HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

NEW YORK EXCHANGE ENROLLMENT OVERVIEW

This week, our *In Focus* section reviews the 2014 open enrollment report from New York's health insurance Exchange, known as NY State of Health. The report, published June 25, 2014, reviews the demographics and qualified health plan selections of NY State of Health enrollees as of April 15, 2014. New York is one of the few states so far that has published detailed enrollment data for their Exchange. Additionally, New York was one of the only states to make qualified health plans (QHPs) available to small businesses through the Small Business Marketplace (SBM).

Link to NY State of Health Open Enrollment Report

Enrollment Overview

While NY State of Health processed enrollments for more than 960,000 individuals, roughly 55 percent were determined eligible for and enrolled in Medicaid. Another 7 percent were enrolled in the state's Child Health Plus program. The remaining 38 percent, around 370,600 individuals, selected a qualified health plan (QHP) through NY State of Health.

Marketplace Enrollment by Program	As of April 15, 2014	%
Medicaid	525,283	54.7%
Qualified Health Plan	370,604	38.6%
Child Health Plus	64,875	6.8%
Total Enrollment	**960,762**	

Source: NY State of Health Open Enrollment Report, June 2014.

Notably, the Medicaid enrollments in the above table only represent those who enrolled in Medicaid through NY State of Health and does not represent full new Medicaid enrollment. Most of the Medicaid enrollments were for individuals who were already eligible for coverage, as New York had already expanded eligibility.

Financial Assistance

Of the 370,600 QHP enrollees, nearly three-fourths are receiving some financial assistance. Individuals enrolled in a QHP with incomes under 400 percent of FPL are eligible for advanced premium tax credits (APTCs) to offset a portion of monthly premium costs. Additionally, individuals with incomes under 250 percent of FPL who enroll in a Silver tier QHP are eligible to receive additional cost-sharing reductions (CSRs) to offset co-pays and other out-of-pocket costs. Of the NY State of Health QHP enrollments:

- 57 percent (approximately 211,000) are receiving both APTC and CSR financial assistance;
- 17 percent (approximately 63,000) are receiving APTC financial assistance only; and
- 26 percent (approximately 96,000) are paying the full cost of QHP premiums and cost-sharing themselves.

Pre-Enrollment Insurance Status, Age, and Source of Enrollment

Across all programs (Medicaid, QHP, and CHP), 81 percent of enrollees reported being uninsured at the time of application, with higher percentages of Medicaid and CHP enrollees reporting being uninsured. Sixty-three percent of QHP enrollees reported being uninsured at the time of application; however, 79 percent of the roughly 274,000 QHP enrollees receiving some form of financial assistance reported being uninsured prior to enrollment, while only 21 percent of those not receiving financial assistance reported being uninsured.

QHPs attracted a significant number of young people. Over one-third of QHP enrollees are age 34 or younger; 25 percent are over the age of 55.

The majority (53 percent) of QHP enrollees applied through the NY State of Health website with no additional assistance, a higher percentage than reported in Medicaid and CHP. QHP enrollments handled through an insurance broker

also made up a higher percentage of total enrollments than in the Medicaid and CHP populations. However, Medicaid and CHP saw much higher instances of certified application counselors (CACs) handling enrollment than was reported for the QHP population.

QHP Enrollment by Issuer and Metal Tier

In the NY State of Health Open Enrollment Report, statewide enrollment in QHP by issuer is presented as a percentage of market share. We, therefore, have calculated estimated enrollment totals in the table below based on percentage of the total enrollment. Actual enrollment numbers by issuer for each region is available in the appendices of the report.

Four issuers – Health Republic Insurance of New York, Fidelis Care, MetroPlus Health Plan, and Empire Blue Cross Blue Shield - account for nearly two-thirds of all QHP enrollments. Health Republic is a Consumer Oriented and Operated Plan (CO-OP).

Qualified Health Plan	Enrollment	%
Health Republic Insurance of NY	70,400	19%
Fidelis Care	63,000	17%
MetroPlus Health Plan	55,600	15%
Empire Blue Cross Blue Shield	51,900	14%
EmblemHealth	33,400	9%
MVP Health Care	29,600	8%
Excellus BlueCross BlueShield	14,800	4%
Oscar	11,100	3%
Healthfirst	11,100	3%
UnitedHealthcare	7,400	2%
North Shore - LIJ Insurance Co. Inc.	3,700	1%
BlueCross BlueShield of Western NY	3,700	1%
Independent Health	3,700	1%
Affinity Health Plan	3,700	1%
CDPHP	3,700	1%
Univera Healthcare	<1,000	<1%
Empire Blue Cross	<1,000	<1%
Today's Option of New York	<1,000	<1%
BlueShield of Northeastern NY	<1,000	<1%
Total Enrollment	**370,604**	

Source: NY State of Health Open Enrollment Report, June 2014

Note: Enrollment totals are calculated by HMA based on percentages provided in the report. These totals may not be additive due to rounding and timing issues noted in the report.

The majority of QHP enrollees selected a Silver tier plan, with 55 percent (around 204,000 individuals) enrolling in a Silver plan, including those who received additional subsidies in the form of cost-sharing reductions. Consistent with nationwide trends, Silver and Bronze plans represented the significant majority of enrollment.

Metal Tier	Actuarial Value	Enrollment	%
Platinum	90%	48,200	13%
Gold	80%	37,100	10%
Silver, CSR 3	94%	33,400	9%
Silver, CSR 2	87%	96,400	26%
Silver, CSR 1	74%	37,100	10%
Silver	70%	37,100	10%
Bronze	60%	70,400	19%
Catastrophic	<60%	7,400	2%
Total		**370,604**	

Source: NY State of Health Open Enrollment Report, June 2014.

Small Business Marketplace

Nearly 9,800 individuals enrolled in the Small Business Marketplace as of April 15, 2014. As in the individual market, Health Republic Insurance of New York received the highest market share of enrollment, at 34 percent. Along with Excellus BlueCross BlueShield (22 percent), Oxford (12 percent), and MVP Health Care (11 percent), these four issuers accounted for nearly 80 percent of all SBM enrollment. A total of 10 issuers were available in the SBM.

Whereas the individual market clearly favored Bronze and Silver tier plans, 35 percent of SBM enrollees are in a Platinum tier QHP, with 27 percent each in Gold and Silver tier plans, and just 11 percent enrolled in a Bronze plan. Notably, people enrolled in employer plans are not eligible for either the APTCs or cost-sharing reductions that drive enrollment into Silver plans in the individual market.

HMA Medicaid Roundup

Arizona

Banner Health and UA Health Network Set to Combine. On June 25, 2014, *AZ Central* reported that the Arizona Board of Regents is deciding whether to authorize an agreement that would transition the $1 billion-University of Arizona Health Network into Banner Health. Banner Health is the state's largest health provider and the second-largest non-government employer. Under the agreement, Banner Health would acquire UA's two teaching hospitals, a faculty physicians practice, and three health plans. Banner Health would also pay off UA's long-term debt of $146 million and invest in UA's facilities and employees. Read more

California

HMA Roundup – Alana Ketchel

Covered California Announces New Navigator Grants. On July 1, 2014, Covered California announced that it is accepting applications for $16.9 million in grant funds for its Navigator Program. The intent of the Navigator Program is to help consumers shop for and compare plans and enroll in QHPs. The announcement stated that over 135 organizations could receive grants that would cover the period of Oct. 1, 2014 – June 30, 2015. The application can be found here.

Medi-Cal Application Backlog Persists. On June 28, 2014, the *San Jose Mercury News* reported on the status of the massive backlog of Medi-Cal applications. The state has fallen significantly behind in processing Medi-Cal applications and sending final notifications to enrollees. This backlog was caused primarily by major technical difficulties with the Medi-Cal eligibility verification systems and higher-than-expected application volume. Some critics also posit that the Covered California exchange was made a higher priority than improving the Medi-Cal application process. The Medi-Cal backlog affects approximately 900,000 applications. The state says that about half of these applications have been filed in the past 45 days, the maximum processing period allowed by law. Read more

Bill Requires Hospital Disclosure on Charity Care. On June 25, 2014, the *California Health Report* reported on an Assembly bill that would force non-profit hospitals to disclose expenditures on charity care based on a standardized methodology. The bill does not specify how much hospitals should spend on charity care; rather, it promotes transparency in reporting expenditures. If the

bill were to become law, hospitals could face a fine if they do not comply with reporting requirements. Read more

Medical Interpreter Access Bill Advances. On June 25, 2014, the *California Healthline* reported that the Assembly advanced a bill to improve Medi-Cal beneficiary access to medical interpreter services. The bill (AB 2325) would create a system called CommuniCal that would enhance access to interpreters in physician offices and hospitals. The legislation would also establish certain protections for interpreters as well as training and certification requirements. Governor Brown vetoed a similar bill last year, citing too much complexity in the midst of health reform. The bill now goes to the Senate Appropriations Committee. Read more

Colorado

HMA Roundup – Joan Henneberry

Accountable Care Collaborative Update. On June 30, 2014, the Colorado Department of Health Care Policy and Financing announced that enrollment into regional Accountable Care Collaborative (ACC) organizations is now up to 613,431 as of June 1, 2014. The ACC represents a committed effort to transform the Medicaid program into a system of better care for all its members and lower costs for the State of Colorado. Total Medicaid enrollment is now 1,021,745. The state is also seeking stakeholder input and feedback on the future of the ACC. Stakeholder meetings will run through late June, and a Request for Information will be released this summer. The full RFP for rebidding the regional organizations is expected to be released in February 2015.Read more

2015 Health Insurance Filings. On June 23, 2014, the KidsWell Campaign Colorado division reported that more than 1,000 medical and dental plans were submitted to the Colorado Division of Insurance, and 312 have applied to be offered through Connect for Health Colorado, the state Marketplace. The Division of Insurance's initial examination found most of the plans requested between a 10 percent decrease and 10 percent increase in premiums from 2014. Colorado compiled the 2015 rate filings in an online searchable database.

Delaware

Delaware Awards HP $147 Million Medicaid Contract Extension. On July 1, 2014, Hewlett-Packard (HP) announced that the Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance has signed a $147 million contract with HP Enterprise Services for the company to implement its flagship interchange Medicaid Management Information System (MMIS). Delaware will be the 16th state to use the interChange platform. HP will also provide Applications Services for the design and implementation of the Delaware Medicaid Enterprise System (DMES), which will streamline claims and document processing and provide the State with real-time healthcare trend data to identify emerging needs. Read more

Florida

HMA Roundup – Elaine Peters

Florida Kicks off Medicaid Managed Care Model. On June 30, 2014, the *Miami Herald* reported that Florida has begun transitioning Medicaid beneficiaries to managed care plans this week. Around 511,000 Floridians from Broward, Miami-Dade and Monroe counties have now transitioned to the model in which they will be covered by private insurers, mostly HMOs or Provider Service Networks. Of these new managed care enrollees, 210,000 selected their own health plan, 175,000 were automatically assigned to a plan in which they already participated, and 125,000 were assigned a plan using a state-designed algorithm. All 3.6 million Medicaid beneficiaries will be moved to the managed care model over the next four months. Read more

More Insurers Interested in Offering Plans in Florida's Exchange Next Year. On June 30, 2014, *Health News Florida* reported that more insurers are interested in participating in Florida's health insurance exchange in 2015 compared to this year. It is not yet clear what this will mean for next year's premium rates; two insurers have released their rates, but the others have withheld this information under the state's "trade secrets" law. Read more

Georgia

HMA Roundup – Mark Trail

DCH Announces New Choices for 2015 State Health Benefits Plan. On July 1, 2014, *Georgia Health News* reported that state's 650,000 employees and school personnel will have more health plan choices in 2015. Some employees and teachers have voiced complaints about the lack of choices in the 2014 State Health Benefit Plan (SHBP) which resulted in higher healthcare costs. The Department of Community Health, which runs the SHBP, announced this week that UnitedHealthcare will offer members a statewide HMO, a high-deductible health plan, and a statewide Medicare Advantage plan for retirees. Kaiser Permanente will offer an in-network-only plan in metro Atlanta. Blue Cross and Blue Shield of Georgia, the only insurer to offer plans to SHBP members this year, will also offer a diverse selection of plans in 2015. DCH will vote on plan designs and proposed premium rates in August. Read more

Health Insurance Exchange Sees More Interest From Insurers in 2015. On June 30, 2014, *Georgia Health News* reported that four insurers who did not participate in the Georgia exchange this year are interested in offering plans in 2015. UnitedHealthcare, Coventry, Cigna and Time Insurance Company have submitted applications for the 2015 exchange. It is not yet known whether these potential new entrants plan to offer coverage in all areas of the state. Five insurers that participated in the 2014 exchange have also submitted applications to participate next year. Read more

DCH Issues "Past Due" Notices to Medicaid Healthcare Providers, Could Jeopardize Their Provider Status. On June 26, 2014, *Georgia Health News* reported that providers treating Medicaid beneficiaries could lose their provider status due to overpayment debt they have with the state. DCH has sent "past due" notices to 23 nursing homes stating that they owe DCH money, most often due to unpaid provider fees. The state uses provider fees to gain more federal match funds for its Medicaid program. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

Medicaid Managed Care Rollout Begins in East St. Louis. Illinois began mailing enrollment packets to Medicaid enrollees in the Metro East Region (East St. Louis) on June 13, 2014, which was also the first day that the state's client enrollment broker would begin accepting enrollment. Medicaid beneficiaries will have 60 days to select a health plan available in their region or be auto-assigned. Metro East mailings will be followed by Central Illinois later in July. Chicago will not see its first enrollment mailings until September. The state intends to conclude mailing of enrollment packets to all five mandatory managed care regions by the end of the year. Details of the managed care rollout were presented in a webcast on June 30, 2014. Slides from the webcast are available here.

Chicago Hospital Bought by Newly Formed Benefit Corporation. On July 1, 2014, *Crain's Business Chicago* reported that Presence Health's Our Lady of the Resurrection Medical Center, located in northwest Chicago, has been acquired by Community First Healthcare of Illinois. The newly formed Community First Healthcare of Illinois was formed with the intent of acquiring the hospital and received financial backing from Muneris Capital Group. Illinois recently established benefit corporations under 2013 law, requiring organizations to document and report on the public good generated by the corporation. Read more.

Indiana

Pence Submits HIP 2.0 Waiver to Feds. On July 1, 2014, the *Indiana Business Journal* reported that State officials are submitting the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion waiver to the federal government this week. If approved, it could extend health insurance to as many as 350,000 Hoosiers. HIP 2.0 would apply to all non-disabled adults ages 19-64 who earn between 23 percent and 138 percent of the federal poverty level. It would provide three plan options to consumers, each rooted in promoting personal responsibility for one's health. Read more

Kansas

Indefinite Delay of Health Homes Program Catches Medicaid Providers by Surprise. On July 1, 2014, the Kansas Health Institute reported that the Kansas Department of Health and Environment (KDHE) has chosen to indefinitely delay much of the implementation of the new health homes initiative, giving providers less than 24 hours-notice of the change in plans. KDHE officials explained that there were not enough providers statewide to address the initiative's plan for treating Medicaid enrollees who are chronically ill with asthma or diabetes. This part of the initiative will now be reconsidered on January 1, 2015. Community providers that were preparing for the health homes initiative are concerned that this delay will kill the program altogether. Read more

Louisiana

State Sues Molina Healthcare on Charges of Processing False Medicaid Claims for Prescription Drugs. On June 30, 2014, the *Advocate* reported that the Louisiana Attorney General's office has filed a lawsuit against Molina Healthcare Inc. for allegedly processing false or misleading Medicaid claims for prescription drugs, resulting in the "exponential" growth of state spending on drugs for Medicaid beneficiaries in recent years. Molina has processed Louisiana's Medicaid pharmacy reimbursement claims for the past 30 years; according to the lawsuit, the company did not follow the state formula for those payments from 1989 to 2012. Read more

Massachusetts

Legislature Considers Suspending Inmates' Medicaid Coverage During Incarceration. On June 26, 2014, *AP*/the *Columbus CEO* reported that the State is considering legislation that would allow it to suspend Medicaid coverage of inmates instead of terminating it after arraignment, as is now required. The change would allow an inmates' Medicaid coverage to be reinstated immediately after release, and would grant prisoners Medicaid coverage for hospital stays longer than 24 hours while in prison. Together, these changes would save the state and its prison system millions in healthcare and administrative costs. Allowing inmates access to much-needed mental health and substance abuse services immediately after their release could also go a long way towards preventing them from committing future offenses. If the Legislature approves the change, Massachusetts will become the thirteenth state to suspend rather than terminate inmates' Medicaid coverage. Read more

Michigan

Proposed Michigan Health Plan Rates Vary in 2015, But Represent Modest Increase Overall. On June 25, 2014, the *Detroit Free Press* reported on the recently-released 2015 rates for health plans purchased on the Michigan Health Insurance Marketplace. Next year's exchange plans will increase 2.2 percent on average, meaning that the state's average premium cost of $326.74 remains lower than the national average of $360. Seventeen insurers will be offering a combined 345 individual and small group plans when state exchanges reopen for general enrollment on November 15. At least four insurers are proposing rate increases greater than 9 percent, while others plan to cut prices significantly. Read more

Montana

Montana Medicaid Expresses Concern Over Xerox Corporation's Progress on State Medicaid Management and Information System. On June 30, 2014, the *Great Falls Tribune* reported that the State is considering ending its contract with Xerox due to missed deadlines and inadequate planning for the design of the state's Medicaid Management and Information System (MMIS). The MMIS is supposed to replace the state's antiquated system for processing payments of Medicaid providers. State Medicaid Director Mary Dalton wrote to Xerox saying the company is not meeting the requirements of its $70 million contract.

However, it is not the state's objective to terminate the contract or seek damages from Xerox; rather, they want to make sure the company has incentive to deliver a workable plan for establishing the MMIS. A Xerox spokesperson said the company is working with the state to address its concerns and comply with State contract requirements. Read more

New Jersey

HMA Roundup – Karen Brodsky

Medicaid Managed Long Term Care Begins in New Jersey. On July 1, 2014, New Jersey's Department of Human Services, Division of Medical Assistance and Health Services implemented managed long term services and supports (MLTSS), a centerpiece of its 1115 Comprehensive Medicaid Waiver. This marks the beginning of a capitated arrangement with four managed care organizations to cover the Medicaid costs for custodial care and home and community based services for MCO members who meet the criteria for nursing facility level of care. According to a report by *NJ Spotlight,* long term care "represented 34.1 percent of the state's total of $10.39 billion in Medicaid spending" in state fiscal year 2011-12. Four MCOs are taking part in the program: Amerigroup New Jersey Inc., Horizon NJ Health, UnitedHealthcare Community Plan, and WellCare Health Plans of New Jersey. Members formerly in Healthfirst Health Plan of New Jersey Inc. began receiving coverage from WellCare, also beginning July 1, 2014, as a result of the completion of an asset purchase agreement between the two plans. Healthfirst NJ members who qualify for MLTSS will receive these benefits from WellCare. Read more

New Jersey Seeks a Medicaid State Plan Amendment to Establish a Miller Trust for Eligible Medically Needy Individuals. On June 25, 2014 the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued a public notice of its plan to request a State Plan Amendment (SPA) from CMS to cease providing nursing facility services to eligible Medically Needy individuals. This will allow individuals to qualify for Medicaid Managed Long-Term Services and Supports (MLTSS), which includes nursing facility services, by establishing a Qualified Income Trust also known as a Miller Trust. This is an irrevocable trust that allows individuals with monthly income above the state's special income limit (SIL) to qualify for Medicaid. Income that exceeds the SIL would be transferred to the trust. The state must receive SPA approval from CMS before it can implement this feature of its 1115 Comprehensive Medicaid Waiver. DMAHS is accepting comments in response to the public notice through July 30, 2014. Read more

Division of Disability Services Issues Fiscal Intermediary/Counseling Services RFP. The state's Department of the Treasury, Division of Purchase and Property released a Request for Proposals (RFP, T-2949, Solicitation #: 15-X-23219) on June 23, 2014 on behalf of the Department of Human Services, for use by the Division of Disability Services (DDS), Division of Aging Services (DoAS) and Division of Developmental Disabilities (DDD). This is a reprocurement for participant direction services of the T-2240 Third Party Services: Fiscal and Support Services, Cash and Counseling Program and T-1876 Third Party Services: DHSS, Senior Initiatives term contracts, due to expire on December 31, 2014. The contracts are currently with Community Access Unlimited Inc. and Public Partnership LLC. This reprocurement will combine the two contracts into a single fiscal intermediary contract.

The successful bidder will function as a fiscal/employer agent and perform financial management services for individuals on Medicaid served under a managed care plan or in fee-for-service and receiving home and community based services (HCBS) through the Personal Preference Program. The vendor will also provide counseling support services. In addition, the vendor will serve state-only clients in the Jersey Assistance for Community Caregiving (JACC) and Veterans-Directed Home and Community-based Services (VD-HCBS) programs and the Community Living Program (CLP) who receive participant direction services.

Current and projected program enrollments are provided:

Participant Direction Program	Current Enrollment	Projected Enrollment
Medicaid Managed Care and Medicaid Fee-for-Service	3,900	5,400
Community Living Program	75	75
Jersey Assistance for Community Caregiving Program	50	50
Veterans-Directed Home and Community-based Services	65	200
Total	**4,090**	**5,725**

Prospective bidders may submit questions electronically by 5:00 pm on July 8, 2014. Proposals are due by 2:00 pm on August 12, 2014. Read more

Division of Medical Assistance and Health Services Confirms FQHC Wraparound Reimbursement Policies for Determining Valid Medicaid-Eligible Encounters and Provides FQHC Appeals Process. The state's Medicaid agency released a newsletter in response to a July 9, 2013 U.S. Court of Appeals for the Third Circuit decision in *New Jersey Primary Care Association (NJPCA) v. State of New Jersey Department of Human Services, et al.*, in which the Court affirmed that the State of New Jersey's policies on Medicaid wraparound payments to health centers violated federal law. NJPCA disputed Medicaid's practice of making FQHC wraparound payments on claims for Medicaid managed care encounters after the health plan had first paid the claim. The Court held that the state could not make the calculation of wraparound payments dependent upon the payment of a claim by a health plan. It further noted, "Nothing prevents the State from shifting claim verification from the FQHCs to the MCOs, and, consistent with the federal Medicaid statute, states may rely on MCOs to determine whether a claim is Medicaid eligible." Yet the court held, Medicaid must provide for a "process by which an FQHC may promptly and effectively challenge an adverse MCO determination within the statutorily mandated time period." Read more

New York

HMA Roundup – Denise Soffel

FIDA Duals Demonstration Enrollment Postponed to January 1, 2015. On July 2, 2014, the New York State Department of Health (DOH) and CMS announced that the Fully Integrated Duals Advantage (FIDA) enrollment start date will be postponed to January 1, 2015. DOH and CMS have decided to give plans three

additional months to complete readiness review activities and fix plan deficiencies before FIDA begins. This additional preparation time should ensure that dual-eligible residents are able to seamlessly transition to the FIDA demonstration without disruption of current services.

Medicaid Managed Care Program Update. The Medicaid Managed Care Advisory Review Panel, the oversight body established by the legislature, had its quarterly meeting on June 20, 2014. The following updates regarding the Medicaid managed care program were provided.

MAXIMUS - A growing number of counties across the state are turning responsibility for Medicaid enrollment to Maximus, the state's enrollment broker. As of July, only 14 counties continue to process Medicaid enrollment. As part of the state take-over of Medicaid eligibility and enrollment, counties have been encouraged to turn enrollment functions over to Maximus. As the state moves to implement mandatory managed care for individuals in nursing homes, they have highlighted the amount of work entailed in outreach and education of this population. The state wants to maintain statewide uniformity for the eligibility and enrollment process by eliminating the role of the local districts in the process.

Nursing Home Carve-In - Although NYS had proposed carving in the nursing home benefit and population effective April 1, 2014, CMS has not yet approved the transition, expressing concerns about rates and reimbursement. There has been some discussion about whether it makes sense to delay the transition until the duals demonstration, FIDA, begins in January 2015.

School-Based Health Clinics - The carve-in of school-based health has been delayed until July 2015, providing the state more time to work through the credentialing and contracting issues. In recognition of the large number of school-based sites, the state has agreed that managed care plans will contract with the health care entities sponsoring a school-based center, rather than with each individual site.

Managed Long-Term Care - The Department of Health has moved forward with the next step in the transition of fee-for-service (FFS) community based long term care services to mandatory Managed Long Term Care in Greene, Saratoga, Schenectady, and Washington Counties. Originally scheduled for June, the mailing of announcement notices to the FFS population will begin during the week of June 30, and the mailing of mandatory letters will begin during the week of July 14, 2014.

New Medicaid Managed Care Plan - A new entity is in the process of certifying to become a Medicaid managed care plan. Crystal Run is a network of integrated physician practices operating in the Hudson Valley region. They have applied to operate managed care for commercial and Medicaid populations in Orange and Sullivan counties.

Revisions to the Medicaid Managed Care Contract. The state has proposed revisions to the managed care contract that would reflect enhancements and additional consumer protections for special populations. These revisions come as the state continues to transition more vulnerable populations into managed care. Modifications to the grievance system are being proposed to make it easier for consumers to navigate the grievance system, providing more opportunity to file a formal complaint. Changes to the definition of medical necessity are being

proposed for medically fragile children, highlighting best practices to ensure that plan services align with children's need, rather than using adult models of care. Finally, the state is proposing more rigorous screening to identify individuals in need of long term services and supports and requiring that a care management plan be developed, mirroring the process required by managed long term care plans.

Office for People with Developmental Disabilities (OPWDD) and the *People First* Waiver. OPWDD and the Department of Health are working with CMS on an agreement called the *People First* Waiver, a 1915 (b)/(c) concurrent Comprehensive Home and Community Based Services (HCBS) waiver. This agreement will renew the OPWDD 1915(c) Comprehensive HCBS Medicaid Waiver for People with Developmental Disabilities and will also be the vehicle OPWDD uses to authorize the creation of a managed care delivery system for individuals with disabilities. The managed care delivery system will allow individuals to enroll on a voluntary basis in a Developmental Disability Individual Support and Care Coordination Organization (DISCO). Originally planned for October 2014, the state now expects that DISCOs will begin providing service in October 2015. DISCOs will be voluntary for both enrollees and providers and will be implemented in select geographic regions across the state. While the state hopes to create a mandatory managed care program for Medicaid beneficiaries with developmental disabilities, they expect that full implementation will take several years as DISCOs are established and approved. DISCOs will be prohibited from doing direct marketing, and all education and enrollment activities will be conducted by Maximus. The DISCO will be responsible for providing care management to its enrollees, based on the HCBS standards of the current 1915-c waiver, including the use of a care coordination team and coordination of care across waiver providers, specialists, behavioral health providers, and long-term care providers.

OPWDD is reviewing Medicaid managed care standards regarding network adequacy to assess their relevance for the I/DD population. The state typically requires a minimum of two of each type of provider in a region, but the concern is that this standard may not be sufficient given the variety of needs of the population and the range of services included in the benefit package. OPWDD is also reviewing credentialing requirements for the DISCO, trying to determine the division of responsibility between plans and providers. DISCOS will be required to verify the license of all individual practitioners as well as ensuring that all Direct Care Support professionals are evaluated for core competencies. A self-directed program will be required of all plans. Finally, OPWDD must establish an independent ombudsman program, provide consumer education and advocacy services, and maintain a state-wide database on consumer concerns and complaints.

New Mexico

Records Show State Paid Agave Health Prior to Completing Audit of Mental Health Providers. On June 28, 2014, the *Santa Fe New Mexican* reported that the outcome and procedures of a state mental health provider audit last year have come into question. Last June, the administration of Governor Susana Martinez paid Agave Health Inc. to replace providers who lost their contracts for allegedly overbilling Medicaid, but state records show that the State paid Agave

well before the audit was complete and at much higher rates than the providers Agave replaced. Read more

North Carolina

UnitedHealthcare to Join North Carolina Exchange in 2015. On June 27, 2014, the *News & Observer* reported that UnitedHealthcare will join the North Carolina health insurance marketplace as the exchange's third insurer to sell subsidized health plans. The two insurers that offered plans this year, Blue Cross Blue Shield and Coventry Health Care, will also be participating next year. Read more

Medicaid Spending Plans Challenged by State Senate. On June 26, 2014, *AP*/the *News & Observer* reported that the North Carolina Senate Appropriations Committee and Governor Pat McCrory are in disagreement over the amount the state should budget to pay for unpaid claims for the year ending June 30 and additional enrollment and services for next year. The Senate proposes spending $250 million more than the McCrory administration on these initiatives, which state Budget Director Art Pope considers to be overfunding that could lead to cuts in other important healthcare and education initiatives. Read more

Oregon

OHSU Hospital Reports Significant Drop in Uninsured Patients in 2014 Compared to Last Year. On June 26, 2014, the *Oregonian* reported that the Oregon Health & Science University (OHSU) hospital saw a significant drop in the number of uninsured patients it has treated this year. Five percent of patients seen by OHSU last year were uninsured; in April and May of 2014 only one percent of patients were uninsured. OHSU President Lawrence Furnstahl said that the drop in uninsured patients occurred much faster than the institution had anticipated, likely driven by the state's high volume of new Medicaid enrollees. Read more

Coordinated Care Organizations Show Signs of Promise in Overseeing Care for Medicaid Patients. On June 24, 2014, *AP*/the *SF Gate* reported on the progress of Oregon's coordinated care organizations (CCOs) over the past two years. CCOs were tasked with overseeing care for Medicaid patients. A recent report from the Oregon Health Authority shows that emergency room visits for Medicaid patients dropped by 17 percent in 2013 from two years earlier. This data represents the first full-year data since the state's 15 coordinated care organizations started seeing Medicaid patients. The Health Authority also reported reduced emergency visits for Medicaid beneficiaries with congestive heart failure, COPD and adult asthma. Read more

Pennsylvania

HMA Roundup – Matt Roan

PA Legislature Passes $29.1 Billion Spending Plan, Governor is Withholding Signature, Requests Pension Reform. On July 1, 2014, the *Patriot-News* reported that despite severe revenue challenges, the PA General Assembly passed a budget for State Fiscal Year 2014-15 on June 30, meeting the Commonwealth's

constitutional deadline for passage of a spending plan. Governor Corbett in a statement that took many in the state capitol by surprise indicated that he is reviewing the budget bill which he describes as "not previously agreed to" and is not immediately willing to sign the bill. In the meantime, the Governor has reiterated his position that the Legislature must pass meaningful pension reform to address ballooning unfunded pension liabilities. Critics of the budget bill claim that it relies on overly optimistic revenue projections and uses a patchwork of gimmicks to ensure the budget is balanced. The budget bill also assumes federal approval of the Governor's Healthy PA proposal which is still under review by the Centers for Medicaid and Medicare Services. Read more

Governor Corbett and Attorney General Kane Announce Highmark/UPMC Agreement on Transition. On June 27, 2014, Governor Tom Corbett and Attorney General Kathleen Kane announced that Highmark and UPMC have agreed to sign a consent decree outlining patient protections during an anticipated transition period beginning in January 2015 when UPMC, the largest health system in Western PA, will sever its network relationships with Highmark, the region's largest health insurer. According to a press release issued by the Governor and the Attorney General, the agreement will address concerns including:

- **Continuity of care**: UPMC and Highmark agree that the care of a Highmark member in the midst of a course of treatment at UPMC will be continued on an in-network basis for as long as the patient and his or her doctor deem it necessary.
- **Vulnerable Populations**: UPMC and Highmark agree that vulnerable populations such as consumers age 65 or older, Medicare, Medicaid, CHIP, Medigap and Signature 65 will not be affected and will continue to have access to UPMC providers and facilities.
- **Unique/Exception Hospitals/Physicians**: UPMC and Highmark are to negotiate a contract for Western Psychiatric Institute and Clinic; UPMC Bedford; UPMC Venango (Northwest), Hamot and Altoona; and other UPMC unique services that may be delivered outside the Greater Pittsburgh area or any future acquired hospital by UPMC. The still ongoing contract for Children's Hospital is not affected.
- **Emergency Services**: UPMC and Highmark will negotiate an agreement so that emergency and trauma services will continue to be accessible at in-network rates at UPMC and Allegheny Health Network hospitals.
- **Local Community Needs**: Highmark members will have ongoing access to unique UPMC local providers and services where the patient's treating physician believes the patient needs such services and they are not available from another source.
- **Oncology**: Highmark members will have ongoing access to UPMC providers for cancer treatment on an in-network basis if a patient's treating physician makes that determination. That may include treatment of illnesses resulting from cancer, such as mental health, endocrinology, orthopedics and cardiology related conditions. This includes UPMC joint ventures, physician services provided at or on behalf of independent hospitals as well as services provided through Hillman and at Magee.

- **Safety Net**: UPMC and Highmark agree that there will be a one-year safety net beginning January 1, 2015, for any existing UPMC patient and Highmark subscriber who is unable to find alternative physicians and services in their area. Read more

Health System Consolidation Trend Continues in PA. On June 26, 2014, the *Patriot-News* reported on the partnership between the Penn State Milton S. Hershey Medical Center and Harrisburg-based Pinnacle Health System, demonstrating that the trend of health system affiliation and mergers is growing. Hershey Medical Center and Pinnacle Health announced this week that they are forming a single "health enterprise" to bring innovative approaches to healthcare to central Pennsylvania. Leaders from the two organizations touted the benefits of the proposed partnership between Hershey, a high performing university medical center and Pinnacle, a community health system known for quality and patient-focused care. The announcement comes only a week after the announcement of a partnership between Danville-based Geisinger Health System and Camp Hill-based Holy Spirit Health System. Earlier this year a similar collaboration was announced between Lebanon County-based Good Samaritan Health System and York-Based Wellspan Health. Read more

Puerto Rico

HMA Roundup – Juan Montanez

Puerto Rico's ASES Reissues Managed Care RFP. Last week Puerto Rico's Health Insurance Administration (ASES) reissued the RFP for the Government Health Plan (GHP), the program that incorporates Medicaid, CHIP and local funding to provide health insurance to almost 1.5 million residents. Following is a table that highlights key differences between this RFP and the RFP that was issued in February and retracted in May.

Item	Previous RFP/Contract Language	New RFP/Contract Language
Implementation	Previous schedule had an implementation timeframe of 3 months (April-June) with a go live date of July 1st, 2014.	New schedule is as follows: 1) Proposals due 8/11/14 2) Notice of Award no later than Sept. 30, 2014 3) Contract Execution targeted for early October 4) Go Live 4/1/15.
Profit	"Excess" profit (Article 2): Profit greater than 1.5% of premium will be split 50/50 with ASES if 85% of the quality criteria are met by plan; otherwise ASES retains 100% of "excess" profit	Section 22.1.18: 'Profit' shall not exceed 2.5% of premium. Profit above 2.5% will be shared 50% with ASES.

Reserve Requirement	RFP required a 7:1 "premium capital" ratio. The cancelled RFP also included a 200% Risk-based Capital (RBC) requirement, which is an Insurance Department standard.	Section 23.2.2: The Contractor shall comply with a minimum two hundred percent of risk-based capital. ASES reserves the right to require additional capital guarantees as ASES deems reasonably necessary.
Revenue Withhold	Withhold of 5% of the monthly premium tied to compliance with Quality Incentive Program.	Section 22.3.1: new quality revenue withhold will be 0% from 4/1/14 - 12/31/14; 1% from 1/15-6/15; and 2% from 6/15 - 6/16.
Data Book	RFP included a data book with utilization and cost data based on 2012 and prior year experience.	The new Data Book provides information in the same manner and level of detail but incorporates 2013 claims experience.
Network Adequacy	Article 9 of the Model Contract outlines provider network adequacy requirements.	No change in standards, but the following language was added: "Each Contract year, the Contractor shall submit for review and prior approval by ASES a Specialist Recruitment and Retention Plan for further ensuring the adequacy of the specialist providers considered critical. The annual plan shall include but not be limited to, activities the Contractor will undertake to identify deficiencies including but not limited to: Enrollee complaints regarding access, significant reductions in the number of specialist providers after transition is complete, and denied provider requests for inclusion in network. In addition the plan shall describe how the Contractor will increase the number and variety of specialists to meet the needs of the Enrollees."
Reference Letters		In the new RFP Section 5.4 was added. This section requires three business references, with at least one from a state or Commonwealth Medicaid program or other large similar government or large private industry project within the last five years...

Subcontractors	The previous RFP Section 6 stated, "In responding to each question, the Offeror shall explicitly state whether a subcontractor will be used. If the Offeror intends to use a subcontractor, the Offeror must provide the name of the subcontractor in the response."	In the new RFP Section 6 puts on BOLD the same sentence of the previous RFP and adds "If the Offeror uses subcontractors, describe how it will work with subcontractors to ensure seamless integration of those subcontracted services."

A combined bidders/actuarial conference will be held in Puerto Rico on July 9, 2014.

Vermont

Department of Vermont Health Access Releases MMIS Design RFP. On June 30, 2014, the Vermont Agency of Human Services, Department of Vermont Health Access released an RFP (03410-143-15) for Medicaid Management Information System Design, Development and Implementation. Under the contract, vendors will be responsible for MMIS software design, development and implementation, ongoing technical support, and Medicaid operations services. The RFP also seeks bids to implement and operate an integrated customer contact center. Proposals are due on September 5, 2014, with an anticipated award announcement date of November 18. The contract is scheduled to start on February 3, 2015. Read more

Virginia

GOP Lawmakers Plan Legal Strategy to Combat Governor McAuliffe's Potential Attempt to Expand Medicaid. On June 25, 2014, *AP/Yahoo News* reported that Virginia House Republicans are preparing for a potential legal battle with Governor Terry McAuliffe regarding his ability to unilaterally expand Medicaid eligibility. The lawmakers have retained former solicitor general Paul Clement to represent their argument against McAuliffe. Clement stated on a conference call that the Virginia Constitution prevents the Governor from expanding Medicaid without the legislature's consent. Read more

Washington

Costs to Run Health Exchange Estimated to Exceed Budgeted Amounts. On June 26, 2014, the *Seattle Times* reported that officials from the Washington Health Benefit Exchange presented a draft of the 2015 budget to the exchange board, estimating it will cost $53 million to run the exchange next year. That amount is more than the $40 million allocated by the state Legislature and is of particular concern since the exchange is supposed to be self-sustaining by January 1, 2015. Exchange officials are asking for an extension of federal grants and are assessing what it would lose based on different cost-cutting scenarios. Read more

National

Most ACA Exchange Consumers Will Be Able to Automatically Renew Coverage. On June 26, 2014, the *New York Times* reported that most people who purchased health plans through the federal exchange will be able to renew their coverage without filing an application or using the HealthCare.gov website. The Obama administration announced that consumers will be able to automatically renew their coverage and premium subsidies. The new rules will spare the federal government from the logistical headache of re-enrolling consumers for coverage, and will also support to long-term viability of the exchange marketplace. Read more

Industry News

Centene Completes Transaction with Community Health Solutions. On July 1, 2014, Centene Corporation announced that it has completed a transaction in which Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to Centene's wholly owned subsidiary, Louisiana Healthcare Connections, Inc. Read more

WellCare Health Plans of New Jersey Completes Acquisition of Healthfirst NJ assets. On July 1, 2014, WellCare Health Plans, Inc. announced the completion of its asset purchase agreement with Healthfirst Health Plan of New Jersey, transitioning approximately 42,000 members from Healthfirst to WellCare. Read more

Gentiva Board Unanimously Rejects Unsolicited Tender Offer from Kindred. On June 30, 2014, home health and hospitce provider Gentiva announced that its Board of Directors unanimously rejected the unsolicited tender offer from post-acute care provider Kindred Healthcare, Inc. to acquire all of the outstanding shares of Gentiva, together with the associated preferred share purchase rights, for a price of $14.50 per share in cash. The Board determined that this offer significantly undervalues the company. Kindred made similar offers to Gentiva in April and May of this year, both of which were rejected. Read more

WhiteGlove Health, Inc. Announces Acquisition of Glenridge HealthCare Solutions. On June 30, 2014, chronic care and population health management provider WhiteGlove Health, Inc. announced the acquisition of Glenridge HealthCare Solutions, a network development provider and consultancy. Glenridge uses proprietary tools and software to help customers outsource their managed care network development and provider engagement needs. WhiteGlove is a portfolio company of Enhanced Equity Funds and Biomark Capital. Read more

WellCare Names Gregg MacDonald President in Florida. On June 26, 2014, WellCare Health Plans Inc. selected Gregg MacDonald as the official president of the company for Florida. MacDonald has been acting president in the state since April and previously served as Chief Operating Officer since 2007. As President, MacDonald will be in charge of WellCare's Medicaid and Medicare Advantage business across Florida. He will also lead WellCare's expansion initiatives in the state. Read more

WellCare Named Kelly Munson Region President for Arkansas, Kentucky, Mississippi, and Tennessee. On July 2, 2014, WellCare Health Plans, Inc. announced that it has named Kelly Munson region president, with responsibility in Arkansas, Kentucky, Mississippi, and Tennessee. She will have profit and loss responsibility for WellCare's Medicaid and Medicare Advantage

businesses across these states. Munson has served as president of WellCare of Kentucky since August 2013 and has been working for WellCare since 2006. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Indiana ABD	RFP Release	50,000
TBD	Washington Foster Care	RFP Release	23,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Implementation	68,000
July 14, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
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
August 11, 2014	Puerto Rico	Proposals Due	1,600,000
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
January 1, 2015	New York Duals	Implementation	178,000
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		62,714	Not pursuing Financial Alignment Model						
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	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
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	3/1/2015	4/1/2015	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**	**1.35M Capitated 513K FFS**	***12***			***11***			

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA Welcomes…

Pat Casanova, Principal – Indianapolis, Indiana

Pat comes to HMA most recently from the Indiana Office of Medicaid Policy and Planning where she served in many different roles over her 20 year career with them. Her latest role with the State was as the Medicaid Director. As Medicaid Director, Pat led a team of 115 to direct and manage Indiana State Medicaid and CHIP programs with an $8.6M budget. Some of the projects under her leadership included risk-based and PCCM care models; 1115 demonstration; 1915c,b,i waiver programs as well as the successful design and development of ICD-10 conversion; DDI of HITECH EHR adoption/Meaningful Use funding mechanism; Pharmacy Benefit Management system; and Medicaid Data Warehouse.

Prior to her role as Medicaid Director, Pat was the Director of Care Programs for several years. There she served as the Senior Manager of the Medicaid medical policy section; Home and Community Based Waiver policy, and CHIP. During her tenure with the State, Pat also served as the Director of Home and Community Based Waiver Services; the Deputy Director of Long Term Care, OMPP; the Director of the HCBS Program Development and Implementation; the State PAS/PASRR Manager; and a Nurse Consultant.

In Pat's "prior life" before working for the State, she was in Clinical Nursing/Nursing Education for 23 years where she served as a critical care specialist for open heart and transplant services; multi-trauma services; and care of active duty enlisted officers after medical evacuation from Vietnam.

She received her BSN from Alverno College in Milwaukee. She is a founding member of the National Association of Medicaid Directors and currently serves as a member on their Board of Directors.

Amy Einhorn, Senior Consultant – Austin, Texas

Amy comes to HMA most recently from the Department of Insurance with the State of Texas where she served as the Director of the Office of Research and Policy Initiatives. In this role Amy served as the key resource for the Department of Insurance, the Legislature, and other external stakeholders on the health insurance market, coverage issues, and health insurance regulation. She directed a project in collaboration with the University of Texas School of Public Health to improve health care price transparency for Texas consumers. Amy also directed the implementation and ongoing operations of Healthy Texas (a $36M public/private health insurance option funded by the Texas Legislature for uninsured Texas small businesses).

Prior to working with the State of Texas, Amy formed The Einhorn Group – her own public policy consulting practice. Amy also worked for Blue Cross Blue Shield Hawaii as the Project Manager for External Relations and Government Programs where she led legislative analysis and strategic planning for the implementation of the Medicare Modernization Act; directed the implementation of Medicare Part D; and developed and wrote the Ten-Year

Strategic Plan for the Senior (age 65+) Market. Prior to being Project Manager, Amy served in the role of Legislative and Policy Analyst for Government Relations with BCBSH. Before joining BCBSH, Amy was the Project Manager for the Kaiser Foundation Health Plan in Oakland, CA where she managed the strategic and operational planning processes related to hospital system and health plan financing and operations.

Amy received her Master of Public Policy degree from the University of Southern California and her Bachelor of Psychology degree from Wesleyan University in Middletown, CT.

Rebecca Kellenberg, Senior Consultant – Denver, Colorado

Rebecca comes to HMA most recently from her own consulting company, Kellenberg Consulting. Her seven years of independent consulting has allowed her to assist public and private health care organizations with Requests for Proposal Development and RFP responses; conduct research and analysis on Medicaid, SCHIP and mental health policy issues such as eligibility and enrollment, benefits and delivery system design, managed care, and quality assurance; and develop and perform program evaluations including survey development, implementation, and data analysis.

Prior to Kellenberg Consulting, Rebecca worked for the Department of Community Health in Atlanta, GA first as Program Director for PeachCare for Kids and then as Director of Member Services and Policy. In these roles, she developed, implemented, monitored, and revised Medicaid and PeachCare for Kids policy and programs; led two competitive procurements for Medicaid (a quality assurance initiative and a data broker service); led the PERM eligibility; and participated in the planning teams for Georgia Health Families member and eligibility data systems conversion.

Rebecca worked for HMA from 1997 – 2000 as a Consultant out of the Lansing office.

Rebecca's previous roles include Senior Research Analyst for the Department of Health Care Policy and Financing in Denver, CO; an Intern for CMS; and a Research Assistant for the Center for Urban Research and Policy Studies at the University of Chicago.

She received her Masters in Public Policy as well as her Graduate Certificate in the Program in Health Administration from the University of Chicago. Rebecca received her Bachelor of Science degree in Family and Community Services from Michigan State University.

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

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