital will reopen in June with an emphasis on preventative treatments, a new urgent-care center, and outpatient and public health clinics. The new hospital will have 131 beds, no trauma center in the emergency room, and fewer medical specialties. Healthcare experts say this aligns with the latest thinking on how to provide care in the ACA era, embracing the idea of reducing costly hospital visits by keeping people healthy. [Read More](#)

Medi-Cal Patients Face Large Bills under Estate Recovery Program. On March 27, 2015, *Kaiser Health News* reported that under Medi-Cal's Estate Recovery Program, states can seize the assets of deceased patients for the cost of medical services. Ten states have this optional recovery program. Under this program, California recovered \$61 million, including costs of nursing homes, for 3,900 cases in 2013 and 2014. [Read More](#)

Connecticut

Analysis Finds Thousands Could Drop Medicaid Coverage Due to Cuts. On March 18, 2015, *New Haven Register* reported that an analysis by the Connecticut Health Foundation found that Medicaid eligibility changes could impact between 7,000 and 10,000 parents. The changes are included in Governor Dannel Malloy's proposed 2016-2017 budget, which would eliminate HUSKY coverage for parents with incomes between 138 percent and 201 percent of the federal poverty level who have children enrolled in the same coverage. These individuals would be eligible for subsidized marketplace coverage. [Read More](#)

State-Federal Dispute over Reimbursement for Medicaid Spending. On March 25, 2015, *The CT Mirror* reported that a disagreement between state and federal officials over how much Connecticut should be reimbursed for Medicaid spending has resulted in a \$45 million hole in the state budget. The governor's budget director, Benjamin Barnes, stated that Connecticut's budget deficit has grown by \$72 million to \$133 million. He claims the deficit is attributable to \$45 million in lower-than-anticipated Medicaid payments from the federal government. [Read More](#)

Florida

HMA Roundup – Elaine Peters ([Email Elaine](#))

Senate Passes Budget Bill with LIP Redesign. On April 1, 2015, the *Miami Herald* reported that the Florida Senate unanimously approved an \$80.4 billion budget, including the proposed changes to the Low-Income Pool (LIP) program reviewed in last week's *HMA Weekly Roundup* ([Read More](#)). Of a total health care budget of \$35.2 billion, the Senate's approved budget bill includes \$2.8 billion in federal money to pay for expanded health coverage through a new state-run marketplace. The House is set to vote on its own \$76.2 billion budget, which does not include LIP, on April 2, setting the state for budget conference negotiations between the two chambers before the legislative session ends at the end of April. [Read More](#)

Georgia

HMA Roundup – Kathy Ryland ([Email Kathy](#))

Georgia FY 2016 Budget. The Georgia House and Senate have approved the FY 2016 budget and sent to the Governor for his approval. A summary of the health care-related line items from the budget are detailed below:

Health Care Access & Improvement

- Line 84.4 – Eliminated \$1 million in startup funds for FQHC start up grants.

- Line 84.5 - Added \$250,000 startup funds for a FQHC in Wheeler County.
- Line 84.6 - Increases funds for grants, assisting the Rural Hospital Stabilization Committee with their efforts (state funds of \$3 million).
- Line 84.7 - Increases funds to increase capacity and expand services in charity clinics. (State funds of \$500,000).

Indigent Care Trust Fund

- To convene a task force to address support for uncompensated hospital care and loss of DSH funding.

Medicaid ABD

- Increase funds \$10.8 million total funds to address projected growth.
- Account for increased FMAP; enabling a reduction of \$34 million in state funds, but no change in overall budget.
- Provided no additional funding for high-cost Hep C drugs. (Presumably will be addressed in next year's amended budget).
- Increase funds for nursing home rates when operator changes; total funds of \$26.8 million (was supposed to have been implemented last year).
- Provided no funding for an ABD Care Coordination vendor.
- Restored previous unachieved savings anticipated from the PARIS system, total funds of \$1.5 million.
- Increased funds not realized from hospital cost settlements (\$7.9 million).
- Replaces unrealized savings from not implementing the ABD Care Coordination model, total funds of \$12.7 million.
- Increases funds from the nursing home provider fee (tax); total funds of \$652K.
- Increases the PSS rate in the ICWP by 5%; total funds of just under \$3 million.
- Provide skilled nursing services in the ICWP for those aging out of the GAPP waiver.
- Increase the ICWP rate for PSS provided by Direct Support Professionals by \$0.75 per hour; total funds \$6.1 million.
- Provided no funding for increased nursing home fair market rental rates.

Medicaid LIM

- Increase funds \$72.5 million total funds to address projected growth.
- Increase resulting from ACA presumptive eligibility requirements; total fund increase of \$18.9 million.
- Increase resulting from ACA 12 month eligibility requirements; total fund increase of \$116.1 million.
- Increase resulting from ACA "woodwork effect" on eligibility; total fund increase of \$8.5 million.
- Reduce funds for tax related to discontinuing the PCP rate increase previously required in the ACA; total fund reduction of \$3.3 million.
- Reduce funds for the foster care kids to managed care claims run out; reduction of \$14.4 million total funds.
- Restore funds for the CORE program; total funds of \$690K.
- Restore funds not saved from the PARIS system; total funds \$1 million.

- Account for increased FMAP; enabling a reduction of \$28.6 million in state funds, but no change in overall budget.
- Account for increased FMAP related to movement of CHIP children as required in ACA; enabling a reduction of \$18.9 million in state funds, but no change in overall budget.
- Restore funds not realized from hospital cost settlements; total funds of \$5.4 million
- Transfer funds to the GA Board of Physician Workforce for medical education; state funds of \$8 million.
- Increase funds resulting from increased Hospital Provider Fee reflected back in hospital reimbursements; total funds of \$24.6 million.
- Increase fees for selected OB/GYN codes to the 2014 Medicare fee schedule rate; total fund increase of \$18.1 million. (6 most commonly used codes).
- Increase adult rotary wing air ambulance rates to the pediatric rate; total funds \$1.5 million.
- Increase primary care rates for select codes; total funds of \$52.7 million (presumed to be 6 commonly used codes, at 90% of the 2104 Medicare rate).

PeachCare

- Increase funds \$22.8 million total funds to address projected growth.
- Account for increased FMAP; enabling a reduction of \$74.6 million in state funds, but no change in overall budget.
- Restore funds not saved from the PARIS system; total funds \$160K.
- Restore funds not realized from hospital cost settlements; total funds of \$683K. [Read More](#)

Georgia behind Deadline for Improving Care for People with Developmental Disabilities. On March 25, 2015, *Georgia Health News* reported that Georgia will not meet the July deadline to end admissions of people with developmental disabilities into state psychiatric hospitals and move over 200 patients already in the psychiatric hospitals into more appropriate settings. In addition, Georgia agreed to establish community services for over 9,000 people with mental illnesses and create community support to help prevent hospitalization for people with developmental disabilities and mental illness. [Read More](#)

Georgia Firm on No Medicaid Expansion while Other Republican States Debate Solution. On April 1, 2015, *Kaiser Health News* reported that while a growing number of Republican states are debating on a solution to expand coverage to low-income residents, Georgia stands firm on refusing to expand Medicaid. An estimated \$3 billion of federal money each year would flow to the state under an expansion, while hospitals in Georgia are reporting \$1.7 billion in care provided to the uninsured. [Read More](#)

Illinois

HMA Roundup – Andrew Fairgrieve ([Email Andrew](#))

FY 2015 Budget Fix Passes Senate, Signed by Governor. On March 26, 2015, the Illinois Senate approved a bill (HB0317) to remedy a shortfall in the current state fiscal year budget. The bill, which had been approved by the House earlier in the week, was signed by Governor Bruce Rauner the following day. As HMA reported last week, the bill applies a 2.25 percent annualized cut to Medicaid reimbursements for most providers as part of a remedy to a \$1.6 billion budget shortfall in FY 2015. As noted last week, this reimbursement adjustment will be applied in the last quarter of FY 2015, amounting to a more substantial reduction to reimbursements during that quarter.

Chicago-Area Hospice Provider Merger Announced. On March 31, 2015, Crain's Chicago Business reported that three Chicago-area hospice, palliative, and end-of-life care providers will merge to create the largest not-for-profit hospice provider in the state. Chicago-based Horizon Hospice & Palliative Care, Barrington-based JourneyCare, and Glenview-based Midwest Palliative & Hospice CareCenter will form a single entity to be led by current JourneyCare president and CEO, Sarah Bealles. The merger is expected to close by June 1, pending regulatory approval, and will serve an expected 2,500 patients in Chicago and 10 surrounding counties. [Read More](#)

Indiana

Three-Year Moratorium On Nursing Home Construction Approved. On March 31, 2015, *Indianapolis Business Journal* reported that the Senate approved 36-12 a three-year moratorium on construction of new nursing homes in the state. The state currently has thousands of unused beds that cost millions in annual Medicaid costs, according to supporters. [Read More](#)

Maryland

Exchange Audit Finds State Improperly Bills Federal Government \$28.4 Million. On March 27, 2015, *The Baltimore Sun* reported that a Department of Health and Human Services audit of the Maryland's Health Exchange found the state overbilled the federal government by \$28.4 million during the Exchange website's rollout. Auditors reported that no fraud or criminal wrongdoing took place but rather Maryland lacked oversight and internal controls. They recommended that the state refund the money and reapply for the proper amount. Maryland official, however, dispute most of the audit's findings and said they believed they were following federal guidelines. [Read More](#)

Massachusetts

HMA Roundup – Rob Buchanan ([Email Rob](#))

Over 1.1 Million MassHealth Members Must Reapply for Coverage. On March 26, 2015, *Telegram.com* reported that of the 1.7 million MassHealth members, 1.1 million will need to reapply to receive coverage. For nearly two years, enrollees did not have to verify if they still qualify for MassHealth, preventing anyone from losing coverage but also keeping on those who may no longer qualify. This

was, in part, because of issues regarding the Health Connector website last year. [Read More](#)

Michigan

HMA Roundup – Esther Reagan ([Email Esther](#))

The following updates come from HMA's monthly *Michigan Update*.

Medicaid Managed Care Enrollment Activity. As of March 1, 2015, there were 1,606,323 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled in 13 Medicaid Health Plans (HMOs). This is an increase of 19,994 since February. The enrollment total reflects an increase of 19,720 HMP enrollees since February and an increase of 274 non-HMP Medicaid enrollees. Even with this increase, the total number of non-HMP Medicaid managed care enrollees in March – 1,163,003 – is still well below the June 2014 enrollment figure of 1,330,638. [Read More](#)

Healthy Michigan Plan. At the one year anniversary of implementing the Healthy Michigan Plan (HMP), enrollment continues to grow, far exceeding original expectations. The Michigan Department of Community Health (MDCH) reports that since launching the program on April 1, 2014, enrollment has grown to 603,681 as of March 30, 2015. [Read More](#)

Trends in Medicaid Enrollment. As noted in the Healthy Michigan Plan article, enrollment in the Healthy Michigan Plan (HMP) continues to climb through March 2015. However enrollment in non-HMP Medicaid (or "traditional" Medicaid) has been declining for nearly a year. [Read More](#)

Duals in Medicaid HMOs. There were 56,486 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits in March 2015, an increase of 709 since February. All Medicaid HMOs have duals enrolled, although the numbers vary dramatically across plans. [Read More](#)

CSHCS Children in Medicaid HMOs. The Michigan Department of Community Health (MDCH) requires children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program to enroll in Medicaid HMOs. As of March 1, 2015, there were 17,615 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs – a decrease of 25 since February. All Medicaid HMOs except Harbor Health Plan, Inc., have CSHCS/Medicaid enrollees, although the numbers vary across plans.

Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most CSHCS/Medicaid enrollees receiving their services from an HMO, 25.1 percent of the total. Molina Healthcare of Michigan has 17.7 percent of the total; UnitedHealthcare Community Plan has 16.7 percent; and the other nine plans share the remaining 40.5 percent.

MiChild. According to MAXIMUS, the Michigan Department of Community Health (DCH) contractor for MiChild enrollment, there were 42,490 children enrolled in the MiChild program as of March 1, 2015. The March enrollment total reflects an increase of 1,644 from the 38,196 to 40,846 children enrolled as of February 1, 2015. Of the total number of children enrolled, 872 enrollees are

dually eligible for Children's Special Health Care Services (CSHCS) and MIChild. [Read More](#)

Medicaid Budget for Fiscal Year 2016. The last full week of March saw a flurry of activity on the Michigan budgets for fiscal year (FY) 2016, including action by Appropriations Committees in both the House and Senate on the budget for the Michigan Department of Community Health (MDCH). Both chambers of the legislature proposed significant changes to the governor's recommendations for the Medicaid program. [Read More](#)

Michigan's Blueprint for Health Innovation. As previously reported in *The Michigan Update*, Michigan received a \$70 million award from the federal government under the State Innovation Model (SIM) initiative. The Michigan Department of Community Health, as the awardee, is being assisted by a team led by the Michigan Public Health Institute (MPHI), which is managing implementation of the *Blueprint for Health Innovation (Blueprint)*. As stated in recent MPHI documents, the purpose of this award is to "test strategies to achieve better health and better care at lower costs through service delivery innovations, payment reforms, and population health improvement investments." [Read More](#)

ACA Impact in Michigan. The Center for Healthcare Research and Transformation (CHRT) at the University of Michigan has released two issue briefs related to the impact of the Affordable Care Act (ACA) on Michigan. [Read More](#)

Montana

Medicaid Expansion Compromise Bill Wins Approval in Senate. On March 30, 2015, *Montana Public Radio* reported that Senator Ed Buttrey's Medicaid expansion bill, SB 405, won approval in the state Senate 28-21 on the final vote. [Read More](#)

New Hampshire

House Finance Committee Opts to Maintain Medicaid Funding. On March 23, 2015, the *Concord Monitor* reported that members of the House Finance Committee reversed their decision to eliminate coverage for Medicaid services not mandated by the federal government. Representatives first voted to cut coverage for 20 categories of optional Medicaid services for adults over age 21. The decision to reverse the cuts came as a result of newly available money, according to Representative Richard Berry. [Read More](#)

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

New Jersey Ranks Lowest Among States for Physicians Willing to Accept New Medicaid Patients. According to data recently released by the U.S. Centers for Disease Control and Prevention, only 38.7 percent of New Jersey physicians are accepting new Medicaid patients. The second lowest ranking state is California at 54.2 percent, and the national average rate is 69 percent. The results are striking at a time when the Medicaid enrollment in NJ FamilyCare has grown by over 500,000 as a result of Medicaid expansion. [Read More](#)

State Supreme Court Agrees With 2013 Appellate Court Ruling to Allow the Discontinuation of Medicaid Coverage to Legal Immigrants. On March 30, 2015 NJ.com reports that New Jersey's Supreme Court ruled in favor of the Department of Human Services decision to eliminate eligibility to legal immigrants who are otherwise excluded from receiving any federal means-tested public benefit for a period of five years following their entry into the United States under the Personal Responsibility and Work Opportunity Reconciliation Act. New Jersey removed the residency requirement in 2005 when it determined that without Medicaid coverage, the state experienced higher costs in emergency hospital charity care. The five-year residency requirement was reinstated for most legal immigrants enrolled in NJ FamilyCare in 2010 during the state budget crisis. [Read More](#)

Bergen County Behavioral Health Home Services Approved for Children and Adults. CMS has approved a behavioral health home State Plan Amendment allowing New Jersey's Bergen County to provide BHH services to adults with a serious mental illness who are high or at-risk high utilizers and to children with two or more chronic conditions. The state will work with interested providers to develop an initial BHH network. Adult behavioral health homes will be administered jointly by the NJ Division of Mental Health and Addiction Services (DMHAS) and the Division of Medical Assistance and Health Services (DMAHS). Both divisions will continue to pay for behavioral health treatment. The patients' physical health claims will be paid by Medicaid managed care organizations.

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

Behavioral Health Managed Care Transition. The Medicaid Redesign Team Behavioral Health Work Group met on March 27, 2015, for an update on the transition of behavioral health benefits into the Medicaid managed care benefit. As part of the carve-in New York has also created a Medicaid managed care benefit for individuals with serious mental illness, called Health and Recovery Plans (HARPs), which in addition to mainstream benefits includes a number of home and community based services. The Office of Mental Health and the Office for Alcohol and Substance Abuse Services provided the following information. Meeting materials and a webcast of the meeting are available on the [MRT website](#).

The behavioral health carve-in is scheduled to begin in New York City on July 1, 2015. CMS is expected to approve the standard terms and conditions for the behavioral health carve-in imminently. Mainstream Medicaid managed care plans in NYC responded to an RFQ that qualified them to provide all behavioral health benefits to their members and/or to operate a HARP. While initially the state planned to allow HIV Special Needs Plans (Medicaid managed care plans for individuals with HIV/AIDS that provide enhanced benefits) to offer a HARP product, that has changed. Rather, the HARP benefits will be added to the HIV SNP benefit package so current SNP enrollees will be able to access HCBS benefits not provided by the SNP.

Below is a table indicating how plans have been qualified, as well as identifying their behavioral health partner, when appropriate.

Plan Name	Conditional Designation	BHO Partner
Affinity	Mainstream	Beacon
Amerigroup	Mainstream/HARP	No
AmidaCare HIV SNP	HIV-SNP	Beacon
HealthFirst	Mainstream/HARP	No
HIP	Mainstream/HARP	Beacon
MetroPlus and MetroPlus HIV SNP	Mainstream/HARP/HIV-SNP	Beacon
Fidelis	Mainstream/HARP	No
United Healthcare	Mainstream/HARP	Optum
VNS Choice	HIV-SNP	Beacon
WellCare	Mainstream	No

HARP-eligibles have been identified by the state, based on diagnosis and utilization patterns. Those beneficiaries who are currently enrolled in a mainstream Medicaid managed care plan that will be offering a HARP will be passively enrolled in that HARP, with the option of opting out or selecting another plan. HARP-eligibles in plans that are not offering a HARP will receive a letter explaining the benefits of a HARP; it will include instructions on how to enroll should the beneficiary choose.

The Office of Mental Health expects that the RFQ for the rest of state will be released this week. Plans that do not operate in New York City will have to complete a full response in order to qualify; plans that have already been through the RFQ process in New York City will go through an expedited review for their expansion to non- New York City counties.

Budget Update. The New York legislature completed budget negotiations with the governor's office prior to the April 1, 2015, deadline. Some details of the budget were still being resolved, particularly on proposals related to health care capital spending, and many issues were tabled for resolution post-budget. Below is a list of some budget items that had been disputed by the legislature and how they were resolved:

- Implementation of a Basic Health Program, as proposed by the governor and supported by the Assembly, is included in the final budget. The budget also requires the Executive to provide a contingency plan should Congress change eligibility for and/or repeal the BHP.
- New regulations for retail clinics operated by corporate entities such as in-pharmacy clinics, and additional oversight for urgent care providers, proposed by the governor, are not included in the final budget, although additional reporting requirements will be imposed on office-based surgery centers.
- An increase in managed care co-pays was included in the governor's 30-day amendments because of a federal requirement that managed care co-pays be comparable to co-pays in the fee-for-service system. The Executive has agreed to seek a federal waiver of this requirement; should the waiver be denied, the co-pay increase would go forward.
- The governor proposed a surcharge on private health insurance plans as a way of generating funding to operate New York State of Health, the state's Marketplace. The final budget rejects this assessment without identifying an alternative financing mechanism.

- The governor's budget includes a provision that would allow Performing Provider Systems under DSRIP to negotiate value-based payment arrangements with insurers, something that is required under the federal terms and conditions of the DSRIP waiver. The final budget rejects this provision. The budget includes a requirement that all PPSs must establish a project advisory committee that includes Medicaid beneficiaries to provide recommendations on PPS activities.
- Private equity demonstration projects that would allow a limited number of pilots for private equity to invest in restructuring of hospitals were proposed by the governor for the third year in a row. The proposal was again rejected.
- The budget includes \$850 million in funding to cover a potential take-back from CMS associated with audits of services provided through the Office for People with Developmental Disabilities. The money is part of the \$5.4 billion won from settlements with various banks over the last year.

DSRIP Planning Grants Released. A second round of DSRIP planning grant payments was made to the 25 Performing Provider Systems to cover costs related to establishing a PPS network, developing DSRIP projects, and designing an implementation plan. Each PPS received an additional \$1.3 million, for a total of \$32.5 million statewide. A list of awards by PPS can be found on the [DSRIP website](#).

Incentive Payments for Patient Centered Medical Homes. A revision to the Patient Centered Medical Home incentive payment program, announced in February 2015, has been delayed until January 2016. The delay came as a result of concern raised by stakeholders that PCMH practices had not been given sufficient time to meet the new requirements. The state had announced changes to the incentive program that effectively raise the bar on what is required of a PCMH to receive incentive payments. New York State is planning to revise the incentive payments paid to providers working at practices that are recognized as a Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA). New York's Medicaid program chose to use NCQA's PCMH recognition program as the basis for providing enhanced payment to PCMH providers. NYS has changed the PMPM to reflect the NCQA third iteration of PCMH standards, the 2014 standards. All incentive payments for PCMH-recognized providers under NCQA's 2008 standards will be discontinued as of April 1, 2015. The other revisions to the payment program will be implemented in January 2016. These include the following: Level 2 providers under the NCQA 2011 standards will see their incentive payments reduced from \$4 PMPM to \$2 PMPM; Level 3 providers under the 2011 standards will see their incentive payments reduced from \$6 PMPM to \$4 PMPM. Providers that achieve recognition under the more rigorous 2014 standards, which place a greater emphasis on integrating health information technology and behavioral health services into primary care, will receive incentive payments of \$6 (Level 2) or \$8 (Level 3).

Ohio

HMA Roundup – Mel Borkan ([Email Mel](#))

Ohio Clarifies Independent Providers Not Eliminated in the Budget Proposal. Following several weeks of confusion, controversy, and late-night hearing testimony about an initiative included in the governor's proposed budget that specified the state would phase out payment for Independent Providers of waiver services by 2019, the administration has issued clarification that the budget does not eliminate Independent Providers. Under the initiative, Independent Providers working for individuals receiving waiver services through a self-directed waiver option or working for an agency will be permitted. The clarification stipulates that self-direction will be added to all HCBS waivers in Ohio and that this will result in some changes to the program. Please see the clarification for more detail. [Read More](#)

Joint Medicaid Oversight Committee (JMOC) hears testimony. JMOC, created about a year ago, is a bicameral, bipartisan legislative committee that was created as part of Senate Bill 206. Its role is to review and recommend policies and strategies to improve the Medicaid program in Ohio with emphasis on accountability, health outcomes, and sustainability. JMOC contracts with an actuary to determine the projected medical inflation rate for the upcoming fiscal biennium. At its meeting on March 19, JMOC heard testimony from the State Medicaid Director and by Medicaid contracting Managed Care Plans and their association. Testimony, presentations and meeting minutes can be found for this meeting, as well as earlier meetings at: <http://www.jmoc.state.oh.us/meetings>

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

Pennsylvania Department of Human Services Announces Public Comment Period on Medicaid Program Expansion. At the March 26th Medical Assistance Advisory Committee (MAAC) meeting, Dan DeLellis, Director of the Bureau of Policy Analysis and Planning in the Office of Medical Assistance Programs (OMAP) for DHS, announced the 30-day public comment period for the transition plan for the Health Choices Medicaid Expansion was open. This plan addresses the steps OMAP is taking to transition from the Healthy PA alternative Medicaid waiver expansion program to a traditional Medicaid expansion. The public notice, transition plan, and samples of notices being sent to Medicaid consumers can be viewed at [HealthChoicesPA](#). The site is geared towards consumers, but there is contact information available for providers and plans.

Pennsylvania's Acting Secretary of Health Dr. Karen Murphy Joins Industry Leaders at White House Health Innovation Kick-Off. Dr. Karen Murphy, Acting Secretary for Pennsylvania's Department of Health, represented the commonwealth today at a White House meeting to kick off the Health Care Payment Learning and Action Network (Network). Pennsylvania was one of only six states to participate in the inaugural meeting. President Obama and HHS Secretary Sylvia Burwell addressed private-sector leaders, state representatives, insurers, providers, business leaders, and consumers to promote health care delivery and payment innovations. The Network will serve as a forum where state governments, payers, providers, employers, purchasers,

states, consumer groups, individual consumers, and others can discuss, track, and share best practices on how to transition towards alternative payment models that are based on value versus volume. [Read More](#)

Rhode Island

Budget Proposal to Cut \$88 Million in Medicaid Spending and Issue Premium Tax. On March 13, 2015, *insurancenewsnet.com* reported that Governor Raimondo's budget includes a proposal to cut Medicaid spending by \$88 million in 2016 and to fund HealthSource RI with a new health insurance premium tax. The tax would be issued on all health plans purchased in Rhode Island – 3.8 percent for individuals and 1 percent for small employers. [Read More](#)

Tennessee

Expansion Fails In Senate Again. On March 31, 2015, *Nashville Business Journal* reported that Governor Haslam's Insure Tennessee proposal was voted down 2-6 in the Senate Labor and Commerce committee. The failed bill was a revised version of the proposal that failed to pass out of the Senate Health and Welfare committee in February of this year. [Read More](#)

Vermont

Little Monitoring of Medicaid Managed Care Spending. On March 31, 2015, *The Charlotte Observer* reported that a letter sent to lawmakers from Auditor of Accounts Douglas Hoffer stated that Vermont conducted so little monitoring on how it spent \$675 million on setting up Medicaid managed care programs that it will not be audited at this time. Vermont is currently in a global commitment arrangement with the federal government which allows the state a lot of flexibility in how it spends federal Medicaid dollars so long as it stays under projected spending caps. An internal January report, however, found that government accountability tools, such as performance benchmarks and data on whether they were reached, did not exist. Fewer than half the departments provided results for their performance measures. Additionally, 80 percent of the department's managed care investments lacked performance targets. [Read More](#)

Virginia

Medicaid Expansion Not in State Budget. On March 26, 2015, *The Washington Post* reported that Governor Terry McAuliffe signed the new state budget, despite the General Assembly's not including Medicaid expansion in the budget. [Read More](#)

West Virginia

West Virginia to Switch to Annual Medicaid Cards. On March 31, 2015, *The Baltimore Sun* reported that West Virginia will switch from using monthly cards to annual cards, effective April 1, 2015. Recipients will be issued new cards every January. The change is expected to save the state \$2.5 million a year. [Read More](#)

Wisconsin

Governor Walker's SeniorCare Proposal for Patients to First Sign Up For Medicare Part D is Dead. On March 26, 2015, *The Baltimore Sun* reported that Republican co-chair of the legislature's budget committee said Governor Scott Walker's proposal to have Senior Care enrollees first sign up for Medicare Part D coverage is dead. However, Walker is willing to work with the legislature to agree on a solution. His proposal faced bipartisan opposition from the legislature, AARP, and other groups representing senior citizens because they feared it would increase prices of prescription drugs. It was expected to save the state \$15 million over two years. [Read More](#)

National

US Supreme Court Rules Providers Cannot Sue State To Raise Medicaid Reimbursement Rates. On March 31, 2015, the *Associated Press* reported that the Supreme Court ruled that private health care providers cannot sue the state to raise Medicaid reimbursement rates. The lawsuit claimed reimbursement rates in Idaho have stayed at 2006 levels despite ever increasing medical costs. Many doctors and other providers say they are losing money on seeing Medicaid patients. Lower courts originally sided with providers and increased rates by \$12 million in 2013. The five to four Supreme Court ruling, however, gave power to federal agencies to oversee Medicaid and decide if a state is in compliance with reimbursement rules. [Read More](#)

Office of Management and Budget Reviewing Medicaid Managed Care Rule. The federal Office of Management and Budget (OMB) is currently reviewing a proposed rule on Medicaid managed care and third party liability regulations. The OMB 90-day review period on the proposed rule began on March 19, and OMB should publish the rule under a Notice of Proposed Rulemaking by the end of the 90-day period. According to HHS, the rule would:

- Modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems.
- Align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implement statutory provisions; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; ensure appropriate beneficiary protections and enhance expectations for program integrity.
- Implement provisions of CHIPRA and addresses third party liability for trauma codes.



INDUSTRY NEWS

UnitedHealth to Buy Catamaran for \$12.8 Billion. On March 30, 2015, *The New York Times* reported that UnitedHealth Group has agreed to acquire Catamaran Corporation, a Schaumburg, Illinois-based pharmacy benefit manager, for \$12.8 billion all-cash, paying \$61.50 a share. Catamaran manages over 400 million prescriptions a year for 35 million people. United will combine Catamaran with its own pharmacy services business, OptumRx. The deal is subject to approval by Catamaran's shareholders and regulators. [Read More](#)

Community Health Systems Announces Divestiture of Ownership in Two South Carolina Hospitals. Community Health Systems announced that its subsidiaries have completed the sale of their ownership interest in Chesterfield General Hospital in Cheraw, South Carolina and Marlboro Park Hospital in Bennettsville, South Carolina. The company will still operate six hospitals in the state.

Kindred Healthcare Announces Benjamin Breier as New President and CEO. On March 31, 2015, Kindred Healthcare announced that Benjamin A. Breier will assume the role of President and Chief Executive Officer, effective immediately. Breier succeeds Paul J. Diaz, who is now Executive Vice Chairman of the Board of Directors. [Read More](#)

Industry Research

AHIP Report Finds States Where Medicaid Plans Manage Pharmacy Benefits See Large Scale Cost Savings. On April 1, 2015, America's Health Insurance Plans (AHIP) released a report titled "*Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States.*" The report examined 35 states and DC that used the Managed Care Organization (MCO) model in their Medicaid program and either included (carved-in) or excluded (carved-out) pharmacy benefits from coverage. Findings include:

- Across 28 states using the carve-in model, the net cost per prescription was 14.6 percent lower than in states not carving in pharmacy.
- This 14.6 percent differential created a \$2.06 billion net savings in state and federal spending in FFY2014 for states deploying the carve-in model.
- The seven carve-out states had a 20 percent increase in net costs per prescription from FFY2011-FFY2014, in contrast to the 1 percent increase experienced by the six states that recently switched to a carve-in model.
- The seven carve-out states "missed" a total of \$307 million in savings in FFY2014 which would have occurred had they used a carve-in model.

[Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
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
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 8, 2015	Iowa	Proposals Due	550,000
May 14, 2015	Georgia	Proposals Due	1,300,000
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 (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 (Phase 2 Delayed)	4/1/2015 (Phase 2 Delayed)	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
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 (Centene), 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.

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION ENROLLMENT UPDATE

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

State	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
California	39,731	42,473	44,804	48,976	51,527	58,945	122,908	123,079	124,239
Illinois	37,248	48,114	46,870	49,060	49,253	57,967	63,731	64,199	62,067
Massachusetts	18,836	18,067	17,739	17,465	18,104	17,918	17,867	17,763	17,797
New York							17	406	539
Ohio							68,262	66,892	65,657
South Carolina								83	1,205
Texas									20
Virginia	11,169	11,983	21,958	28,642	29,648	27,701	27,527	26,877	26,250
Total Duals Demo Enrollment	106,984	120,637	131,371	144,143	148,532	162,531	300,312	299,299	297,774

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA NEWS

Mike Nardone to Speak at Health Insights Spring 2015 Conference April 8-10. Kiawah Island, South Carolina.

HMA Principal Mike Nardone (Harrisburg, Pennsylvania) is a featured speaker at Health Insights' Spring 2015 Conference. The Spring 2015 Conference's educational focus is on "Medicaid – The Transformation of America's Largest Health Insurer" and will feature a panel presentation led by Dr. Bruce Vladeck, Sr. Advisor with Nexera/GNYHA Ventures and former Administrator of HCFA. In addition to Mike Nardone, additional featured speakers include Jesus Garza, CEO of Seton Healthcare Family and Arizona/Texas Ministry Market Leader for Ascension Health, and Cindy Mann, JD, former Deputy Administrator of the Center for Medicare & Medicaid Services and Director of Center for Medicaid, CHIP, and Survey and Certification. [More Info](#)

HMA Adds to IT Advisory Services Team

HMA is pleased to announce recent additions to our IT Advisory Services team:

- **Stephen DePooter (Chicago, Illinois)** is the former CIO of the Illinois Department of Healthcare and Family Services (HFS). During his tenure at HFS, Stephen led the development and implementation of a unique Medicaid Management Information System (MMIS) partnership between the states of Illinois and Michigan, the rapid and successful implementation of an integrated program eligibility and enrollment system, and the development and implementation of a case management solution for the state's Money Follows the Person program.
- **Lee Repasch (Denver, Colorado)** is a former health IT specialist at CMS, where she helped states and the healthcare IT industry translate policy into IT requirements and solutions and provided technical assistance and policy guidance to states implementing various provisions of the HITECH Act. Additionally, Lee worked closely with states on funding, and developing and implementing eligibility and enrollment systems that met the requirements of the ACA.
- **Matt McGeorge (Harrisburg, Pennsylvania)** is the former Health IT (HIT) Coordinator for the Commonwealth of Pennsylvania. In that role Matt led administration and oversight of the Commonwealth's Medicaid EHR incentive program, partnered with state HIT colleagues and key stakeholders to promote adoption and use of electronic health records as well as to increase Health Information Exchange (HIE) transactions between providers, and directed the development of a system and process to collect and analyze clinical data for the EHR incentive program and to support other quality initiatives.

Stephen, Lee and Matt add to our growing base of IT advisory services expertise and experience. HMA's **IT Advisory Services** team works with federal and state agencies, health insurance companies, provider organizations and IT solution providers to promote and ensure the optimal use of information technology to achieve the goals of health care reform initiatives across the nation.

HMA WELCOMES...

Nora Leibowitz, Principal – Portland, Oregon

Nora Leibowitz comes to HMA most recently from Cover Oregon where she served as the Chief Policy officer for the past few years. In this role Nora directed policy implementation for Cover Oregon in partnering with state, carrier, consumer, and federal stakeholders to design and build the state Health Insurance Exchange; planned and implemented individual market eligibility and enrollment policy and operations; and built and oversaw the Cover Oregon appeals function that successfully resolved over 200 eligibility appeals.

Prior to her work with Cover Oregon, Nora worked with the Oregon Health Authority as an Exchange Development Director and previously as a Senior Policy Analyst. In her role as the Exchange Development Director, Nora managed the initial development of Oregon's Health Insurance Exchange; successful federal grant proposals worth over \$50 million; and directed the Exchange planning team and partnered closely with Medicaid and IT staff engaged in Exchange development. As a Senior Policy Analyst, Nora provided analysis and recommendations to senior executive staff on health reform in Oregon, staffed legislatively created health reform committees, and facilitated market reform and Exchange workgroups.

Additional roles that Nora has served include Actuarial Services Unit Manager with the Oregon Department of Human Services; Provider Tax Analyst with the Oregon Department of Human Services; Consultant with ACS; and Lead Program Evaluator with HHS Office of Inspector General.

Nora received her Master degree in Public Policy from the University of Chicago, Irving B. Harris Graduate School of Public Policy. She received her Bachelor of Arts degree in History from Reed College.

John O'Connor, Principal – Costa Mesa, California

John O'Connor comes to HMA most recently from Equality California and Equality California Institute where he served as the Executive Director of both organizations for the past few years. In this role John helped organize the many stakeholders and community members involved to lead the nation's largest statewide LGBT political organization to stability. His accomplishments in this role included providing leadership for statewide lobbying and public education organizations with a combined \$3.5 million budget, statewide board of directors, 45 employees and four offices with a 501(C3), a 501(C4), and various political action committees under one umbrella; executing a complete strategic restructuring with strong results of solvency, programmatic effectiveness and expansion, a rebuilt and diverse senior staff, substantially reduced fixed overhead costs, and a dramatically improved reputation; and leading robust fundraising efforts.

Prior to his work with Equality California/Equality California Institute, Jim was the Executive Director for The LGBT Community Center of the Desert. In this role he stabilized, restructured, and grew the organization with strong results of solvency and sound financial management; created successful and diverse development programs to expand the budget with achievements of multi-year grants and corporate partnerships; and established a new counseling center that became fully operational and filled to capacity in less than one year.

Additional roles that John has served include Deputy Director with The California Museum; Director with The California Hall of Fame; National Director of The Gill Foundation; Program Director for The David Geffen Foundation; Director of Charitable Giving with DreamWorks/The Katzenberg Family Trust; and Development Associate with the AIDS Action Foundation.

John received his Bachelor of Science degree in Russian with a minor in business from Georgetown University.

Jim Parker, Principal – Chicago, Illinois

Jim Parker comes to HMA most recently from the State of Illinois Division of Medical Programs, Department of Healthcare and Family Services, where he served as the Deputy Administrator for Operations over the past 14 years. In this role Jim oversaw the operations of the \$20 billion Medicaid program and was responsible for all aspects of the transition of the Illinois Medical program from fee-for-service to managed care, including development of rate structures, design of new delivery models, performance incentives, contract terms, coverage policies, and enrollment processes/contract monitoring to reduce the growth trend in the Medicaid program while improving health outcomes; began the reform of Medicaid with the implementation of primary care case management and disease management programs; and developed one of the first Medicaid Preferred Drugs List in the U.S. and negotiated supplemental rebate agreements that brought hundreds of millions of dollars of new revenue into the State.

Prior to his work with the Department of Healthcare and Family Services, Jim worked in the Office of the General Counsel, HFS as the Chief, Bureau of Administrative Litigation as well as in previous roles as a Chief Administrative Law Judge and Administrative Law Judge. As a Judge, Jim initially presided over medical provider appeals and then assumed responsibility for all administrative hearing processes to include Medicaid recipient fair hearings, child support hearings, and medical provider appeals.

Additional roles that Jim has served include Attorney with the Law Office of Boothby, Ziprick, and Yingst as well as with Springer, Carstedt, and Kurlander.

Jim received his Juris Doctorate from Loyola University of Chicago School of Law and his Bachelor of Arts degree from Marquette University.

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

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