HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 11, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

RHODE ISLAND DUALS PROCUREMENT REVIEWED

This week, our *In Focus* section reviews the recently issued procurement for Rhode Island's duals demonstration. On May 30, 2014, Rhode Island's Executive Office of Health and Human Services (EOHHS) issued a procurement soliciting letters of intent (LOI) to serve the dual eligible population under a capitated financial alignment demonstration, as well as Medicaid-only recipients of long-term supports and services outside of the demonstration. The program, known as the Integrated Care Initiative (ICI), is targeting an April 2015 launch, and will transition dual eligibles and Medicaid LTSS beneficiaries into capitated health plans or enhanced primary care case management (PCCM) options.

Integrated Care Initiative – Phase I

In 2013, Rhode Island's EOHHS issued procurements for the dual eligible and Medicaid LTSS populations that resulted in two options for this population. A fully capitated Medicaid health plan under the Rhody Health Options (RHO) or an enhanced PCCM program, called Connect Care Choice Community Partners

(CCCCP). Neighborhood Health Plan of Rhode Island is currently the only Rhody Health Options plan, and the CCCCP contract is held by Carelink. As of April 2014, there are approximately 16,000 members enrolled in Rhody Health Options and 5,900 members enrolled in CCCCP. An additional 5,700 individuals opted out of Phase 1. An overview of the Phase I procurement was provided in our March 13, 2013 Weekly Roundup.

Integrated Care Initiative – Phase II

The target populations that will be served under the ICI are full benefit dual eligibles who reside in the community, whether or not they are receiving LTSS, dual eligibles in institutional care settings, and Medicaid only adults receiving LTSS in the community. EOHHS intends to carve-out individuals with intellectual or developmental disabilities (IDD) and the serious and persistent mental illness (SMI) population.

Dual eligibles will have a choice of enrollment options, including:

- a RHO plan that offers both Medicare and Medicaid benefits on a capitated basis as a Medicare-Medicaid Plan (MMP);
- a different MMP (if available);
- a RHO plan for Medicaid benefits only, plus FFS Medicare or Medicare Advantage and a prescription drug plan (PDP);
- the CCCCP plus FFS Medicare or Medicare Advantage and a PDP;
- the Program of All-Inclusive Care for the Elderly (PACE) program; or,
- FFS Medicaid plus FFS Medicare or Medicare Advantage and a PDP.

Additionally, the procurement notes that any dual eligible enrolled in a Medicare Advantage plan that is owned by the same parent company as an ICI plan may be automatically passively enrolled into that ICI plan. All dual eligibles will retain the same ability to opt out of the program at any time, as is required under the federal requirements for the CMS financial alignment demonstrations.

Dual Eligible and Medicaid LTSS Population

The dual eligible population breakdown below is provided in the EOHHS procurement. As a note, roughly 4,000 duals with SMI included in the number below will likely be carved out of the demonstration. Additionally, the community LTSS population number includes those with I/DD who will also likely be carved out of the ICI.

Dual Eligibles	Number	Percent
Community, No LTSS (incl. SMI)	20,389	64.4%
Community LTSS (incl. I/DD)	5,694	18.0%
Institutional	5,377	17.0%
PACE	208	0.7%
Total Dual Eligibles	**31,668**	

Contract Award and Timeline

Letters of intent are due to EOHHS on June 30, 2014. A timeline for contract awards is not provided at this time. However, EOHHS intends to have contracts effective and ICI plans accepting voluntary enrollments on April 1, 2015. A passive enrollment period will follow. The ICI demonstration will continue

through December 31, 2018. Bidders who are approved by EOHHS will be announced and will proceed to the readiness review and three-way contracting process with EOHHS and CMS prior to final approval. Since Neighborhood Health Plan of Rhode Island was selected via the 2013 LOI opportunity, they will not be required to reapply through this procurement to participate in ICI Phase II.

ICI Phase II bidders will be evaluated on the criteria detailed below.

Evaluation Criteria	Possible Points
Experience and Understanding	20
Plan for Enrollment	5
Plan for Providing Covered Services and Meeting Accessibility Standards	8
Plan for Maintaining a Robust Provider Network including the Development of Patient Centered Medical Homes	8
Plan for Operating a Person-Centered System	10
Plan for Conducting Risk Profiling	8
Plan for Providing Care Management	10
Plan for Service Nursing Home Transition Members	10
Plan for Providing Member and Provider Services	4
Plan for Conducting Medical Management and Quality Assurance Efforts	5
Plan for Reimbursing Providers	10
Plan for Compliance, Reporting, and Program Integrity	2
Total Points Available	**100**

Managed Care Program Enrollment

February 2014 enrollment across all managed care programs is detailed in the table below. Neighborhood Health Plan of Rhode Island (NHPRI) and UnitedHealthcare are the only two contracted MCOs in the state at this time. Bidders must attest to operating as a licensed health maintenance organization (HMO) or as an MCO within Rhode Island. Bidders must also be NCQA accredited in Rhode Island or NCQA accredited in another state and attest to being NCQA accredited in Rhode Island within 12 months.

RIte Care is the state's Medicaid managed care program for children and families, and also serves children with special health care needs.

Rhody Health Partners, launched in 2009, provides a voluntary Medicaid managed care option for aged, blind, and disabled (ABD) recipients.

Rhody Health Options, launched in 2013, provides Medicaid managed care, including LTSS to Medicaid-only and dual eligible benficiaries.

Program	NHPRI	United	CCCCP	Total
RIte Care	89,412	42,348		131,760
Rhody Health Partners	6,524	7,477		14,001
Expansion	10,945	8,904		19,849
Rhody Health Options	12,801		3,647	16,448
Total	**119,682**	**58,729**	**3,647**	**182,058**

Link to Rhode Island Procurement

https://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7548793.pdf

HMA Medicaid Roundup

Alabama

Alabama Hospitals Reporting Financial Consequences Due to State Not Expanding Medicaid. On June 5, 2014, the *Anniston Star*/the *Miami Herald* reported that Alabama hospitals are reporting significant financial losses which they attribute to the state's refusal to expand Medicaid under the Affordable Care Act. As the federal government cuts reimbursements to hospitals for uncompensated care, states which have not implemented Medicaid expansion are receiving less federal money to provide healthcare services for their poorest residents. This means that Alabama's hospitals, particularly those that are providing an increasing amount of uncompensated care, are facing lower profit margins, which could threaten quality of patient care or even the services hospitals can afford to offer. Read more

California

HMA Roundup – Alana Ketchel

Hospital Medi-Cal Funding Ballot Initiative Delayed. On June 4, 2014, the *California Healthline* reported that a measure that would make permanent the Medi-Cal quality assurance fee hospitals pay to the State will likely not qualify in time for the November 2014 ballot. Hospitals contribute approximately $3 billion for the fee, which the state leverages for Federal matching dollars and then reimburses hospitals for the services they provide to Medi-Cal beneficiaries. Hospital groups wanted to ensure both the state and hospitals receive a set amount of the funding, citing that the state has taken an increasing amount of the fee since 2009. Read more

Alameda to Cover Undocumented Immigrants. On June 4, 2014, *Reuters* reported that Alameda County voters passed a measure to raise $100 million annually for health clinics that serve undocumented immigrants. The measure is funded through a 0.5 percent sales tax between 2019 and 2034. Read more

Two Medi-Cal Managed Care Plans Fined. On June 5, 2014, the *California Healthline* reported that the CA Department of Managed Care (DMHC) has fined two Medi-Cal managed care plans. Care1st Health Plan was fined $75,000 over alleged problems with care delivery for a prostate cancer patient in 2011. DHMC also fined Contra Costa Health Plan $20,000 for lacking a dispute resolution process. Read more

New Leadership for CA Association of Health Plans. On June 6, 2014, the California Associate of Health Plans (CAHP) announced that Charles Bacchi will

be the association's next President and CEO once Patrick Johnson retires at the end of the year. Bacchi has been with CAHP for eight years, serving most recently as Executive Vice President. Read more

Concerns Over Availability of Special Needs Dental Care. On June 10, 2014, the *California Healthline* reported that representatives of the California Dental Association are warning that patients with special needs have poor access to dental care. The Association cited inadequate rates of Medi-Cal reimbursement for hospital room, anesthesia fees and dental care, which force facilities to cut or discontinue services for special needs patients. Sutter Memorial Hospital in Sacramento will stop accepting Denti-Cal special needs patients effective July 31, 2014. Read more

New Enrollment Schedule for Cal MediConnect. On June 4, 2014, the California Department of Health Care Services (DHCS) released an updated enrollment timeline for the duals demonstration. DHCS noted separately on June 9 that eligible beneficiaries enrolled in the Multipurpose Senior Services Program (MSSP) in Los Angeles, Riverside, San Bernardino and San Diego will now enroll in Cal MediConnect on October 1, 2014, rather than during the originally scheduled enrollment month of August. Read more

U.S. Supreme Court Maintains that California State Government Should Maintain Legal Duty to Ensure Well-Being of Prisoners in County Jails. On June 9, 2014, the *Los Angeles Times* reported that the U.S. Supreme Court has rejected the appeal from California Governor Jerry Brown which objects to a judge's order requiring state officials to monitor each of about 2,000 disabled prisoners who are held in county jails. Many low-level offenders were recently transferred to county jails in an effort to address overcrowding in state prisons. Because the move meant that these inmates were in the "sole legal custody" of county officials, Brown argues that the state should not be held accountable for these prisoners. The state Appeals Court and the Supreme Court disagree, arguing that it is still the state's responsibility to ensure that the disabled in county jails are given the appropriate accommodation and tools needed to manage their disabilities. Read more

Colorado

HMA Roundup – Joan Henneberry

Connect for Colorado Exchange Board Institutes a Carrier Fee for Insurers. On June 9, 2014, the *Daily Caller* reported that the board of the Connect for Health Colorado exchange has approved a carrier fee on all health plans in order to raise money to operate the exchange. The carrier fee of $1.25 per month per policy would generate over $13 million for the exchange this year, and would go a long way towards making the exchange financially self-sufficient once its federal start up grants are exhausted. On top of the carrier fee, the state is considering charging a tax of 1.4 percent on exchange customers' monthly premiums, which could raise up to $6.9 million for the 2015 budget. Read more

Florida

HMA Roundup – Elaine Peters

AHCA Plans to Give Insurers "Kick Payment" to Cover Expensive Hepatitis C Treatment. In June 10, 2014, *Health News Florida* reported that the Agency for Health Care Administration (AHCA) plans to give health plans additional funds to help them cover the extremely expensive hepatitis C treatment Sovaldi. Press Secretary Shelisha Coleman said that the details on the payments should be released by June 30. AHCA has also set up strict guidelines for insurers to use for approval of Sovaldi (as well as another expensive hepatitis C drug, Olysio) in order to limit the drugs' use and curb costs. Read more

Governor Scott Nixes Proposal to Transition "Medically Needy" to Managed-Care Plans. On June 5, 2014, *WUSF News* reported that Governor Rick Scott has signed the legislature's repeal of part of a state law that would require "Medically Needy" people with debilitating illnesses to enroll into managed-care plans and to pay monthly premiums. CMS did not support the requirement of the Medically Needy to pay monthly premiums, but they never formally denied the state's waiver request for this requirement. Floridians in the Medically Needy program will continue to receive services billed under the traditional fee-for-service model. Read more

Georgia

HMA Roundup – Mark Trail

DCH Cancels RFP for ABD Medicaid Managed Care. On June 9, 2014, *Georgia Health News* reported that the Georgia Department of Community Health has cancelled its RFP to establish a contract with a vendor to provide Medicaid managed care to 400,000 Medicaid beneficiaries who are aged, blind or disabled (ABD). According to the Georgia Procurement Registry, contract proposals that were received were "over budget." The ABD population represents 28 percent of Medicaid beneficiaries in Georgia; the RFP would have allowed enrollees to have access to a nurse phone line and case management services in order to better coordinate their care. For now, services provided to ABD Medicaid beneficiaries will continue to be paid for using the traditional fee-for-service model. Read more

Rural Hospital Stabilization Committee Discusses Growing Rural Health Care Crisis. On June 9, 2014, *Georgia Health News* reported on discussions at the Rural Hospital Stabilization Committee meeting regarding how to meet the healthcare needs of rural counties. Eight rural hospitals that were financially struggling have been closed since 2000; this has left some counties without a hospital or other critical health services. Among the ideas discussed were the prospects of expanding Medicaid in the state, transitioning hospitals to free standing emergency departments, and increasing financial incentives for providers to increase retention in rural health care facilities. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

State Delays Medicaid Managed Care Kickoff. On June 10, 2014, the *Chicago Tribune* reported that Illinois is delaying the launch of all Medicaid managed care programs by at least one month in much of the state, including the Chicago area. Because the state has yet to finalize contracts with some insurers or mail patients' informational packages asking them to select health plans, it will be unable to begin transitioning beneficiaries to managed care programs on July 1, 2014, as originally scheduled. Once the state settles on a new start date, beneficiaries will get 60 days to select one of several managed care plans offered in their area. Read more

Illinois Renews Medicaid Eligibility Contract with CSG Government Solutions. The Illinois Department of Healthcare and Family Services (HFS), announced on June 5, 2014, that is was exercising the two-year renewal term on its integrated eligibility system contract with CSG. The contract renewal will extend through June 30, 2016. CSG was awarded the integrated eligibility system contract in March 2012, with the intent of redesigning the state's Medicaid eligibility system to comply with ACA requirements and improve the experience of Medicaid and other HFS beneficiaries.

Kansas

Kansas Prepares for New Federal HCBS Rules. On June 10, 2014, the Kansas Health Institute reported on new federal rules that are intended to assure that people who receive home- and community-based (HCBS) services have more say in their care and living conditions. The new rules will require that the various settings where HCBS are provided be "non-institutional" so that consumers can participate in the community as much as possible. While the new rules should improve beneficiary communication and quality of care, they also have unintended consequences, including the delay of HCBS Medicaid waivers which now have to incorporate the new rules. The state is required to develop a transition plan for how it will implement the new changes; public hearings to gain information for this transition plan will take place next week. Read more

Kentucky

Mental Health Center Shuts Down Two Programs. On June 5, 2014, *WKMS/National Public Radio* reported that the Pennyroyal Center has announced the closure of its Madisonville and Hopkinsville therapeutic rehabilitation programs, effective June 27, 2014. The rehab programs are for adults with chronic mental illness; these adults are often low-income individuals that are able to participate in the programs because of state subsidies. Executive Director David Ptaszek cites "a $1.2 million funding cut from the Department for Behavioral Health, decreased income from Medicaid managed care and steep obligations to the Commonwealth's retirement system" as reasons for the closures. The closures represent a statewide trend that could jeopardize access to mental health, especially for poor Kentuckians. Read more

Maryland

CareFirst Proposes Premium Increase of 23 to 30 Percent for Individual Plans in 2015. On June 6, 2014, the *Washington Post* reported that Maryland's dominant insurance company, CareFirst, is proposing 23 to 30 percent premium increases for consumers buying individual plans in 2015. The Maryland Insurance Administration will review the plans and has the ability to ask insurers to lower their rates. CareFirst CEO, Chet Burrell, states that the insurer's rates will still be competitive compared to the other insurance options Marylanders have. Read more

Massachusetts

HMA Roundup – Rob Buchanan

Nearly All Massachusetts State Residents Have Health Insurance Coverage. On June 9, 2014, *WBUR Boston NPR* reported that nearly all residents of Massachusetts now have health insurance coverage. After the federal government's campaign earlier this year to enroll people into health insurance plans, the state estimated that less than one percent of residents still did not have insurance coverage. But many new enrollees are currently in temporary plans while the state government determines their eligibility for free or subsidized care. It remains to be seen whether these enrollees would pay insurance premiums if they were required to. Read more

Attorney General Grants Partners Health Care Option of Acquiring Emerson Hospital. On May 27, 2014 the *Worcester Business Journal* reported that Boston-based health care system Partners HealthCare has been given legal approval to acquire Emerson Hospital, despite an agreement they signed which barred them from acquiring any more hospitals for the next seven years. As the state's largest health care system, Partners was prohibited from acquiring any more hospitals in Eastern Massachusetts in an effort to maintain a competitive landscape and prevent Partners from monopolizing the state's health care industry. But the Attorney General agreed to make an exemption for Emerson Hospital, as the facility already collaborates significantly with Partners and is currently struggling financially. It is not yet clear whether Emerson and Partners will indeed enter into merger agreements. Read more

Michigan

HMA Roundup – Esther Reagan

Michigan Aims to Increase "Personal Responsibility" of Medicaid Enrollees. On June 7, 2014, *USA Today* reported on efforts by the Health Michigan Medicaid program to engage consumers more in improving their health. Program administrators are considering giving people a financial incentive to change their behaviors as a means of improving their health and controlling Medicaid spending. The state also plans to make beneficiaries pay co-pays or premiums (or both) through a health savings account. Read more

New Hampshire

Lawmakers OK Hospital Settlement. On June 5, 2014, *AP*/the *Eagle Tribune* reported that lawmakers passed a bill that will implement a settlement with 25 New Hampshire hospitals over Medicaid rates and a tax on hospital revenues that was deemed unconstitutional. The tax brought in $185 million this year and was used for Medicaid and other state spending. Hospitals have objected to the tax because the state has retained the proceeds while simultaneously cutting Medicaid spending by more than $130 million. Under the settlement, the tax rate would drop from 5.5 percent assessed on net patient revenues to 5.45 percent in 2016, and to 5.4 percent in 2017. The tax could drop to 5.25 percent in 2018, depending on if the total cost of uncompensated care provided by hospitals drops below $375 million. Read more

New Jersey

HMA Roundup – Karen Brodsky

NJFamilyCare Enrollment Continues to Grow. On June 5, 2014, *NJ Spotlight* reported that Medicaid expansion has contributed to continued high levels of enrollment in New Jersey's Medicaid and CHIP programs, with 45,674 individuals signing up in May. A total of 1,485,576 state residents are now enrolled according the state's May 2014 enrollment report. That represents a 201,095 increase since January 2014, and a 13 percent increase in enrollees from one year ago. The Rutgers Center for State Health Policy originally projected that Medicaid expansion would increase New Jersey enrollment by 234,000 and did not expect enrollment to reach 201,000 until October 2015. The increased enrollment is highest for adults without children. Read more

Medicaid Expansion Enrollees Who Are Declared Medically Exempt from Participation in the Alternative Benefit Plan (ABP) May Qualify for Long-Term Services and Supports. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued a June 2014 newsletter to Medicaid providers to notify them how to assist Medicaid expansion enrollees who meet one of the State's medically exempt criteria, and therefore, have a choice of either NJ FamilyCare Plan ABP or an alternate plan that includes all NJFamilyCare (NJFC) State Plan benefits, *including* Long Term Care. As a result of the Affordable Care Act, the State offers NJFC ABP to Medicaid expansion enrollees, which includes all NJFC State Plan benefits with the *exception* of Long Term Services and Supports, and includes additional mental health and substance abuse services. A Medicaid expansion enrollee may qualify as medically exempt if they have:

- A disabling mental disorder (including adults with serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- Physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living
- A disability determination based on Social Security criteria. Read more

New York

HMA Roundup – Denise Soffel

Staff Changes at NY Department of Health. On June 9, 2014, *Capital New York* reported that Jim Introne, the former Deputy Secretary for Health, is returning to state government to help oversee the Delivery System Reform Incentive Payment (DSRIP) program. New York's DSRIP program, part of its recently approved Medicaid waiver, will provide $6 billion in over 5 years in incentive payments aimed at reducing avoidable hospital use and transforming the health care system into a more integrated delivery system. Introne retired from his position in the Governor's office in 2013. Additionally, Dan Sheppard, formerly at the Division of the Budget, has been appointed Deputy Commissioner, Office of Primary Care and Health Systems Management. Read more

Revised Waiver Terms and Conditions. The NYS Department of Health has posted revisions to the 1115 waiver terms and conditions based on public comment. Some of the changes were clarification of the attribution process; stronger language about consumer engagement in the community needs assessment, delivery system assessment and project planning (including references to Olmstead and to language access); the addition of a state-wide education campaign to inform consumers about the benefits of DSRIP and the availability of services through the PPS's; adding community stakeholders to the PPS learning collaboratives; and adding consumer and local government representatives to the Department of Health Quality Committee, which is responsible for reviewing performance metrics and high performance target goals. The state has not yet finalized the methodology for establishing the valuation of DSRIP projects for public hospitals, which is critical as the program will be financed through federal match of IGT payments made by the public hospitals. Read more

Advanced Home Health Aides. Governor Andrew Cuomo introduced a program bill that would allow advanced home health aides to perform certain tasks—in particular, dispensing medication—that can currently only be done by nurses. The bill reflects a recommendation of the Medicaid Redesign Tem, whose workforce flexibility work group proposed creating a certification for advanced home care aides who could carry out an expanded range of tasks. The bill would create a program for home health aides to get additional training; after the training, advanced home health aides could administer premeasured medication under a nurse's supervision.

Oklahoma

Mercy Health System Plans to Lay Off Up to 300 Employees, States' Refusal to Expand Medicaid Likely Key Driver. On June 9, 2014, the *Oklahoman* reported that Mercy health system's imminent layoff of up to 300 employees in four states, including Oklahoma, is largely the result of lawmakers in these states refusing to expand Medicaid coverage. Not expanding Medicaid, along with lower reimbursements and decreased inpatient activity, has caused the state's health system revenues to drop significantly. Mercy has hospitals in Oklahoma, Kansas and Missouri, none of which are expanding Medicaid. Read more

Pennsylvania

HMA Roundup – Matt Roan

State HHS Committee Advances Medicaid Expansion Bill. On June 9, 2014, the *Pittsburgh Post-Gazette* reported that twelve members of the state House and Human Services committee, including three Republican members, voted to advance a Medicaid expansion bill in Pennsylvania. As lawmakers aim to close a $1.2 billion gap in the 2014-2015 budget and the fate of Governor Corbett's "Healthy PA" Medicaid alternative remains in limbo, lawmakers are considering the prospect of traditional Medicaid expansion as a means to bring more federal funds into the state and increase healthcare coverage for poor Pennsylvanians. The state HHS measure would allow expansion to go into effect at least until there is a verdict for Corbett's Healthy PA initiative. Read more

Pennsylvania Attorney General Eyes Potential Legal Complaint Against UPMC. On June 9, 2014, the *Pittsburgh Post-Gazette* reported that Pennsylvania Attorney General Kathleen Kane's office has prepared a legal complaint against UMPC which it will consider filing in the event that contract disputes between Highmark and UPMC are not resolved in an equitable manner. Kane participated in a meeting with Leadership from UPMC along with members of Governor Corbett's cabinet in an effort to find a resolution to the conflict. UPMC, the largest hospital system in Western Pennsylvania, has not agreed to renew contracts with Highmark, the region's largest health insurer. UPMC objects to plans by Highmark to direct some of its members towards service at the West Penn Allegheny Health System, a hospital system which Highmark purchased last year. If UPMC refuses to contract with Highmark, concerns over possible disruptions of care for Highmark members who will have to change providers are being raised by advocates and local legislators. Kane's legal complaint would focus on consumer protections, and UPMC's obligations as a non-profit entity. Read more

Independence Blue Cross Reports a 25 Percent Reduction in Net Income. On June 10, 2014, the *Philadelphia Inquirer* reported that Independence Blue Cross (IBC) has released its Annual Report for 2013, which shows a sharp decrease in net income when compared to the insurer's financial performance from 2012. IBC reported net income of $142.6 million in 2013, which is approximately 25 percent less than its net income of $191.5 million in 2012. Despite the drop in net income, total revenues grew from $10.48 billion in 2012 to $11.05 billion in 2013. IBC attributed the decrease in net income to increasing medical costs and administrative expenses related to serving the new individual market through the Health Insurance Marketplace. Medical expenses increased from 83.9 percent of premium revenue in 2012 to 84.7 percent in 2013. As for costs associated with entering the Health Insurance Marketplace, an IBC spokesperson said, "it was necessary to make significant investments in the right technology, tools, and processes in order to prepare for servicing our new individual customers - many who have never had health plans before." Read more

Allegheny County Jail Oversight Board Examines Health Care Concerns. On June 5, 2014, the *Pittsburgh Post-Gazette* reported that nurses serving inmates at the Allegheny County Jail raised concerns about understaffing and quality of care to the County's Jail Oversight Board. Board members plan to form a subcommittee to investigate reports of understaffing, and concerns about the quality of care which have arisen since the administration of healthcare services

in the jail was assumed by Corizon Health Inc. in September 2013. Nurses testifying in front of the Board provided accounts of single staff members dispensing medications to units which included up to 700 inmates. Corizon officials provided the board with a report detailing process improvement efforts underway to address quality concerns. They also testified that there have been ongoing challenges with waiting lists for psychiatric care provided at the Torrence State Hospital. Currently, about 20 inmates are awaiting treatment at Torrence. Corizon reported that their mental health director recently resigned, and they are in the process of recruiting a replacement. In the meantime, a behavioral health nurse is available 24/7 to address inmate needs. Read more

Texas

Rising Dialysis Use in Texas Prisons Prompt Discussion on How to Improve Care, Lower Costs. On June 2, 2014, the *Texas Tribune* reported on the rising numbers of Texas inmates given dialysis and the subsequent increased burden on taxpayers. Today, the 228 inmates in the state who receive dialysis three times a week cost taxpayers $1.25 million per year, which is the equivalent of 3 percent of the prison system's annual pharmaceutical budget. With the rate of inmates with chronic kidney disease increasing, prison officials and lawmakers are now discussing ways to improve management of chronic kidney disease and associated conditions in order to reduce the need for dialysis. Read more

Virginia

Virginia Budget Bill Advances without Medicaid Expansion as Governor Looks for Alternatives. On June 10, 2014, the New York Times reported that Virginia Governor Terry McAuliffe may consider options to expand Medicaid through executive action after Democrats conceded on the Medicaid expansion, facing a June 30, 2014, budget deadline. The resignation of Democratic state senator Phillip Puckett gave Republicans a majority in the Senate and effectively ended hopes for Medicaid expansion. Governor McAuliffe's administration estimates that roughly 400,000 could gain coverage if the state expanded Medicaid. Read more

National

New Tax on For-Profit Health Plans to Raise $8 Billion in 2014. On June 6, 2015, the *CQ HealthBeat* reported on an upcoming health insurance tax on Medicaid managed care plans, which is expected to raise about $8 billion this year. The fee will apply to all fully-insured, for-profit health plans; the IRS will tell plans how much they are expected to pay by June 15. The Medicaid Health Plans of America, America's Health Insurance Plans and the National Association of Health Underwriters say that the tax will increase health insurance costs overall. Because of this, many healthcare industry officials worry that state governments will experience significant increases in their Medicaid costs to health plans.

1.7 Million Backlogged Medicaid Applications Nationwide in Expansion and Non-Expansion States. On June 9, 2014, *Kaiser Health News*/the *Washington Post* reported that 1.7 million Americans are still waiting for their Medicaid applications to be processed by their state of residence. This includes applicants

from non-expansion states, some of which experienced a surge in Medicaid enrollment. Federal regulations require that Medicaid applications are processed by the state within 45 days of receipt; but many states have experienced application backlogs due to insufficient staffing, their own computer problems, and issues in determining Medicaid eligibility. Advocates are concerned that providers may decide not to see patients without confirmation they have insurance coverage and that patients may not have the funds to pay doctors up-front. Read more

Granting Patients Access to Their Medical Records Could Help Reduce Errors, Improve Doctor-Patient Communication. On June 9, 2014, the *Wall Street Journal* reported on new studies which show that giving patients increased access to their medical records can help play a role in managing their own care by identifying errors and omissions. As more of the nation's doctors transition to electronic health records, patients have an increased opportunity to easily access their records; patient feedback could be extremely valuable in decreasing the likelihood of adverse drug reactions, improving doctor-patient communication and reducing medical liability. Read more

Center for Health Care Strategies Releases Tool Outlining Cost-Sharing and Wellness Incentive Programs in Various State Medicaid Programs. This week, the Center for Health Care Strategies released a Technical Assistance Tool which outlines current and proposed cost-sharing and wellness incentive policies in several state Medicaid programs. The policies aim to improve Medicaid beneficiaries' ability to make informed decision about their health and their health care. Read more

Hospitals in Expansion States Reporting Less Charity Care, Less Self-Pay Patients, and Increased Medicaid Patient Volume. On June 3, 2014, the *Denver Post* reported on a recent study released by the Colorado Hospital Association, which showed that hospitals in states that have expanded Medicaid provided less uncompensated care and saw less self-pay patients in the first quarter of 2014. On average, Medicaid volume at these hospitals rose 29 percent. The findings demonstrate that those living in expansion states who previously lacked health insurance coverage are successfully obtaining coverage, largely through Medicaid expansion. Read more

Industry News

Centene Corporation Announces Transactions with Community Health Solutions. On June 5, 2014, Centene Corporation announced that it has entered into a transaction whereby Community Health Solutions of America (CHS) will assign its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Medicaid program to Centene's wholly owned subsidiary, Louisiana Healthcare Connections, Inc. The purchase price will be between $110 million and $140 million and is contingent upon regulatory approval. Once the transaction is finalized, Medicaid recipients enrolled in CHS will have the opportunity to transfer to Louisiana Healthcare Connections, or to choose among the other four private companies providing insurance coverage in Bayou Health. If approved, the transaction would be the first change since the Jindal administration began the program to privatize health care delivery for two-thirds of the state's 1.2 million Medicaid recipients. Read more

MAXIMUS Appoints Richard Nadeau as CFO and Treasurer. On June 6, 2014, government services provider MAXIMUS announced the appointment of Richard J. Nadeau as Chief Financial Officer and Treasurer. In this role, Mr. Nadeau will be responsible for the Company's financial operations, including all corporate accounting and financial planning analysis. He will also oversee the corporate controllership, treasury and tax functions, and will provide leadership assistance for the Company's mergers and acquisitions activities. Nadeau joins the company from SRA International, which serves several U.S. federal government agencies, and has spent the last ten years as CFO for three NYSE-listed companies. He will begin his appointment at MAXIMUS on June 23, 2014. Read more

Envision Healthcare to Acquire Phoenix Physicians. On June 10, 2014, Envision Healthcare Holdings, Inc. announced that its EmCare division has entered into an agreement to acquire Phoenix Physicians, LLC. The deal is expected to add an estimated $125 million in revenues and approximately 800,000 patient encounters annually. Read more

RFP CALENDAR

Date	State	Event	Beneficiaries
June 12, 2014	Delaware	Contract awards	200,000
June 26, 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
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 Expands Consulting Reach with HMA Community Strategies

Health Management Associates (HMA) is pleased to announce the creation of a new operating division, HMA Community Strategies (HMACS).

The new division is based in HMA's Denver office. HMA Managing Principal Joan Henneberry is the managing director.

HMACS is designed to complement and enhance HMA's consulting services, with a focus on supporting the efforts of a broad range of community stakeholders working to develop healthy, equitable, and sustainable communities.

There is growing recognition that the vision of healthier people and communities will require new partnerships and dedication of resources to population health and social determinants of health, including education, housing, environment, food, economic security, and safety. As experts in health and health care, HMA recognized the need to expand its reach to include these social determinants that so clearly influence individual and community health.

HMA Community Strategies provides research, evaluation, policy work and program development and implementation to support the crucial work being done on the front lines of health and human services. We know our clients aspire to solve social, economic, and health problems through community-generated solutions that are sustainable. That's why our services support and build stronger connections among stakeholders to help advance those community goals. HMACS serves as a support system for communities as they build the partnerships necessary to sustain and promote a broad vision of health for all of its members.

HMACS is designed to assist community-based organizations; city, county, and local municipalities; foundations; or groups of individuals with a shared goal of community health. We offer a depth and breadth of experience and expertise that is unmatched, yet HMACS was purposely designed to be accessible to these groups which we know often have limited resources.

HMACS offer an array of services, consultants who are health and human services leaders, and a fee structure crafted to reflect the needs of our clients.

HMA Upcoming Webinar: *"Medicare ACOs: The Value Proposition"*

Wednesday, June 18, 2014
2:00 PM EDT
Register Here

HMA's Accountable Care Institute is hosting the third in a three-part webinar series on becoming a Medicare Accountable Care Organization (ACO), "Medicare Accountable Care Organizations: The Value Proposition."

CMS has approved 375 Medicare ACOs to date, and others are preparing to apply. Of the 114 ACOs who started the program, 54 saved money and 29 saved enough money to receive bonus payments.

Shifting to an accountable care model is a multi-year transition and must be viewed as a long-term investment. Join us June 18, 2014, as HMA Principal Dr. Art Jones, MD, a pioneer in the accountable care organization movement, explores the financial considerations for establishing a Medicare ACO.

HMA Client, Clifford Beers Clinic, Selected for CMS Health Care Innovation Award

The CMS Innovation Center announced the first group of prospective recipients for the Health Care Innovation Awards Round Two on May 22, 2014. HMA congratulates our client, the Clifford Beers Clinic, for being selected as one of the 12 awardees.

Clifford Beers Clinic, a 100-year old mental health organization based in New Haven, CT, offers a wide array of mental health programs and services to children and families in the Greater New Haven area. They are being awarded an estimated $9.7 million to implement an integrated, trauma-informed, and family-oriented model of care to low-income families experiencing chronic and toxic stress. Their partners include Fair Haven Community Health Center and Yale-New Haven Hospital.

The HMA team of Principal Deborah Zahn and Senior Consultants Melissa Corrado and Robert Buchanan helped Clifford Beers and their partners develop the care model, financial plan, and budget for this project proposal. We are proud to continue working with Clifford Beers to implement this innovative project. Read more