HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 4, 2014

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THIS WEEK

IN FOCUS

FLORIDA UPDATE ON MEDICAID MANAGED CARE INITIATIVES

This week, our *In Focus* section comes from HMA Tallahassee Principal Elaine Peters. Elaine reviews the status of the Agency for Health Care Administration's implementation of Medicaid managed care. The 2011 Florida Legislature passed HB 7107 which directed the Agency to restructure the Medicaid program into an integrated managed care program that requires almost all Medicaid recipients

(including TANF, SSI and duals) to receive covered services through the Statewide Medicaid Managed Care (SMMC) program. The goals of SMMC are: improved coordination of care; improved health of recipients; enhanced accountability; recipient choice of plans and benefit packages; flexibility to offer services not otherwise covered; and enhanced fraud and abuse prevention through contract requirements.

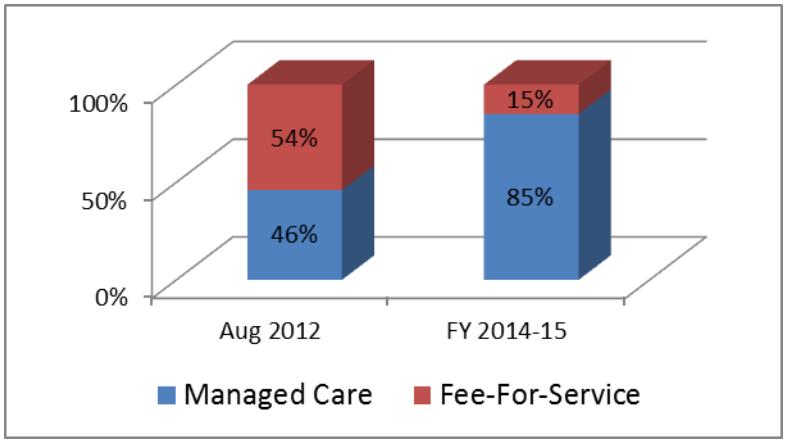
The SMMC program has two key components:

1. Long-term Care (LTC) program
2. Managed Medical Assistance (MMA) program

A limited number of plans in each of 11 regions were selected through a competitive procurement. The SMMC is comprised of several types of managed care organizations (MCOs): Health Maintenance Organizations (HMOs); Provider Service Networks (PSNs); and Children's Medical Services (CMS) Networks. With the transition to SMMC, the responsibility for claims management and provider payment management will be transitioned to risk-bearing MCOs.

As of August 2012, 1.7 million or 54 percent of Florida's 3.2 million Medicaid beneficiaries were served by fee-for-service providers and 1.5 million or 46 percent by managed care plans. When fully implemented, the Agency expects 3.1 million or 85 percent of the 3.6 million Medicaid beneficiaries estimated for FY 2014-15 to be enrolled in SMMC. This reflects more than a 50 percent increase in managed care beneficiaries.

Statewide Medicaid Managed Care Enrollment



Source: Agency for Health Care Administration

The Agency developed the following timeline for these program initiatives:

Managed Care Initiative	Estimated Enrollment	Implementation Date
Long-term Care (LTC) Program	90,489	Aug. 2013 – March 2014
Managed Medical Assistance (MMA) Program	3,071,171	May 2014 – Aug. 2014
Total	**3,161,660**	

Source: Agency for Health Care Administration

Long-Term Care Program

The LTC program provides home and community-based services (HCBS) and nursing home services to recipients who are aged 65 and older or are individuals with physical disabilities aged 18 through 64, in need of nursing facility level-of-care. Additionally, individuals enrolled in the following waiver programs are also included in the LTC population:

- Individuals enrolled in the Aged and Disabled Adult (A/DA) Waiver
- Individuals who are enrolled in the Consumer-Directed Care Plus for individuals in the A/DA waiver
- Individuals enrolled in the Assisted Living Waiver
- Individuals enrolled in the Nursing Home Diversion Waiver
- Individuals who are enrolled in the Frail Elder Option
- Individuals enrolled in the Channeling Services Waiver.

The Agency projects that the program will serve over 90,000 individuals. The LTC program was procured under an Invitation to Negotiate (ITN) issued on June 29, 2012. The Agency had selected the health plans by the end of March 2013, and awarded contracts in various regions to seven managed care companies: American Eldercare; Amerigroup; Coventry; Humana; Molina; Sunshine State Health Plan (Centene); and United Healthcare. The contracts are effective for a 5-year period (2013 – 2018).

The LTC roll-out began in Region 7 in August 2013 and ended in Regions 1, 3 and 4 in March 2014. The Agency reports that the roll-out went smoothly, and recipients are receiving services with no disruption in care. The Agency continues to be aggressive with recipient and provider outreach. The LTC program has enrolled 83,446 individuals as of May 1, 2014. The LTC timeline and enrollment numbers by region are presented below.

Long-Term Care (LTC) Program			
Regions	Enrollment Date	Projected Enrollment	May 1, 2014 Enrollment
7 - Orlando	August 1, 2013	9,338	8,029
8 - Sarasota	September 1, 2013	5,596	4,919
9 - Palm Beach	September 1, 2013	7,854	7,240
2 - Tallahassee	November 1, 2013	4,058	3,671
10 - Ft. Lauderdale	November 1, 2013	7,877	5,849
11 - Miami-Dade	December 1, 2013	17,257	17,864
5 - St. Petersburg	February 1, 2014	9,963	9,016
6 - Tampa	February 1, 2014	9,575	8,711
1 - Pensacola	March 1, 2013	2,973	2,950
3 - Gainesville	March 1, 2013	6,911	6,570
4 - Jacksonville	March 1, 2013	9,087	8,627
Total		**90,489**	**83,446**

Source: Agency for Health Care Administration

Current LTC program enrollment by health plan as of May 1, 2014, is presented below.

LTC Managed Care Enrollment by Plan - May 1, 2014												
Plan	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL
AMERICAN ELDERCARE	1,547	1,274	685	1,302	1,408	960	2,485	1,096	1,478	407	1,327	13,969
AMERIGROUP FLORIDA										1,663	3,058	4,721
COVENTRY HEALTHCARE OF FL (Aetna)						1,176	879		1,312		1,162	4,529
HUMANA MEDICAL PLAN				1,300						1,217	1,648	4,165
MOLINA HEALTHCARE OF FL					1,533	1,209					2,602	5,344
SUNSHINE STATE HEALTH PLAN (Centene)	1,403		3,702	3,608	3,461	3,258	2,622	2,450	2,887	2,562	4,212	30,165
UNITED HEALTHCARE OF FL		2,397	2,183	2,417	2,614	2,108	2,043	1,373	1,563		3,855	20,553
TOTAL	**2,950**	**3,671**	**6,570**	**8,627**	**9,016**	**8,711**	**8,029**	**4,919**	**7,240**	**5,849**	**17,864**	**83,446**

Source: Agency for Health Care Administration

Managed Medical Assistance Program

The MMA program provides primary care, acute care and behavioral health care services to nearly all Medicaid recipients, with few exceptions. The 2011 law exempted the following individuals from participation in statewide managed care: women who are eligible only for family planning services; women who are eligible through the breast and cervical cancer services program; persons who are eligible for emergency Medicaid for aliens; and children receiving services in a prescribed pediatric extended-care center (PPEC). Additionally, the following individuals are not required to enroll, but may voluntarily enroll: Medicaid recipients who have other creditable health care coverage, excluding Medicare; persons eligible for Refugee assistance; Medicaid recipients who are residents of a developmental disability center; Medicaid recipients enrolled in the developmental disabilities HCBS waiver or Medicaid recipients waiting for waiver services.

The 2014 Legislature passed HB 5201, which made several changes to managed care eligibility, including repealing the requirement that Medically Needy recipients enroll in managed care plans. In waiver negotiations, CMS expressed concerns actuarial soundness of rates paid across all rate cells. In addition, the legislation added to the list of types of recipients who are exempt from managed care but may voluntarily enroll in managed care; these include recipients residing in group homes for individuals with developmental disabilities and children residing in PPECs.

The MMA program is projected to serve 3.1 million individuals. The MMA program was procured under an Invitation to Negotiate (ITN) issued on December 28, 2012. The Agency had selected the health plans in each region by the end of October 2013. The contracts were signed in February 2014 for a 5-year period (2014-2019). Following are the two types of contracts:

- Standard Plans - A total of 14 companies were awarded contracts to serve as Standard Plans: 1) Amerigroup; 2) Coventry; 3) Humana; 4) Molina; 5) Preferred; 6) Simply; 7) Sunshine (Centene); 8) United Healthcare; 9) Staywell (WellCare); 10) Better Health (PSN); 11) First Coast Advantage (PSN); 12) Integral (PSN); 13) Prestige (PSN); and 14) South Florida Community Care Network (PSN).

- Specialty Plans – A total of five companies were awarded contracts to provide Specialty Plans: 1) Clear Health Alliance (HIV/AIDS); 2) Freedom Health (Disease Management); 3) Magellan (SMI); 4) Positive Healthcare Florida (HIV/AIDS); and 5) Sunshine State (Child Welfare). The Children's Medical Services Network is also a Specialty Plan that must meet all other MMA plan requirements; participation is pursuant to a single, statewide contract that is not subject to the procurement requirements.

MMA enrollment in Regions 2, 3 and 4 were rolled out May 1, 2014. Regions 5, 6 and 8 will be rolled out on June 1, 2014, and Regions 1, 7 and 9 on August 1, 2014. The MMA timeline, projected, and actual enrollment for Standard and Specialty plans is presented below.

Managed Medical Assistance Program				
Regions	Enrollment Date	Projected Enrollment	May 1, 2014 Enrollment Standard	May 1, 2014 Enrollment Specialty
2 - Tallahassee	May 1, 2014	118,181	93,857	1,133
3 - Gainesville	May 1, 2014	260,346	209,151	2,485
4 - Jacksonville	May 1, 2014	302,581	250,646	2,229
5 - St. Petersburg	June 1, 2014	189,529		
6 - Tampa	June 1, 2014	413,256		
8 - Sarasota	June 1, 2014	208,587		
10 - Ft. Lauderdale	July 1, 2014	253,299		
11 - Miami-Dade	July 1, 2014	575,187		
1 - Pensacola	August 1, 2014	103,383		
7 - Orlando	August 1, 2014	388,517		
9 - Palm Beach	August 1, 2014	258,305		
Total		**3,071,171**	**553,654**	**5,847**

Source: Agency for Health Care Administration

Standard Plans

MMA program enrollment for standard plans as of May 1, 2014, for Regions 2, 3 and 4 is presented below.

MMA Managed Care Enrollment by Plan - May 2014												
MMA Standard Plans	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL
Amerigroup					X	X	X				X	
Better Health						X				X		
Coventry (Aetna)											X	
Humana	X					X			X	X	X	
Molina							X		X		X	
Preferred Medical											X	
Simply											X	
Sunshine (Centene)			25,897	71,267	X	X	X	X	X	X	X	97,164
United			54,720	61,106			X				X	115,826
Staywell (WellCare)		54,623	77,861	55,148	X	X	X	X			X	187,632
First Coast Advantage - PSN				63,125								63,125
Integral - PSN	X					X		X				
Prestige - PSN		39,234	50,673		X	X	X	X	X		X	89,907
SFCCN - PSN										X		
Total		**93,857**	**209,151**	**250,646**								**553,654**

Source: Agency for Health Care Administration

Specialty Plans

Specialty Plans serve populations with a distinct diagnosis or chronic condition, tailored to meet the specific needs of the specialty population. MMA Specialty Plans are required to cover the same standard services available in the non-Specialty plans. Each Specialty plan may not be available in all 11 regions of the state. Below are brief descriptions of the Specialty plans and their criteria.

- Child Welfare (Sunshine Health Plan) - Medicaid recipients under the age of 21 who have an open case for child welfare services in the Department of Children and Families' Florida Safe Families Network database.
- Serious Mental Illness (Magellan Complete Care) - Medicaid recipients diagnosed with Schizophrenia, Bipolar Disorder, Major Depressive Disorder, or Obsessive Compulsive Disorder. The Agency will identify the eligible population using specific diagnosis codes and/or medications used to treat the diagnoses specified above. *NOTE: Operations begin July 1, 2014.*
- Children's Medical Services Network - Medicaid recipients under the age of 21 who meet the Department of Health's clinical screening criteria for chronic conditions. *NOTE: Operations begin August 1, 2014.*
- HIV/AIDS (Positive and Clear Health Alliance) - Medicaid recipients diagnosed with HIV or AIDS. The Agency will identify the eligible population using specific diagnosis codes, laboratory procedure codes, and/or medications commonly used to treat HIV or AIDS.
- Chronic Conditions (Freedom Health, Inc.) - Medicaid recipients aged 21 and older eligible for both Medicare and full Medicaid benefits with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) or Cardiovascular Disease (CVD). *NOTE: Operations begin January 1, 2015.*

Current MMA program enrollment for Specialty plans as of May 1, 2014, is presented below.

MMA Managed Care Enrollment by Plan - May 2014

MMA Specialty Plans	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL
Clear Health Alliance - HIV/AIDS	X	263	566		X	X	X	X	X	X	X	829
Freedom Health - Duals w. Chronic conditions			X		X	X	X	X	X	X		
Magellan Complete Care - Serious Mental Illness		X		X	X	X	X		X	X	X	
Positive Healthcare Florida - HIV/AIDS										X	X	
Sunshine Health Plan - Child Welfare	X	870	1,919	2,229	X	X	X	X	X	X	X	5,018
Children's Medical Services - Children w. Chronic Conditions	X	X	X	X	X	X	X	X	X	X	X	
Total Specialty Plans		**1,133**	**2,485**	**2,229**								**5,847**

Source: Agency for Health Care Administration

Additional information on Florida's Statewide Medicaid Managed Care expansion can be found at the following websites:

Link to Statewide Medicaid Managed Care:
http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml

Link to Comprehensive Medicaid Managed Care Enrollment Reports:
http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/med_data.shtml

HMA Medicaid Roundup

Arizona

Health Insurers Expected to Raise Rates for 2015. On June 2, 2014, *AZ Central* reported on new filings submitted to the State Department of Insurance that indicate at least two health insurers plan to increase their rates by more than 10 percent in 2015. Cigna plans to increase rates an average of 14.4 percent, and Humana plans on a 25.5 percent rate increase. The Department of Insurance will now begin a mandatory review of these filings and those submitted by other insurers. Of the states that adopted the federal health insurance marketplace, Arizona had among the largest selection of health plans and lowest average rates during the first year of ACA enrollment. All insurers planning on participating in 2015 must submit rates by the end of June. Read more

California

HMA Roundup – Alana Ketchel

Safety Net Hospital System Could Face $1.3 Billion Shortfall. On June 2, 2014, the UCLA Center for Health Policy Research and Virginia Commonwealth University released a study that showed that California public hospitals could face up to $1.54 billion in uncovered costs in 2019, threatening financial sustainability. The budget shortfall is attributed to the planned cuts in Disproportionate Share Hospital (DSH) payments, which subsidize hospital care for uninsured and under-insured patients. The policy to cut DSH payments was based on the ACA allowing for a higher proportion of reimbursed care. The study finds that, instead, a large uninsured population remains and the newly insured population will not generate adequate revenue to offset the need for DSH subsidies. Read more

Medi-Cal Approved to Cover Podiatric Services. On May 28, 2014, the *California Healthline* reported that the State Assembly unanimously approved reinstating foot and ankle care as a Medi-Cal benefit. The benefit was cut in 2009 due to state budget woes and had only been reinstated at rural clinics and rural federally qualified health centers after the cut was challenged in court. The bill has to be approved by the Senate prior to becoming law. Read more

Mental Health Bills Proposed In Reaction to Isla Vista Shooting. On May 28, 2014, the *Los Angeles Times* highlighted Senate Democrats' package of proposals to add $165 million to bolster the mental illness identification and treatment system. The proposals' funds would be allocated partially toward law enforcement officer training, establishing Mental Health Courts, and adding treatment programs to reduce the number of mentally ill criminals who are

incarcerated. According to Senator Darrell Steinberg, almost half of California's inmates have received mental illness treatment in the past year. Read more

Counties Moving to Enroll Jail Inmates in Medi-Cal. On May 30, 2014, the *Press Enterprise* reported that Riverside and San Bernadino Counties are joining other California counties in pursuing jail inmates' enrollment in Medi-Cal. Counties are charged with caring for these inmates by law, so obtaining Medi-Cal reimbursement from the state offsets some of the cost to the county. Assuming inmates maintain their eligibility for Medi-Cal once released, the inmates can stay enrolled. Riverside County has requested $10.6 million in Medi-Cal reimbursement for jail health care costs. Read more

Rehab Clinics Challenged Under New Certification Process. On June 1, 2014, the *California Health Report* reported that rehab clinics seeking to treat Medi-Cal patients are struggling to complete certification and re-certification required by the DHCS. DHCS added more stringent certification requirements in response to an earlier discovery of fraudulent billing activity. Demand for addiction services is expected to increase under Medi-Cal expansion, raising concerns about patients' access to rehabilitation therapy if clinics are not certified in a timely manner. Read more

Colorado

HMA Roundup – Joan Henneberry

State Hires DentaQuest to Implement Medicaid Dental Program. On May 30, 2014, the Colorado Department of Health Care Policy and Financing announced in its monthly newsletter that a comprehensive new statewide Medicaid dental program is scheduled to be implemented on July 1, 2014. The new benefit, which will be administered by DentaQuest, will cover Medicaid-enrolled adults aged 21 and over for up to $1000 in dental services per year. DentaQuest will equip providers in the state with a web portal that will allow them to submit claims and prior authorizations, attach X-rays and documentation, check history and eligibility, review remittances and track payments. The company will also contact patients who break their appointments to reinforce the importance of honoring appointments and maintaining dental health. Read more

Connecticut

Two Marketplace Insurers Propose Rate Increases in 2015, while One Insurer Proposes Lower Rates. On June 3, 2014, the *CT Mirror* reported on 2015 marketplace premium rate proposals submitted by insurance companies to the Connecticut Insurance Department (CID). Of the three insurers currently offering plans through the state's Access Health CT health insurance marketplace, Anthem Blue Cross and Blue Shield and ConnectiCare Benefits have proposed average rate hikes of 12.5 percent and 11.8 percent, respectively. The companies explain that they expect enrollees to increase utilization of services in 2015. Combined with increasing ACA fees next year, the insurers decided to increase their rates. Meanwhile, insurer HealthCT is proposing a reduction of rates by an average of 8.9 percent. The insurer reports that 2014 enrollees used services less than expected. Actuaries from CID will now review rate proposals from the three insurers (as well as from new marketplace entrant UnitedHealthcare) and issue a decision on each one. Read more

Governor Malloy Signs For-Profit Hospital Bill. On June 3, 2014, the *CT Mirror* reported that Governor Daniel Malloy has signed a bill that permits nonprofit hospitals to convert to for-profits. The bill also expands the state's oversight of the sale of non-profit hospitals and gives the state more oversight of transactions involving physician practices. Read more

Florida

HMA Roundup – Elaine Peters

Two New Florida Medicaid Programs Continue Expanding Across State. On June 2, 2014, *Sunshine State News* reported that Florida's new Medicaid programs, the Statewide Managed Medical Assistance (MMA) and Child Welfare (CW) programs, rolled out in three more regions in the state. The programs now cover 14 counties. Sunshine Health, a Centene subsidiary coordinating expansion of the two new programs, has been tasked with making sure enrollees receive seamless continuity of care. Read more

Governor Scott Approves State Budget for Next Year, Vetoes All Telemedicine Proposals. On June 3, 2014, the *Tallahassee Democrat* reported that Florida Governor Rick Scott approved a record-high $77 billion budget for the state for the coming year. The passage of the bill came with nearly $69 million in line-item vetoes for various initiatives; this includes vetoes of all three telemedicine initiatives included in the budget. Baptist Health South Florida, St. Vincent's Health Care, and Tallahassee Memorial Healthcare asked for a combined $1.75 million to begin telemedicine projects or intensive care units, but none will receive funding next year. Despite these vetoes, Tallahassee Memorial spokesperson, Warren Jones, said he expects the "future of medicine" will come up again next year. Read more

Illinois

Cook County Health and Hospitals System Releases Data on Health of CountyCare Enrollees. On June 2, 2014, the *Chicago Tribune* reported on new data from the Cook County Health and Hospitals System on the demographics of the nearly 100,000 new CountyCare enrollees, who have gained health insurance coverage through ACA Medicaid expansion. Many of the new enrollees report poor doctor's appointment attendance and limited access to care. Many also have expensive, chronic health problems like high cholesterol or hypertension, and practice unhealthy habits like smoking. The county intends to use this data to set an initial baseline on the health of its members and develop plans and programs targeted at specific diseases. Read more

Illinois House Votes to Restore Dental and Podiatric Benefits for Adult Medicaid Beneficiaries. On May 28, 2014, the *AP* reported that the Illinois House has voted to expand dental and podiatric services to adults on Medicaid, despite concerns by Republican lawmakers about how the state will pay for these services. Adult dental and podiatric benefits were terminated in 2012 to save the Medicaid system money. Representative Greg Harries says that the state actually spent more money treating dental and podiatric conditions in the emergency room. Covering the additional services will cost about $221 million this year, of which taxpayers will be responsible for $125 million. Read more

Indiana

Healthy Indiana Plan 2.0 Receives Praise During Public Hearings. On May 28, 2014, the *Indianapolis Business Journal* reported that health care professionals and advocates for the poor voiced their support for Governor Mike Pence's Healthy Indiana Plan (HIP) 2.0 to provide more insurance coverage to Hoosiers. Officials from private and nonprofit health plans all spoke highly of the original HIP during the public hearing, citing that most HIP enrollees paid their premiums on time and that they were very satisfied with their coverage. Read more

Kentucky

Paroling Prisoners Could Help State Shift the Health Care Costs of the Sickest to the Federal Government. On June 1, 2014, the *AP/Washington Post* reported a new pilot program that requires Kentucky to parole some sick inmates to private nursing homes in order to shift their health care costs from the state to the federal government. The inmates who are housed in the Kentucky State Reformatory's nursing care facility currently cost state taxpayers $4.4 million per year, a cost the state hopes to shift to the federal government by paroling sick inmates and providing them Medicaid coverage. However, private nursing homes are hesitant to take on these inmates due to the added risk and liability they bring with them. Read more

Louisiana

Governor Jindal's "America Next" Bill Advances. On May 29, 2014, the *Advocate* reported that the Louisiana House Appropriations Committee approved SB 682, which would institute Governor Bobby Jindal's "America Next" health care legislation. But the America Next plan still lacks important details, like its total cost and number of residents who would receive coverage. The bill states that the Department of Health and Hospitals will fill in the budget details and logistics for America Next, provided the bill gets a hearing and approval by the House. There are just five days left in the legislative session. Read more

Maryland

Maryland Exchange Board Awards Xerox and Deloitte Contracts to Fix Troubled Health Exchange Marketplace. On May 30, 2014, the *AP/ Washington Post* reported that the Maryland Health Benefit Exchange Board voted to grant a five-year, $29.3 million contract to Xerox to host new technology used in the more successful Connecticut health exchange marketplace. The state decided to scrap its own troubled exchange model in favor of Connecticut's to ensure state residents can experience a seamless enrollment process during future enrollment periods. The Board also granted Deloitte a $14.2 million contract for development and software licenses. The new contracts will not require any additional federal grant funding. Read more

Minnesota

MNsure Chief Operating Officer Erik Larson to Step Down. On May 30, 2014, *Minnesota Public Radio* reported that MNsure's Chief Operating Officer, Erik Larson, is stepping down in mid-July. Larson is the second top MNsure executive to leave in recent months, after CFO, Barb Juelich, departed in May. Read more

New Hampshire

Meridian to End Medicaid Managed Care Contract. On June 3, 2014, *New Hampshire Public Radio* reported that Meridian Health Plan will cease its Medicaid MCO activities in New Hampshire at the end of July. Meridian was one of three private companies hired by the state's Department of Health and Human Services to manage Medicaid benefits. The company's CEO, Dr. David Cotton, explains that the company's growing MCO activities in the Midwest have compelled it to focus its energy on strengthening those initiatives. The 31,000 New Hampshire residents currently enrolled in Meridian Health Plan will move to a managed care plan offered by either New Hampshire Healthy Families or Well Sense Health Plan. Read more

New Hampshire Submits $275 Million Medicaid Waiver. On May 30, 2014, the *Union Leader* reported that New Hampshire has submitted a $275 million waiver to the federal government as part of the state's "NH Health Protection Program" Medicaid expansion initiative. The federal funds would be used to increase Medicaid rates paid to hospitals and community mental health centers, enhance the state's mental health system, and institute substance abuse treatment and an oral health program. Governor Maggie Hassan said that the waiver "compliments the implementation of our historic bipartisan health care plan and Medicaid Care Management," while also addressing many important statewide health challenges. Read more

Maine Co-Op Insurer to Participate in New Hampshire Insurance Marketplace Next Year. On June 4, 2014, the *Portland Press Herald* reported that insurer Maine Community Health Options is planning on offering plans on the New Hampshire health insurance marketplace next year. The nonprofit insurer will hire an additional 30 employees in New Hampshire over the next two years to facilitate the new growth initiative. Initially, Maine Community Health Options will offer plans in the four New Hampshire counties that border Maine, but plans will expand to other counties in 2016. The insurer currently covers 80 percent of Maine's 44,000 marketplace enrollees and will join four other insurers in the New Hampshire marketplace next year. Read more

New Jersey

HMA Roundup – Karen Brodsky

New Jersey Hospitals Consider Transforming the Focus of Health Care Systems from Inpatient to Outpatient Care to Remain Viable. On May 29, 2014, the New Jersey Health Care Quality Institute (NJHCQI) convened a panel discussion to consider the future viability of New Jersey hospitals. New Jersey hospitals are facing a period of transition that will determine their future. Expert panelists predict that hospitals of the future "will have fewer beds, more links

with primary care and medical specialty providers, and more partnerships with other hospitals in which each hospital only provides specific services," as reported in *NJ Spotlight*. While hospital revenue has historically been driven by inpatient services, hospital systems are investing in the growth of outpatient services to feed their bottom line. The panelists encouraged the state to change regulations that have made it difficult for hospital systems to make changes. Read more

New York

HMA Roundup – Denise Soffel

Developmental Disabilities Commissioner Resigns. Laurie Kelley, Acting Commissioner for the Office for People with Developmental Disabilities (OPWDD), has resigned. The new acting commissioner is the agency's Executive Deputy Commissioner Kerry A. Delaney. No statement has been released explaining the circumstances. Kelley was appointed in July 2013. Although she had not yet been confirmed by the Senate, which is not unusual for a recent appointment. OPWDD is in the midst of a significant effort to reorient its system, moving away from large institutions in favor of community-based care. OPWDD is part of an on-going negotiation regarding an appropriate rate-setting methodology in light of universal agreement that the current rate setting system has resulted in significant over-payment for many years.

North Carolina

Federal Regulators Reject Governor McCrory's Plan to Tax Certain Managed Care Medicaid Providers to Draw Down Federal Funds. On June 4, 2014, the *Charlotte Observer* reported that federal regulators have rejected a plan from Governor Pat McCrory's administration to tax some managed care Medicaid providers as a way to draw down more federal money for the state budget. Federal regulators said the tax would have to be collected from all MCOs in order to gain federal approval. Rejection of McCrory's tax plan means that the state Medicaid budget now faces a $60 million shortfall. Read more

Senate Budget Addresses Concerns Regarding Management and Sustainability of State Medicaid Program. On May 30, 2014, *North Carolina Health News* reported that the Senate budget presented to the General Assembly last week includes a proposal to pull the state's control of Medicaid from the Department of Health and Human Services (DHHS). Senate Bill 744, or the "Appropriations Act of 2014," signifies lawmakers' dissatisfaction with how DHHS has managed the Medicaid program. In Subpart XII-H of the bill, lawmakers state they will create a new Medicaid agency to oversee operations of the Medicaid and NC Health Choice programs. Under the new agency, the Medicaid program would move away from the fee-for-service model toward a managed care model involving full-risk, capitated health plans. The agency would also provide budget predictability for the Medicaid program and improve the program's IT infrastructure. The Senate budget also makes major changes to the state's Medicaid eligibility guidelines and cuts state funding for services under aged, blind and disabled (ABD) coverage. Read more

Senate's Proposed Medicaid Cuts Concern the Elderly and Disabled. On June 4, 2014, *North Carolina Health News* reported that advocates for seniors and the disabled are voicing their concerns to the General Assembly regarding the recently-passed Senate budget, described above, which would cut funding for caring for the Medicaid ABD population. The Senate budget proposes that anyone earning over 100 percent of the Federal Poverty Level be moved from Medicaid to a private insurance plan; without federal Medicaid funds to pay for their care, most ABD patients would not be able to afford the adult care homes or in-home care they currently depend on for essential services. Read more

Ohio

Premiums for Individual and Small Group Market ACA Health Plans to Increase in 2015. On May 29, 2014, the Ohio Department of Insurance reported that average premiums for ACA health plans will increase by 13 percent for individuals and 11 percent for small businesses in 2015. The 16 companies filing to sell plans on the federal exchange in the individual market proposed average premiums of $374.42 per month compared to $332.58 per month for the same coverage last year. The eight companies filing to sell plans in the small group market proposed average premiums of $446.78 compared to $401.99 in 2014. Read more

Oregon

Oregon Insurer Providence Health Plan to Cut Premiums by 16 Percent in 2015. On June 3, 2014, the *Hill* reported that Oregon insurance marketplace participant Providence Health Plan is proposing a 16 percent rate decrease for health coverage purchased in 2015. The insurer reports that it expects enrollees to utilize services less than originally anticipated, thus allowing a decrease in rates for the coming year. The two other insurers participating in the exchange, Regence BlueCross Blue Shield and Kaiser Permanente, are proposing modest rate increases of 5 percent and 0.2 percent, respectively. Read more

Pennsylvania

HMA Roundup – Matt Roan

Pennsylvania Managed Care Gross Receipts Tax under OIG Scrutiny. The Office of the Inspector General for the US Department of Health and Human Services (HHS) issued a report on Friday suggesting that Pennsylvania's use of the proceeds of the Managed Care Gross Receipts Tax (GRT) to draw down federal Medicaid matching funds should be considered impermissible. The GRT was implemented in 2009 and is applied to the Medicaid revenue of MCOs throughout the Commonwealth. The proceeds from the tax are then used to support the state's share of Medicaid expenditures, drawing down federal-matching funds. The OIG found the tax to be impermissible because it fails two standards outlined in federal law: 1) the tax should not be considered "broad based" because it does not apply to MCOs with no Medicaid revenue; and 2) there is a "hold harmless" provision, in that MCOs that pay the tax must receive offsetting revenue from the enhanced Medicaid capitation payments that the tax enables. The OIG recommended that HHS determine whether the state's use of the GRT is permissible, and offset more than $1.7 billion in state Medicaid

expenditures for the two fiscal years covered by the OIG report (FY 2009-2010 and FY 2010-2011). The OIG also recommended that HHS clarify its policy on permissible health-related taxes. HHS provided comments in response to the report, in which it agreed that the policy needed to be clarified, but stated that offsets would likely not be pursued due to the lack of sub-regulatory guidance or appropriate notice to states that the approach taken in Pennsylvania was impermissible. Read more

Governor Corbett Sends Cabinet Officials to Help Settle Highmark/UPMC Dispute. As the contract dispute between Highmark and UPMC continues in western Pennsylvania, Governor Corbett has announced the formation of a "Patients First" leadership team, which will meet with leadership from both organizations to press for a resolution that reflects the interests of health care consumers. According to a June 2, 2014, report from the *Pittsburgh Post-Gazette*, the Governor has directed State Insurance Commissioner, Michael Consedine, and State Secretary of Health, Michael Wolf, to meet with executives and the Boards of Directors of Highmark and UPMC to discuss plans to resolve the dispute. Corbett also announced plans to personally meet with the boards of directors of both organizations to seek solutions. Read more

With Budget Deadline Looming, Legislature Considers Spending Cuts and New Revenue Sources. On May 31, 2014, the *Times Leader* reported that legislative leaders are considering a host of spending cuts and revenue enhancements to make up for an estimated budget deficit of $1.2 billion. The budget situation was made worse after reports from the Pennsylvania Department of Revenue showed that May tax collections fell short of projections by over $100 million. The reduction in revenue collected is being attributed to slower than expected job growth, and the impact of the phased reduction of the state's Capital, Stock and Franchise Tax. Facing the need to make changes to the budget proposed by Governor Corbett in February, legislative leaders are evaluating opportunities to reduce spending, although they acknowledged that in an election year further reductions will be difficult to achieve. On the revenue side, proposals to privatize the state liquor store system are being reexamined, with proponents of privatization claiming that the move could bring in $1 billion from wholesale and retail liquor license sales. Also, a severance tax on natural gas drilling has been gaining bipartisan support as a means to generate revenue to support education funding. Democrats have proposed a 5 percent severance tax on top of the drilling impact fee currently paid by drillers, which would produce approximately $700 million of revenue. Also under discussion are the Governor's plans for an alternative to Medicaid expansion, known as Healthy PA. The Governor's plan is expected to produce approximately $125 million in savings, but is still pending approval by CMS. Meanwhile, Medicaid expansion proponents argue that full expansion as allowed under the ACA would generate higher savings and help address the state's budget shortfall. Read more

Capital Blue Cross Hit with Medicare Sanctions. On May 30, 2014, *PennLive* reported that CMS notified central Pennsylvania insurer Capital Blue Cross (CBC) that it is immediately imposing intermediate sanctions as a result of a CMS audit which found widespread and systemic violations in CBC's Medicare Advantage Prescription and Prescription Drug Plans. While under sanction, CBC may not enroll new members into the affected plans, or market the plan offerings to potential beneficiaries. The sanctions will remain in place until CBC demonstrates that the violations have been resolved and are unlikely to re-occur.

The violations stem from "ineffective oversight" and "serious deficiencies" in the administration of the prescription drug benefit. The audit found that beneficiaries were inappropriately denied coverage for medications, and that the appeals and coverage determination process failed to comply with Medicare rules. CMS has instructed CBC to submit a written corrective action plan by June 5, 2014. Read more

Rhode Island

Rhode Island Issues Duals Demonstration Solicitation. On May 30, 2014, the Rhode Island Executive Office of Health and Human Services released a pre-RFP solicitation for bids to draft a Medicare Medicaid Plan under the Rhode Island Integrated Care Initiative. The initiative represents the state's capitated Financial Alignment Demonstration, created by CMS to address issues associated with serving dual-eligible individuals. Under the demonstration, successful bidders would enroll dual-eligible adults for health care services through a managed care program under a capitation contract. The demonstration would begin on April 1, 2015 and continue until December 31, 2018. The deadline for submissions is June 30, 2014. Read more

Texas

Texas Officials Discuss Care for Individuals with Disabilities. On June 3, 2014, the *Texas Tribune* discussed a continuing debate in Texas over how to care for individuals with disabilities. Opponents of state-supported living centers argue that conditions at these centers are often dangerous and treatment is expensive. They feel more state dollars should be invested into community-based services. But supporters of such centers, which include many family members of Texans with disabilities, argue that individuals with certain physical or behavioral disabilities cannot be adequately looked after in a community-based setting. Several state-supported living centers have recently been cited for abuse and neglect of patients, prompting state officials to carefully reconsider the efficacy of this care model. Read more

Utah

Governor Herbert Considers Extending Work Requirement to Medicaid Recipients. On June 3, 2014, the *Salt Lake Tribune* reported that state lawmakers are considering adding a work requirement for Utah residents gaining health coverage through a Medicaid expansion. Work requirements are already enforced for those who receive SNAP benefits (food stamps); however, Governor Gary Herbert believes extending the requirements to Medicaid recipients could help recipients make productive contributions to their communities and eventually help them get off public assistance. Opponents of the requirement argue a majority of Medicaid recipients in the state are employed. Those who are not employed often struggle with mental illness and substance abuse; an employment requirement might jeopardize their ability to access needed care, according to opponents. Read more

Vermont

Blue Cross Blue Shield of Vermont Requests 9.8 Percent Health Exchange Premium Increase for 2015. On June 2, 2014, *VT Digger* reported Blue Cross Blue Shield (BCBS) of Vermont has asked state regulators to approve an average 9.8 percent increase in premiums for plans it offers next year through the state's insurance marketplace, Vermont Health Connect. BCBS said the rate increase is needed to cover rising medical costs of enrollees and increasing federal fees. If the Green Mountain Care Board approves the BCBS request, monthly premiums for the six standard plans the insurer offers on the exchange would increase between $20 and $70 in 2015. BCBS currently covers about 200,000 Vermonters, or roughly one-third of the state's total population. Read more

Vermont Health Connect Hires Optum to Address Backlog Generated by Poor Exchange Functionality. On June 3, 2014, *VT Digger* reported that the Vermont Health Connect marketplace exchange board has hired Optum to work through the backlog caused by "changes of circumstance" reported by exchange enrollees. The Vermont Health Connect website does not allow users to notify insurance companies about divorces, marriages, births, or address changes; this inhibits users from updating their insurance coverage to account for important changes in life circumstances. Read more

Virginia

Senator Offers Proposal to End Medicaid Expansion Stalemate in the General Assembly. On May 29, 2014, the *Washington Post* reported that Virginia Senator Emmett W. Hanger, Jr., has offered a proposal to end the General Assembly's stalemate over Medicaid expansion. If lawmakers' decision on expansion is not resolved by the start of the new fiscal year on July 1, 2014, the state's two-year $96 billion budget will be unresolved and the entire state government could shut down. Hanger's plan would separate the Medicaid expansion issue from the budget, but it would also remake a state Medicaid commission so it could no longer block expansion. Read more

West Virginia

State Expands Medicaid Benefits to Recently Paroled or Discharged Inmates in Effort to Reduce Recidivism. On June 2, 2014, the *Charleston Gazette* reported on the benefits of expanding Medicaid coverage to recently released prisoners. West Virginia has followed the example of several other states expanding Medicaid coverage to former inmates in an effort to improve the health of former prisoners and reduce the likelihood they will commit repeat offenses. Division of Corrections spokesman, Lawrence Messina, says the state is currently identifying Medicaid-eligible inmates and helping them enroll in coverage upon parole or discharge. Read more

National

CMS Reports More Than 65 Million Enrolled in Medicaid/CHIP, up 6.05 Million from Last Year. On June 4, 2014, CMS released an updated report on Medicaid enrollment increases as of April 2014 across 48 states that reported enrollment data. Enrollment in these states increased by more than 1 million from March to April 2014, with enrollment up more than 6.05 million from summer 2013, prior to the open enrollment period. Read more

CMS Delays Proposed Shift of Prescription Drug Reimbursement Formula from Estimated Acquisition Cost to Actual Acquisition Cost. In February 2012, CMS issued a proposed final rule that included changes to the upper payment limits for prescription drugs in the Medicaid program. This rule would have accomplished two things: 1) change how and when the Federal Upper Limit (FUL) for multiple source (generic) drugs would be calculated and published and 2) change the payment limit for non-multiple source drugs from Estimated Acquisition Cost (EAC) to Actual Acquisition Cost (AAC).

Currently the EAC allows a state Medicaid agency to estimate a pharmacy acquisition cost based on a set formula. These formulas, though originally based on a survey, may not have changed for several years. Many of these formulas are based on the Average Wholesale Price (AWP) which, due to much litigation, is being phased out of the marketplace. CMS believes that using the AAC in determining drug reimbursement will be more reflective of actual prices paid, as opposed to unreliable published compendia pricing (i.e. AWP). Some states, including Alabama, Colorado, Idaho, Iowa, Louisiana, and Oregon, have already begun to base some of their drug prices on survey data based on pharmacy invoice prices. CMS believes that these surveys of pharmacy providers will assist states in determining valid reference prices from which to develop drug reimbursement rates.

CMS had previously indicated its intent to finalize this rule in May 2014. In a November 2013 Informational Bulletin CMS had indicated that it would begin implementation of the new FULs on July 1, 2014. To date, CMS has not published a final rule on prescription drugs, nor has it indicated approximately when this will occur. Additionally, CMS notified stakeholders on June 2, 2014, that it will "not be finalizing the Affordable Care Act Federal Upper Limits (FULs) in July 2014, as we previously announced." In this note, CMS also states that it expects "to provide a new finalization date for the FULs" when it releases subsequent guidance to states. It is therefore unclear when these changes in prescription drug reimbursement will be imposed on Medicaid pharmacy providers who believe their reimbursement rates will be cut due to these changes. As an example, Alabama reportedly reduced their pharmacy budget by $30 million with the implementation of AAC reimbursement.

Industry News

Consonance Capital Partners Acquires KEPRO. On May 29, 2014, Consonance Capital Partners announced the acquisition of KEPRO from the Pennsylvania Medical Society, the terms of which were not disclosed. KEPRO is a leading medical management and cost containment solutions provider for government and private sector clients in the healthcare sector. HMA served as an advisor to Consonance Capital Partners on the transaction.

Consonance Capital Partners released the following announcement upon closing the transaction: Consonance Capital Partners, the private equity arm of Consonance Capital, a leading health care-focused investment firm, announced today that it has completed the acquisition of KEPRO from The Pennsylvania Medical Society. Founded in 1985, KEPRO is a leading medical management and cost containment solutions provider for government and private sector clients in the healthcare sector. Terms of the transaction were not disclosed.

Stephen McKenna, Managing Partner of Consonance Capital Partners, said, "KEPRO is an established national brand with an unparalleled reputation for quality in the medical management space, an area that will continue to experience strong demand as a result of shifting reimbursement models and changing regulatory requirements. We believe that KEPRO, with its world class employee base and talented management team, is poised for the next level of growth, and our investment and support for the business will help facilitate that success."

Commenting on the transaction, Joe Dougher, President and CEO of KEPRO, said, "We are excited to work with Consonance and believe KEPRO will now be better positioned to capitalize on the many growth opportunities we are seeing in the market. We are confident that Consonance's national reach as well as its financial and health care-specific industry expertise will solidify our commitment to our government and private sector customers, while improving outcomes for their members. This partnership will also enable us to accelerate our pace of expansion and contribute to the development of innovative products and services to complement our integrated suite of medical review and care management solutions." Read more

AMSURG Corp. Acquires Sheridan Healthcare. On May 29, 2014, ambulatory surgery center operator AMSURG Corp. announced that it will acquire Sheridan Healthcare, a leading provider of multi-specialty outsourced physician services, in a $2.35 billion cash and stock transaction. Christopher A. Holden, President and CEO of AMSURG Corp stated that there are many strategic and financial benefits to the pairing, including the diversification of AMSURG's growth profile and significantly enhanced competencies for addressing innovation and change in health care over a large geographic area. The combined company will encompass more than 4,600 physician relationships across 38 states, with a total market worth about $70 billion. The transaction is expected to close in the third-quarter of 2014. Read more

Blue Cross of New Mexico to Acquire Lovelace Health Plan This Week. On May 28, 2014, the *Albuquerque Journal* reported that Blue Cross Blue Shield (BCBS) of New Mexico has been officially cleared by the Department of Justice to acquire Lovelace Health Plan's Medicare Advantage operation. The companies declined to disclose the details or price of the transaction. Lovelace decided last year to sell all of its insurance operations after the state rejected its bid to provide managed care services to Medicaid recipients. The transaction will expand BCBS of New Mexico's Medicare rolls by 28,000 people, a significant boost from the 3,500 Medicare beneficiaries it now covers. Read more

Ventas Acquires ARC Healthcare Trust in a $2.6 Billion Deal. On June 2, 2014, Ventas announced that it will acquire all outstanding shares of the American Realty Capital (ARC) Healthcare Trust in a $2.6 billion stock and cash transaction. The boards of directors for the two companies agreed upon a stock price of $67.13 per share, representing a 14 percent increase over ARC Healthcare's closing stock price on May 30. Ventas also announced that it will acquire 29 independent living senior housing communities in Canada from Holiday Retirement in a separate transaction worth $900 million in cash. Read more

Ensign Group Acquires Skilled Nursing Facilities in Wisconsin, Adding to its Growing Enterprise. On June 3, 2014, Ensign Group announced that it acquired two skilled nursing facilities in Wisconsin. Ensign purchased the facilities with cash and will retain ownership of the real estate for both facilities. These acquisitions, together with the Washington and Colorado acquisitions completed on the same date, bring Ensign's growing portfolio to 126 health care facilities, eight hospice companies, 10 home health agencies and 11 urgent care clinics across 12 states. Read more

Tenet Healthcare Acquires Majority Interest in Texas Regional Medical Center. On June 3, 2014, Tenet Healthcare Corporation announced that it acquired a majority interest in Texas Regional Medical Center in Sunnyvale, Texas. The comprehensive community hospital serves an area of Dallas that is experiencing a 2.5 percent population growth annually, which is nearly four times the national rate. Physician owners continue to retain a minority interest in the hospital. Read more

RFP CALENDAR

Date	State	Event	Beneficiaries
June 6, 2014	New York Behavioral (NYC)	Proposals Due	NA
June 12, 2014	Delaware	Contract awards	200,000
June 13, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June, 2014	Indiana ABD	RFP Release	50,000
June, 2014	Washington Foster Care	RFP Release	23,000
June 30, 2014	Rhode Island (Duals)	Proposals due	28,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Implementation	68,000
July 16, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
October 1, 2014	Washington Duals	Implementation	48,500
Late October 2014	Texas STAR Kids	Proposals Due	200,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Michigan Duals	Implementation	70,000
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
January 1, 2015	Texas Duals	Implementation	168,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
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
Arizona		98,235	Not pursuing Financial Alignment Model						
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	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
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
Iowa	MFFS	62,714						TBD	
Idaho		22,548	Not pursuing Financial Alignment Model						
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	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000				5/23/2014	1/1/2015	3/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.3M Capitated 520K FFS**	***12***			***11***			

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

[1] Capitated duals integration model for health homes population.

HMA News

HMA/Kaiser Family Foundation Medicaid and CHIP Enrollment Snapshots for December 2013 Published

On June 3, 2014, The Kaiser Family Foundation (KFF), in partnership with HMA, published December 2013 enrollment snapshots with state-by-state Medicaid and Children's Health Insurance Program (CHIP) enrollment trends and analysis.

The *Medicaid Enrollment: December 2013 Data Snapshot* (available here) is authored by KFF's Laura Snyder and Robin Rudowitz, and HMA's Eileen Ellis and Dennis Roberts.

The *CHIP Enrollment Snapshot: December 2013* (available here) is authored by HMA's Vernon Smith, Ph.D., and KFF's Laura Snyder and Robin Rudowitz.

HMA Webinar Replay: *"The Medicare ACO: Effective Care Management and its Anticipated Impact"*

Link to Webinar Slides and Replay

On May 28, 2014 HMA's Accountable Care institute (ACI) presented "The Medicare ACO: Effective Care Management and its Anticipated Impact," the second in a three-part webinar series.

HMA Principals Lynne Fagnani, Dr. Art Jones, MD, and Nancy Jaeckels offered lessons learned from the latest Medicare demonstrations and talked about the importance of effective care management and its return on investment. Webinar highlights include characteristics of successful programs, population management and workflow, and building blocks for care management success.

The third and final webinar in the series will focus on Finances of the Medicare ACO and is slated for 2 p.m. EDT, June 18, 2014.