HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 24, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CONSUMER ENGAGEMENT IT

This week, our *In Focus* section comes from HMA Senior Consultant Matt McGeorge, of our IT Advisory Services (ITAS) team. HMA's ITAS team is continuously tracking and assessing the impact of developments in the health care information technology industry that have the potential to be transformational by changing the way that health care services are managed and delivered. This is the second in a series of three *In Focus* briefs that elaborate on some of these developments. Our first ITAS Issue Brief, on Telehealth IT, is available here.

HMA ITAS Issue Brief #2: Consumer Engagement IT

Consumers of healthcare can now engage with the healthcare delivery system in a variety of ways. Many of these engagement opportunities are available because of advances in and the adoption of health information technology (health IT). Today's healthcare consumer can get information through various online "portals", use secure electronic messaging to communicate with their providers or even generate and collect their own health information by using mobile applications and wearable technology.

In this article we will focus on:

1. **What is driving the use of health IT to engage consumers?**
2. **What health IT tools are being used to engage consumers?**
3. **What are strategic considerations for an organization related to health IT and consumer engagement?**

Background

There is increasing recognition that to support the delivery system reforms being implemented a concerted effort must be made to engage healthcare consumers. The National Quality Strategy, which was published in 2011, identified a number of guiding principles to achieve the triple aim of better care, healthy people/healthy communities, and affordable care. A number of the principles focus on consumer engagement and these include:

- Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and improvement efforts
- Providing patients, providers, and payers with the clear information they need to make choices that are right for them will be encouraged[1]

The Office of the National Coordinator for Health Information Technology (ONC) states that, "engaged [consumers] seek information about their health and healthcare, make informed decisions with their healthcare, takes steps to manage their health and healthcare and act as partners with their healthcare team".[2] As the general population and healthcare providers rely more on technology to manage information and to communicate, an opportunity exists through health IT to utilize non-traditional methods in connecting providers and their patients.

Health IT and Consumer Engagement Drivers

An important driver for using health IT to engage consumers is the Medicare and Medicaid Electronic Health Record (EHR) incentive program. The program requires providers to meet objectives and measures in order to receive an incentive payment for the meaningful use (MU) of their EHRs. Certain MU measures specifically relate to engaging the consumer/patient. These measures include providing clinical summaries and educational resources to patients. As the program is evolving additional emphasis is being placed on patient engagement.

[1] (Quality, 2011)
[2] (Technology, 2013)

The Centers for Medicare & Medicaid Services (CMS) believes that "[providers] are in the best position to encourage patients to use health IT to better understand and participate in their own health care."[3] In an effort to have providers engage their patients through health IT, CMS made patient engagement more of a focus in the Stage 2 MU rule by introducing the objectives of secure messaging and patient viewing, downloading and transmitting their online health information. In March 2015, CMS issued a proposed rule outlining Stage 3 MU requirements that includes measures that introduce application program interfaces as a mechanism to make information available to patients as well as the incorporation of patient generated information into EHRs. The inclusion of these objectives and measures indicate that patient engagement is a priority but there are challenges that remain with using health IT to engage consumers/patients.

According to survey results published in a September 2014 ONC data brief, almost 30% of patients were provided online access to their health information but less than half of those who were provided access actually did so. Nearly 60% of patients that did access the health information stated that the information was very useful.[4] Although the information was gathered in 2013 ahead of the effective date for the Stage 2 rule, the findings identify an ongoing challenge to effective consumer/patient engagement, a challenge that requires the implementation of an appropriate solution and strategy.

Health IT Tools for Consumer Engagement

Incentives disbursed via the EHR incentive programs have been helpful but are likely not sufficient to drive consumer engagement. Through the certification and broad adoption of EHRs, the MU program has been successful in establishing an expectation that health IT tools are part of the strategy to engage consumers. Beyond that, there are number of health IT tools available which include:

- ✓ Portals: Secure online websites that consumers can use to access to their health and healthcare information.
- ✓ Electronic Messaging including use of targeted text messaging: This tool offers consumers a secure vehicle to communicate with providers that has traditionally not been available and supports information sharing and gathering. The use of this type of messaging may result in the delivery of services at a more appropriate level of care.
- ✓ Consumer-Generated Health Data: There are a growing number of tools that consumers can use to gather, store and analyze health information that they create. The broad array of information that consumers might create and enter into a tool includes symptoms, vital signs or other biometric data. As the information is generated, stored and analyzed consumers can gain a better understanding of their overall health and healthcare needs.

[3] (Tagalicod, 2013)

[4] (Patel, Barker, & Siminerio, 2014)

Strategic Considerations for Health IT and Consumer Engagement

Healthcare providers and other healthcare system participants such as payers and government agencies must consider how to effectively use health IT to engage their consumers.

- Organizations that are sharing health information with their consumers/patients must determine the expectations they have regarding consumer/patient action when the information is accessed.
    - The consumer/patient will want to know how to act on the information; therefore having a health IT tool that not only presents information but offers a vehicle to act on the information can be invaluable.
- Consumer/patient generated information is becoming more widely available, so an organization must consider how they will incorporate this information into the health record.
    - An organization's ability to incorporate the consumer/patient generated information into a health record demonstrates a commitment to engaging with the consumer/patient and presents an opportunity to use the information to gain a better understanding of the consumer/patient's health.
- An increase in consumer/patient demand for health information and for consumer engagement tools will likely coincide with an expectation that signing into multiple systems or portals in order to gather a complete health record is not acceptable.
    - This will be a driver for cross organizational collaboration and greater system interoperability.

More Information

For more information on the Consumer Engagement IT Issue Brief and ITAS team, please contact:

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HMA Medicaid Roundup

California

HMA Roundup – Warren Lyons (Email Warren)

Audit Reveals California Failing to Guarantee Medi-Cal MCOs Provide Access. On June 22, 2015, *Kaiser Health News* reported that the California State Auditor found the state is not ensuring Medi-Cal managed care organizations are providing the access to health care that they promise. The state did not verify that insurers' directories of physicians were accurate or that plans had enough doctors to meet their patients' needs. Furthermore, the state Department of Health Care Services did not perform annual audits of health plans. Advocates and experts have stated that the state was too quick to shift patients into MCOs. Medi-Cal, which serves 12 million beneficiaries, with approximately three-quarters in managed care, lacks sufficient oversight, according to the article. Read More

Connecticut

Hospital Operator Cites Funding Cuts at Root of Layoffs. On June 17, 2015, the *CT Mirror* reported that Hartford HealthCare announced plans to eliminate 335 jobs across the organization, citing cuts in Medicaid funding as one driver of the layoffs. State hospital systems have been pushing for changes to the state budget approved in early June, which calls for increased hospital taxes and reduced Medicaid payments. Hartford HealthCare operates five hospitals in the state. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Tentative Deal Reached with CMS on LIP Funding. On June 23, 2015, Politico reported that Governor Rick Scott's administration had reached a tentative agreement with CMS officials on more than $1 billion in Low-Income Pool (LIP) funding for hospitals. According to CMS, the agreement in principle includes the stipulation that LIP funding cannot be used to pay costs that would be covered in a Medicaid expansion. Florida lawmakers must still approve the new LIP model during the upcoming legislative session. Read More

KidCare Expansion to Children of Legal Immigrants Rejected in Budget. On June 22, 2015, *FlaglerLive.com* reported that a proposal to extend the KidCare program to children of legal immigrants did not pass the special legislative session. The proposal would have eliminated a five-year waiting period for legal immigrants to qualify for the program, allowing 25,000 more children to become

eligible for coverage. Senator Rene Garcia has tried to eliminate the waiting period for the last three years. Read More

House, Senate Approve $78.7 Billion State Budget, End Special Session. On June 19, 2015, *The Palm Beach Post* reported that the Florida House and Senate approved a $78.7 billion budget, ending a three-week special session. The budget now goes to Governor Rick Scott for approval. The Senate's Florida Health Insurance Exchange (FHIX) was not included in the budget, but the House agreed to give $400 million in taxpayer money to over 200 hospitals to ease losses in the low income program, which reimburses them for charity care. However, hospitals will still face a loss of $700 million in funding in the upcoming year. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Neighborhood Health Plan Seeking to Expand into Large Business Market. On June 22, 2015, *The Boston Globe* reported that Neighborhood Health Plan is looking to expand its coverage to large businesses in an effort to rebuild its finances after suffering a $100 million loss last year. The deficit came from an increase of sick new patients, high Hepatitis C drug costs, and reimbursements that failed to match costs, according to health plan executives. The Massachusetts commercial market is currently dominated by Blue Cross Blue Shield, Harvard Pilgrim, and Tufts Health Plan. Neighborhood Health Plan has a total of 381,441 members, with 70,488 enrolled in employer plans.

Michigan

HMA Roundup – Eileen Ellis (Email Eileen)

Supreme Court Ruling Could Create Uncertainty around Healthy Michigan Plan. Michigan residents have more at stake in the King v Burwell decision than residents of many other states. The Michigan Department of Health and Human Services held a public hearing on June 24, 2015 on a waiver that must be approved by the federal government by the end of the calendar year or else nearly 600,000 Michigan residents will lose their coverage under the Healthy Michigan Plan (Michigan's Medicaid expansion). Michigan legislation requires the state to seek a waiver that would require that adults with incomes above 100 percent of the federal poverty level who are enrolled in Medicaid expansion for 48 months must either buy insurance through the government exchange or pay more to stay on Medicaid. *Crain's Detroit Business* notes that the court ruling will affect tax subsidies for 228,000 Michigan residents who bought health insurance for 2015 through the federal marketplace. However if the marketplace ceases to exist, it is unclear what will happen to the Healthy Michigan Plan. Read More

Mississippi

$38 Million Pharmacy Settlement Challenged by Sandoz. On June 17, 2015, the *Dispatch/Associated Press* reported that drug manufacturer Sandoz, the generic drug division of Novartis, is asking the Mississippi Supreme Court to overturn a $38.2 million judgement for the state in a 2011 Medicaid drug-pricing lawsuit. A

Rankin County judge ruled that Sandoz inflated the average wholesale prices for its drugs, causing Mississippi Medicaid to overpay pharmacies. Read More

New Mexico

Director of Legislative Finance Committee Predicts Rising Medicaid Costs. On June 17, 2015, the *SunHerald/Associated Press* reported that David Abbey, director of the Legislative Finance Committee, told lawmakers that the state costs for the Medicaid expansion population in New Mexico will be approximately $120 million per year when federal funding drops to 90 percent in 2020. He warned that other parts of the state budget may be forced to absorb this increase. Read More

New Law Allows Inmates to Apply for Medicaid Upon Release from Prison. On June 19, 2015, *The Santa Fe New Mexican* reported that a new law that went into effect that day allows inmates to apply for Medicaid once they are released from prison in an effort to reduce recidivism. According to advocates, access to medical and mental health treatment after release could prevent future offences. David Abbey, the Legislative Finance Committee Director, stated that Medicaid will continue to be a major part of future budget talks. As a result, other parts of the budget will need to shrink. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Regulation of CDPA Fiscal Intermediary Proposed. Both houses of the legislature have unanimously passed a bill that would require licensing fiscal intermediaries in Consumer Directed Personal Assistance (A-7535 B/S-5565 B). The bill has now awaits action by the Governor. The bill passed both houses unanimously. According to the Sponsor's Memo, the recent shift to mandatory enrollment in Managed Long-Term Care has led to a 50 percent growth in the use of CDPA, and a new and unregulated industry has emerged to provide payroll services, while leaving care coordination to the consumer. Establishing licensure criteria is meant to provide oversight, ensure quality, and prevent fraud.

In a recent Facebook post the trade organization CDPAANYS indicated "Licensure is critical to the ongoing success of CDPA. While the lack of regulations is key to the consumer control that CDPA offers, the growth of the program has led to a growing exploitation of that lack of regulation, threatening the consumers, workers and program just as it is emerging into prominence." The Association's Memorandum of Support can be found here.

DSRIP Valuations. *Crain's HealthPulse* reports that funding for the DSRIP program in NYS, originally approved at $6.4 billion over 5 years, has been increased to $7.4 billion. The Department of Health has not confirmed the increase in funding, nor have they publicly released the valuation of each Performing Provider System. Nonetheless, Crain's posted a list of the valuations, which represent the maximum incentive payment potentially available to a PPS. Valuation ranges from $1.2 billion for the NYC Health and Hospitals Corporation to $32 million for the NY Hospital Medical Center of Queens. Valuation is determined by a formula that includes the number of Medicaid lives attributed to the PPS, the number and complexity of the DDSRIP projects

selected by the PPS, and the score that the PPS received on its application. By design five public hospital systems across the state are receiving a disproportionate share of the funding (39 percent) with the remaining funds divided among 19 non-public safety net PPSs. According to Crain's, PPSs received their first payments, totaling over $500 million, in May.

Children's Health Homes Delayed. New York State has announced a delay in implementation of Health Homes for Children. Although the state has completed its review of the applications, and awarded approval to 22 agencies, the date to begin to enroll children in Health Homes has been delayed from October 1, 2015 to January 1, 2016. According to an email notification, the State has concluded there is significant readiness risk around the October 1, 2015 date, including systems design, modifications to the assessment tool, time for designated health homes to respond to contingencies noted in their award letters, and time for appropriate trainings to occur. The state also noted it is still awaiting CMS approval of the required state plan amendment.

North Carolina

House Passes Medicaid Managed Care Bill. On June 23, 2015, the Greensboro News & Record reported that the North Carolina House passed by a vote of 105-6 a Medicaid redesign bill that would transition to a capitated managed care system. The House bill limits managed care entities to organizations comprised of local provider networks, whereas the Senate's proposal would also allow traditional Medicaid MCOs to contract with the state. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Hospitals Demonstrate Improvements in Reducing Hospital Readmissions. The Pennsylvania Health Cost Containment Council or PHC4 report on readmission rates for four conditions (abnormal heartbeat, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes-medical management) indicate that hospital readmission rates are improving. PHC4 Executive Director Joe Martin notes, in the article from the *Carlisle Sentinel*, that this is important because preventable readmissions are high cost drivers. The report examined hospital discharges from Jan. 1, 2013, to Aug. 31, 2014, as well as 30-day readmission rates for the conditions. Read More

Pennsylvania Disburses $674K in Grants for Health Information Exchange. The Pennsylvania eHealth Partnership Authority (the Authority) announced that two health information organizations (HIO) will receive grant funding to connect hospitals and ambulatory practices to their HIO. These connections will enable providers that have participated in the Pennsylvania Medicaid Electronic Health Record Incentive to exchange electronic health information through the Pennsylvania Patient and Provider Network (P3N). The funding is made available from CMS and is being administered in partnership with the Pennsylvania Department of Human Services. Alix Goss, the Authority's Executive Director, stated in a *Health IT Analytics* article that, "as more HIOs join the P3N along with their connected providers, more patients will experience better coordination of their care." Read More

Insurance Department Approves $175M Highmark Payment To Allegheny Health. Highmark was approved by the Pennsylvania Insurance Department to issue a grant that will enable the Allegheny Health Network to modernize the system's hospitals. The approval requires the submission of a plan for how the health system's finances will improve. The article posted to *TribLIVE* indicates that the University of Pittsburgh Medical Center (UPMC) has been critical of this plan but were not available for comment. In a May hearing state senator Randy Vulakovich stated that Allegheny Health Network needed the money to be competitive with UPMC. Read More

Pennsylvania Court Rules that Government is Not Required to Use Tobacco Funds for Health Programs. The Pennsylvania Supreme Court ruled that state policy makers have flexibility in how the funds associated with the 1998 tobacco settlement are used. As reported in *LancasterOnline*, the plaintiffs stated the funds were intended for two healthcare programs, adultBasic and Medicaid for disabled workers. The attorney representing the plaintiffs stated that the ruling was disappointing but now that Pennsylvania is expanding Medicaid through the Affordable Care Act believes that individuals who need coverage can now receive it. The decision reverses the ruling of a lower court. Read More

Wyoming

Lawmakers Look to Help Hospitals with Uncompensated Care after Expansion Rejected. On June 19, 2015, *Wyoming Public Media Statewide Network* reported that two legislative committees are working to help struggling hospitals with uncompensated care. Earlier this year, lawmakers provided small rural hospitals $3 million but some believed it was not enough. As a result, the committees are trying to find a way to work with counties and hospitals to find a solution. Representative Eric Barlow suggested developing clinics or alternatives to hospital emergency rooms in rural areas. Lawmakers will continue to work on the issue. Read More

National

CMS Releases Medicaid Managed-Care Rate Guidelines. On June 22, 2015, *Modern Healthcare* reported that CMS issued a 17-page 2016 Medicaid Managed Care Rate Development Guidance days after the proposed managed care regulation rules. According to the National Association of Medicaid Directors, the new guidelines will frustrate state agencies and create paperwork that CMS may not have the staff to handle. The guidance advises states how to ensure payments are actuarially sound and cover all medical/administrative costs and taxes/fees. CMS released the guidelines in response to states questioning what a "sufficient rate" for plans is. However, the NAMD stated that the document is more like an audit process rather than a review of the rate development process. Read More

Affordable Care Act Drives Sharpest Decline in Uninsured Ever Recorded. On June 23, 2015, Business Insider reported that the CDC's National Health Interview Survey found the uninsured rate for adults under age 65 dropped from 20.4 percent in 2013 to 16.3 percent in 2014. This is the largest single-year decrease in the uninsured rate since the survey began in 1997. According to the survey, states that chose to expand Medicaid saw a more than 5 percent decrease

in the uninsured rate, while states that did not expand saw declines of about 3 percent. Read More

CARE Laws Gain New Focus in Some States. On June 22, 2015, *The Pew Charitable Trusts* reported that some states are focusing on family caregivers. In November, Oklahoma passed a law requiring hospitals to train designated family caregivers to tend to the medical needs of newly released patients. Since then, 12 more states approved similar laws, and an additional two are awaiting the governor's signature. Many of the lawmakers sponsoring Caregiver Advise, Record, Enable (CARE) bills had personal experience as caregivers. However, hospitals and other health care providers are wary or concerned about CARE laws. Some state it could be costly and potentially risky to both patients and hospitals. Legislation can open the door for hospitals to be responsible for the actions or inactions of caregivers. Read More

CBO Finds Repealing Health Law Would Increase Federal Deficit and Cause 19 Million People to Become Uninsured. On June 19, 2015, *Kaiser Health News* reported that a report from the Congressional Budget Office analyzing the costs of the health law found that a repeal would cause 19 million people to become uninsured. By 2024, the number of uninsured would grow to 24 million people. Furthermore, the federal deficit would decrease in the first five years, but increase steadily from 2021 through 2025. Over the next ten years, repealing the health care law would increase the deficit by $353 billion due to higher direct federal spending. Taking into account slightly higher employment as an effect of the repeal, the deficit would increase by $137 billion instead. Read More

Industry Research

UnitedHealth Group Releases Brief on Medicaid Enrollment Strategies. On June 24, 2015, UnitedHealth Group's Center for Health Reform & Modernization released a brief titled *"Successful Medicaid Enrollment Strategies to Cover the Uninsured."* This Brief identifies four strategic approaches Kentucky and Arkansas adopted to increase enrollment for low-income residents and cut their uninsured populations in half:

- Integrating administration and enrollment;
- Establishing multiple application pathways;
- Providing robust consumer assistance; and
- Developing high-impact awareness campaigns.

UnitedHealth Group found the key to achieving robust increases in coverage is not adopting a set of uniform policy prescriptions, but addressing priorities that apply broadly to all states. Read More

INDUSTRY NEWS

Sabra to Acquire Portfolio of Skilled Nursing/Transitional Care Facilities. On June 24, 2015, Sabra Health Care REIT, Inc. announced an agreement to acquire NMS Portfolio, which includes four skilled nursing facilities in Maryland, for $234 million. The skilled nursing facilities that make up NMS Portfolio specialize in transitional care and medically complex post-surgical, ventilator, and dialysis patients with a total of 678 licensed beds. Read More

Blue Cross of Northeastern Pennsylvania and Highmark Merger Completed. Blue Cross of Northeastern Pennsylvania (BCNEPA) has finalized its merger with Pittsburgh-based Highmark Inc. The combined organization, to be known as Highmark Blue Cross Blue Shield, will continue to insure more than 500,000 individuals in northeastern Pennsylvania. Both organizations are licensees of the Blue Cross and Blue Shield Association.

RFP Calendar

Date	State/Program	Event	Beneficiaries
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
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 3, 2015	Michigan	Proposals Due	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (Phase I)	450,000

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; Cigna-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 (*exiting demo*); 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), Cigna-HealthSpring, 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 Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
California	48,976	51,527	58,945	122,908	123,079	124,239	122,520	122,798	122,846
Illinois	49,060	49,253	57,967	63,731	64,199	60,684	58,338	55,672	53,328
Massachusetts	17,465	18,104	17,918	17,867	17,763	17,797	17,621	17,637	17,506
Michigan								9,216	14,867
New York				17	406	539	6,660	7,215	5,031
Ohio				68,262	66,892	65,657	63,625	63,446	62,958
South Carolina					83	1,205	1,398	1,366	1,317
Texas						58	15,335	27,589	37,805
Virginia	28,642	29,648	27,701	27,333	26,877	27,765	27,349	30,877	29,970
Total Duals Demo Enrollment	**144,143**	**148,532**	**162,531**	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,628**

HMA News

New this week on the HMA Information Services website:

- Updated National Medicaid Managed Care RFP Calendar
- Medicaid managed care behavioral health carve-outs detailed
- Massachusetts issues Senior Care Options RFA

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA's Tom Dehner Contributes to Blog Post on King v Burwell: "Achieving Balance After Another ACA Decision"

HMA Managing Principal Tom Dehner contributed to an article on The Health Care Blog this week, looking at the possible outcomes and "sticky" issues if the Supreme Court rules in favor of King. The post, titled "Achieving Balance After Another ACA Decision," provides a snapshot of the fundamental choices Affordable Care Act choices that may come up if federal Marketplace premium subsidies are eliminated. The article is co-authored by Claudine Swartz of Strategic Policy Solutions (a Day Health Strategies Affiliated Consultant) and Rosemarie Day of Day Health Strategies. Read More

HMA's Linda Follenweider and Donna Strugar-Fritsch to Present at Annual Correctional Health Leadership Institutes

July 10-11, 2015
Long Beach, California

HMA's Linda Follenweider (Chicago, Illinois) and Donna Strugar-Fritsch (San Francisco, California) will present at the National Commission on Correctional Health Care's annual Correctional Health Leadership Institutes. Their session, titled "A Call for New Paradigms in Correctional Health" will highlight the challenges and leverage points in bringing innovations in primary care from the community into correctional settings. Read More

HMA Webinar Replay: Minimum MLRs and Rate Setting Requirements

Link to Webinar Replay

On June 16, 2015, HMA Information Services hosted the webinar, "Minimum MLRs and Rate Setting Requirements: Implications of the Proposed Medicaid Managed Care Regulations." HMA Managing Principal Eileen Ellis and Steve Schramm, managing director of Optumas, talked about the proposed changes to the rate setting process and the implications for states, Medicaid managed care plans and other stakeholders.

HMA Webinar Replay: What New Medicaid Managed Care Regulations Mean for Health Plan Quality, Performance Measurement

Link to Webinar Replay

On June 17, 2015, HMA Information Services hosted the webinar, "What the New Medicaid Managed Care Regulations Mean for Health Plan Quality and Performance Measurement."

The proposed Medicaid managed care regulations released last month by CMS include fundamental changes in the way quality and performance is measured among health plans in state-sponsored programs. The rules seek to align quality and performance measures with existing government programs like Medicare Advantage, institute a quality ratings system, support a variety of performance improvement projects, and increase the role of external quality review. During this webinar, HMA Principal Matt Roan and Senior Consultant Lisa Shugarman outline the proposed quality rules and discuss the implication for states, Medicaid managed care plans and other stakeholders.

HMA WELCOMES…

Karen Hill, Senior Consultant – San Francisco, California

Karen Hill comes to us most recently from the University of California San Francisco where she served in various roles for the past 25+ years. Her most recent role was as the Interim Vice President of Programs for her last year with UCSF. Prior to that she served in various roles for 10 years as the Glide Health Services Clinical Nurse Manager; Director of Wellness Center; and Director of Nursing and Case Management and Care Transitions. In these various roles, Karen focused her efforts in patient care and safety; providing evidence-based, patient-centered care; innovative care delivery; clinical operations; health promotion activities; and developing inter-agency relationships and community alliances. Several of the projects she worked on included San Francisco Health Plan Accreditation; National Committee for Quality Assurance level three application; and Patient-Centered Medical Home accreditation.

Additional roles that Karen served in during her tenure with UCSF include Glide Nurse/Walk-In Center; Research Clinical Nurse Coordinator; General Surgery Case Manager; and General Surgery RN/Charge Nurse. Karen was also a Home Infusion Nurse Specialist and the Founder/Vice President of Homeward Bound Medical Transport.

Karen received both her PhD in Family Health Care Nursing and her Master of Science degree in Nursing (Occupational and Environmental Health Nursing subspecialty) from the University of California San Francisco. She received her Bachelor of Science degree in Nursing from the University of San Francisco. Karen is a certified Nurse Practitioner through the Nurse Practitioner American Association of National Certification.

Marlana Thieler, Senior Consultant – Harrisburg, Pennsylvania

Marlana Thieler comes to HMA most recently from the Pennsylvania Department of Public Welfare where she has been a Senior Consultant with the Bureau of Fee-For-Service Programs, Office of Medical Assistance over the past seven years. In this role, Marlana introduced many cross-functional projects and teams to the Commonwealth which resulted in new approached to challenges and goals; served as Lead/Project Manager of several key initiatives and federal mandates including provider enrollment and screening requirements of the ACA, enrollment process streamlining and enhancements, program integrity and reduction of fraud waste/abuse, health information technology, provider

credentialing, and high cost case management; management, analysis, and oversight of all budget initiatives; and system business requirement, testing, and implementation support of projects and programs.

Prior to her work with the PA Department of Public Welfare, Marlana was the Business Transformation Office Coordinator with Capital BlueCross for five years. Here she was provided support for strategic projects including corporate planning as well as merger and acquisition integration activities; high-level analysis for strategic projects such as Medicare reassessment; and management/design of several Microsoft Access databases. Additional roles that Marlana has served in include Consultant, Strategic Technology Sourcing with JP Morgan Chase as well as Client Services Representative with The Jay Group.

Marlana is completing her Master of Business Administration degree from Penn State University. She received her Bachelor of Science degree in Business Information Systems with a Concentration in Database Management Systems from Elizabethtown College.