HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 15, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

The HMA Weekly Roundup will not publish Wednesday, July 22, 2015. We will resume publication the following Wednesday, July 29, 2015.

IN FOCUS

MONTANA ANNOUNCES MEDICAID EXPANSION WAIVER

This week, our *In Focus* section reviews Montana's proposed Medicaid expansion waiver and third-party administrator request for proposals (RFP). In late April, 2015, Montana Governor Steve Bullock signed into law Senate Bill 405, establishing the Montana Health and Economic Livelihood Partnership (HELP) Program, with the goal of expanding Medicaid coverage to more than 70,000 residents. On July 1, 2015, the state issued a RFP for a third-party

administrator (TPA) to administer the HELP Program, and on July 7, 2015, published a proposed 1115 Demonstration waiver for public comment. The state is aiming for a short turnaround on implementation, hoping to begin enrollment and coverage as early as January 1, 2016.

1115 Waiver Proposal Overview

Covered Populations: The HELP Program would cover childless adults with incomes between 0 percent and 138 percent of the federal poverty level (FPL) and parents with incomes between 50 percent and 138 percent of FPL. The state estimates anywhere from 40,000 to more than 70,000 people could gain coverage, increasing the state's Medicaid enrollment by more than 40 percent.

Excluded Populations: The following populations are excluded from TPA reimbursement under the HELP Program:

- American Indians and Alaskan Natives.
- Individuals with exceptional health care needs, including individuals who are medically frail or have mental health needs and individuals with developmental disabilities.
- Additionally, the state may exclude individuals in regions where the TPA is unable to provide an adequate network.

Premiums and Copayments: The HELP Program would require individuals enrolled through the TPA to pay monthly premiums equal to 2 percent of household income, with a maximum combined premium and copayment amount of up to 5 percent, in accordance with federal law. As has been proposed in other states, higher income enrollees (those with income greater than 100 percent of FPL) can be disenrolled because of non-payment unless they opt to enroll in a wellness program. Copayments will not be applied to "high value" services such as preventative screenings and immunizations.

Third-Party Administrator (TPA): Montana aims to leverage a single existing commercial insurance provider as a fee-for-service TPA to operate the HELP Program statewide. The waiver proposal indicates a desire to contract with an insurer with an established statewide network, and the state is looking for alignment with the Federally Facilitated Marketplace to minimize the impact of individuals who transition from Medicaid to the Marketplace due to changes in income. The TPA is responsible for enrollment, handling claims and processing FFS payments to providers, and collecting premiums and copayments from enrollees.

Third-Party Administrator RFP Overview

Reimbursement: The TPA RFP requires that reimbursement rates to providers be comparable to rates in the current Medicaid FFS structure. Potential TPAs must offer the state their lowest contracted provider reimbursement rates.

Per-Member Per-Month (PMPM) Structure: RFP respondents must submit a proposed TPA PMPM fee for administering the HELP Program. The PMPM is fixed for the first six months of the program, regardless of enrollment levels. Beyond six months, respondents may propose different PMPMs based on total enrollment at 5,000 member increments. Beginning in the third year of the contract, respondents may propose annual PMPM fee increases of no more than 3 percent annually.

Contract Terms: The initial contract term will be from October 1, 2015, through December 31, 2017, although services will not be provided until January 1, 2016.

After the initial two-year period, the state and the TPA may agree to renew the contract in one-year periods up to a total contract term of 10 years.

Evaluation Criteria: The single largest component of the scoring, at nearly 30 percent of total points available, is the cost proposal element. Under the cost proposal, respondents will receive a proportion of the total points available (330), based on their proposed cost as a ratio of the lowest proposed cost from any bidder. (For example, if the lowest bid is $10,000, a bidder with a cost proposal of $20,000 would receive 50 percent of overall points).

Scoring Element	Points Available	% of Total
Enrollment and Eligibility, Copays and Premiums	150	13.0%
Provider Network	100	8.7%
Claims Administration/Processing	150	13.0%
Utilization Review	50	4.3%
Administrative Services, Participant Portal, Reporting and Data	100	8.7%
Wellness Programs and Incentives	120	10.4%
IT Systems	60	5.2%
Offeror Qualifications	40	3.5%
Cost Proposal	330	28.7%
Separately Priced IT Development Cost	50	4.3%
Total Points Available	**1,150**	

HELP Program Timeline

The timeline below aggregates the milestones in both the HELP Program waiver approval process and the TPA RFP process. Many of these dates are subject to change as the waiver negotation process plays out with CMS in the coming months.

HELP Program Milestones	Date
RFP: RFP Issued	July 1, 2015
Waiver: Public Notice of Waiver	July 5, 2015
Waiver: Comment Period on Waiver Opens	July 7, 2015
RFP: Pre-Proposal Conference	July 14, 2015
RFP: Deadline for Written Questions	July 20, 2015
RFP: Q&A Posted	July 31, 2015
HELP Act Oversight Committee to Meet	August 17, 2015
RFP: Responses Due	August 18, 2015
Waiver: Conduct Tribal Consultation	August 19, 2015
Waiver: Comment Period on Waiver Closes	September 7, 2015
RFP: Contract Award	October 1, 2015
Waiver: Receive Waiver Approval	November 1, 2015
Begin Enrollment through Marketplace	November 15, 2015
HELP Program TPA Services Begin	January 1, 2016

Links to Waiver Proposal, TPA RFP

The Montana HELP Expansion Homepage is available here.
The HELP TPA RFP is available here.

HMA Medicaid Roundup

Alaska

Governor Bill Walker to Announce Plans for Medicaid Expansion. On July 13, 2015, *Alaska Dispatch News* reported that Governor Bill Walker scheduled an announcement for July 16th to announce his plans of expanding Medicaid. He will speak about how he intends to go forward without a mandate from the legislature. Lawmakers included a provision in the budget barring Walker from expanding Medicaid, but many attorneys say it is unconstitutional. Read More

Arkansas

Governor Asa Hutchinson to Add Resources for Medicaid Eligibility Checks. On July 14, 2015, *Arkansas Online* reported that Governor Asa Hutchinson instructed the state Department of Human Services to bring in additional resources to help with the annual check of Medicaid eligibility. The annual check of 600,000 Medicaid recipients began a month ago and is using an electronic eligibility and enrollment system that has been under construction for over two years. The first round of checks were delayed for months, causing a large backlog. The deadline is September 30. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

DHCS Delays Cal MediConnect Dual Passive Enrollment in Orange County. On July 10, 2015, the Department of Health Care Services announced that Cal MediConnect passive enrollment in Orange County for eligible beneficiaries residing in Long Term Care facilities will begin no earlier than November 1, 2015. Passive enrollment for other counties is beginning August 1, 2015. Beneficiaries who move into LTC facilities after the November 1 passive enrollment period begins will be enrolled based on the birth month schedule. A schedule for all LTC facilities in Orange County can be found here. Cal MediConnect is the state's voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services through a single organized delivery system. It began in April 2014 in the counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Read More

California Begins to Regain Prison Health Care System from Federal Control. On July 14, 2015, *Daily Republic* reported that the California Department of Corrections and Rehabilitation regained control of the medical care at Folsom

State Prison. The decision comes a decade after a federal judge found the conditions in state prisons so poor that an inmate a week was dying from medical malpractice or neglect. Since then, the state has spent $2 billion on new prison medical facilities, increased the annual health care budget to $1.7 billion, and reduced prison population by over 40,000. Read More

CalOptima Pays $8.9 Million to Health Providers to Resolve State Billing Error. On July 2, 2015, *The Orange County Register* reported that CalOptima paid $8.9 million to nearly 500 health care providers to resolve a state billing error. From July 2011 to May 2013, 785 doctors, hospitals, and providers in Orange County were erroneously reimbursed $15 million form the wrong fund for treating Medi-Cal patients. Claims should have been sent to CalOptima. Providers were required to pay the state back. Read More

Colorado

Advocacy Group Argues Proposed Colorado Health Insurance Premium Hikes Too High. On July 7, 2015, *The Denver Post* reported that the consumer advocacy group, Colorado Consumer Health Initiative, is arguing that the proposed health insurance premium rate hikes, which range from 5 percent to 34 percent, are not justified. The group argues that new enrollees will be healthier after having had access to care. The carriers' predictions of medical inflation are higher than the national average, the group says. The insurer rate filings, submitted May 29, are currently under review by the Division of Insurance. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Releases RFI for Health Information Exchange Vendor. The Agency for Health Care Administration issued a Request for Information (RFI) on June 29, 2015, to determine vendor interest and perspectives about the opportunities in operating the Florida Health Information Exchange (HIE) 2017 – 2023. The Florida HIE offers the following health information exchange services either directly or through participating organizations: Patient Look-Up service (PLU); Direct Messaging; and Event Notification Services (ENS). Responses are due no later than 5:00 p.m. on July 22, 2015. The RFI can be found on the Vendor Bid System website.

Governor Rick Scott Creates Special Savings Plan for Individuals with Disabilities. On July 14, 2015, *Governing* reported that Governor Rick Scott signed a new law establishing a special savings program that allows individuals with disabilities to boost savings from $2,000 to $100,000 without jeopardizing their state and federal benefits. The law, Florida Achieving a Better Life Experience (ABLE) Act, will go into effect July 1, 2016. Additionally, approximately 2,000 people on a wait list for a Medicaid waiver from the Agency for Persons with Disabilities will be able to receive care at home rather than be institutionalized. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Pediatria HealthCare to Close Five Day Care Centers for Medically Fragile Children. On July 9, 2015, *Northwest Georgia News* reported that Pediatria HealthCare will close five Georgia day care facilities for medically fragile children as a result of Medicaid becoming more restrictive on allowing medical day care services coverage for children. Georgia's Medicaid agency, the Department of Community Health, stated it is working with the company to transition the children to in-home skilled nursing support services. Read More

Indiana

Lake County Counts 20,000 Newly Insured for HIP 2.0. On July 14, 2015, *Chicago Tribune* reported that Lake County is leading the state with enrolling new residents for HIP 2.0. Of the 25,557 Lake County enrollees purchasing insurance, 20,309 were buying for the first time through HIP 2.0 and were not rolled over from the previous version of HIP or other Medicaid programs. Indiana Medicaid Director Joe Moser praised the outreach efforts of hospitals and health centers. Read More

Louisiana

Louisiana Releases RFI for Management of Specialized Behavioral Health Services and Medicaid 1915 Waiver. On July 8, 2015, The Louisiana Department of Health and Hospitals released a request for information for the management of specialized behavioral health services and Medicaid 1915(b)(3) and 1915(c) HCBS waivers for Louisiana Medicaid's coordinated system of care program. The State is looking for a single vendor to assume and continue all CSoC-related services and functions, including specialized behavioral health services, currently performed or managed by the incumbent vendor whose contract is anticipated to continue through May 31, 2016, until the program can be seamlessly transitioned to the Medicaid Managed Care Organizations participating in the Bayou Health Program on or before December 1, 2017. Responses are due on July 24, 2015.

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Health Connector to Offer Significantly Fewer Choices. On July 9, 2015, *the Boston Globe* reported that the Massachusetts Health Connector will offer 81 plans (currently in consideration) in 2016, down from 126. The number of insurers will remain the same at 11. Approximately 16,500 people are enrolled in plans not being offered in 2016. The agency's governing board argued that the Connector needed to simplify its offerings because the differences were too small to justify the confusion for consumers. A new member of the board, however, questioned the decision, stating that consumers benefit from choices. A final vote on the plans and premiums to be offered will be held in September. Read More

AIS Examines Possible Changes to be Made to the Duals Program After Fallon Departure. On July 8, 2015, *PRWeb* reported that Atlantic Information Services (AIS) released a report examining potential fixes to the Massachusetts Duals Demo. When Fallon Total Care announced it was leaving the demo, it drew questions about the program's viability. The article's potential fixes include streamlining reporting requirements, implementing administrative changes, changing the current risk-adjustment system, and continuing risk-protection programs such as risk corridors. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

State Makes $10.5 million Allocation to Nursing Facilities to Make Up for MLTSS Reductions. On July 10, 2015 *NJ Spotlight* reported that legislators and Governor Christie have approved funding to help close the gap between what nursing facilities receive to provide Medicaid services and their costs. The funds will be provided equally by the state and a federal match. The implementation of managed long term services and supports (MLTSS) in July 2014 is redirecting care, when possible, out of institutional settings and to home- and community-based care. While nursing facility (NF) care continues to remain an option for MLTSS beneficiaries who need it, NF case mix will become increasingly complex over time. The additional funds will help NFs cover the costs for employee compensation and training to care for more patients with greater complex care needs. Read More

Barnabas Health and Robert Wood Johnson Health Systems Approved for Merger. On July 14, 2015 *NJBIZ* reported that the boards of the Barnabas and Robert Wood Johnson Health Systems have approved a merger, which would create the state's largest health network, with over $4.5 billion in revenue and 30,000 employees combined. And according to Modern Healthcare's July 14, 2015 release, Barnabas Health CEO Barry Ostrowsky would serve as the President and CEO of the new system, to be named RWJ Barnabas Health. Regulatory approvals are necessary before the merger can be finalized.

New York

HMA Roundup – Denise Soffel (Email Denise)

Trinity Home Care to Pay $22.4 Million for Allegations of Overcharging Medicaid. On July 10, 2015, *NewsOK* reported that home care provider Trinity Home Care LLC will pay $22.4 million to end allegations of overcharging Medicaid for the drug Synagis. Synagis, which can cost up to $2,000 per dose, is mainly given to premature babies. Attorney General Eric Schneiderman stated that Trinity billed Medicaid for the drug, even when doctors did not prescribe it, going as far as to put pediatricians' names on prescriptions without their permission and contacting doctors or families to try to sell the drug. The billings were made between 2007 and 2011. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio to Release Statewide Patient-Centered Medical Home Model in 2016. On July 12, 2015, *OpenMinds* reported that Ohio will launch the second component of its cross-payer health system reform project, a statewide patient-centered medical home model, in 2016. The state predicts that by December 2018, 80 percent of the state will be participating in a patient-centered medical home for primary care services. On May 27, 2015, the Ohio Department of Medicaid released a request for proposals (RFP) for contractors to design the model. Responses were due by June 22, 2015, with the contract beginning July 2015 and effective through June 30, 2017. However, as of July 9, 2015, the state had not posted a contract award notice to the procurement site. Read More

Ohio Begins Offering Choice of Case Management Entities for HCBS Services: Individuals covered by the Ohio Home Care Waiver will be able to choose their case management agency from among three entities beginning later this year when an open-enrollment period will be held in the Columbus, Cleveland, Cincinnati and Marietta regions. While not all agencies are available in all regions, CareSource, CareStar and the Council on Aging will be offering case management services.

The Ohio Governor's Office of Health Transformation's Top Ten List: OHT has published its 'Top Ten Health Transformation Initiatives in the Budget', a list drawn from Ohio's new biannual budget, House Bill 64, effective July 1, 2015. The list, as published on its website, is as follows:

Modernize Medicaid

1. Holds per member per month cost growth below 3 percent over two years.
2. Preserves Medicaid coverage for children and pregnant women up to 200 percent of poverty and everyone else up to 138 percent of poverty.
3. Speeds up the transition off of Medicaid and requires the Ohio Department of Medicaid to seek a federal waiver to implement Health Savings Accounts.
4. Targets resources to reduce infant mortality in the most at-risk neighborhoods.

Prioritize Home and Community Based Services

5. Invests $286 million over two years to increase opportunities for Ohioans with developmental disabilities to live and work in the community.
6. Modernizes the Medicaid mental health and substance abuse benefits and improves care coordination through managed behavioral health care.
7. Increases access to affordable housing as a strategy to avoid unnecessary institutional placements.
8. Provides "no wrong door" entry into long-term services and supports.

Streamline Health and Human Services

9. Transitions all income-tested programs to the Ohio Benefits eligibility system.

10. Replaces Ohio's two duplicative disability determination systems with one. Read More

Oklahoma

CMS Approves Federal Funding Extension Through 2016 for Insure Oklahoma. On July 10, 2015, *Miami Herald* reported that the Centers for Medicare and Medicaid Services has approved an extension for federal funding through 2016 for Oklahoma's state program that provides coverage to nearly 18,000 low-income people. Insure Oklahoma, created in 2005, uses federal Medicaid money and revenue from the state's tobacco tax. The federal matching funds for the program in 2016 are expected to be about $64 million. The program was scheduled to cease operating at the end of the year, when federal officials expected recipients to become eligible for Medicaid expansion. However, Governor Mary Fallin rejected expansion. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Continues Critical Payments During Budget Impasse. As previously reported (July 1, 2015 HMA Weekly Roundup), the Pennsylvania governor and the Republican legislature in Pennsylvania remain at odds in reaching consensus on a new Commonwealth budget for Fiscal Year 2015 -16, beginning July 1, 2015. Technically, if there is no budget, the Commonwealth is prohibited from making any payments, but there are exceptions. Recently the Pennsylvania Department of Human Services (PA DHS) posted a guidance on their web site explaining the specific payments which may continue during the impasse. These payments are considered critical to ensure the health, safety and/ or welfare of Pennsylvania residents, including:

- Health care services paid for through Medical Assistance, for hospitals, other healthcare providers and nursing homes, and transportation to medical appointments through the Medical Assistance Transportation Program (MATP).
- Home- and community-based services, including attendant care, for seniors and people with disabilities.
- Prescription drug coverage under the PACE program.
- Medicare Part A and B premium payments.

For a complete listing of what PA DHS will and will not continue to reimburse during the impasse see here. Read More

Rhode Island

Medicaid Group Recommends Value-Based Reimbursements for Providers. On July 8, 2015, *The Sacramento Bee* reported that the Medicaid Group formed by Governor Gina Raimondo recommends a switch to value-based payment for providers. The group is working on a strategic plan for the state's Medicaid. One of the mail goals includes transitioning 80 percent of Medicaid payments to quality-based payments by 2018. Other recommendations include coordinating

physical, behavioral and long-term health care, particularly for patients with the most needs, and moving away from high-cost settings. Overall, the group stated that the Medicaid program needs to more efficient, transparent, and flexible. Its first report focused on ways to reduce costs through the FY 2016 budget. Read More

National

Uninsured Rate Drops to 11.4 Percent. On July 10, 2015, *The Hill* reported that 11.4 percent of people were uninsured in the second quarter of this year, down from 18 percent when the insurance Marketplaces opened. Approximately 10.2 million people bought plans through the Marketplaces in the most recent enrollment period. Read More

Cost of Covering People Newly Eligible for Medicaid Significantly Higher Than Expected. On July 10, 2015, *The Wall Street Journal* reported that the cost of covering adults who qualified for Medicaid under health law's expansion is significantly higher than expected, averaging $5,517 per person. In 2014, CMS predicted it to be $1,000 less. However, costs are expected to fall over subsequent years. Read More

HHS Proposes New Nursing Home Regulations. On July 13, 2015, *Kaiser Health News* reported that the Department of Health and Human Services is proposing to modernize the rules of long-term care facilities and nursing homes. The proposed changes can be found here. HHS Secretary Sylvia Burwell, stated that the measures set high standards for quality and safety in nursing homes and long term care facilities. They cover everything from meal times to use of antipsychotic drugs to staffing. Additionally, the proposed regulations include a section on electronic health records and measures to better ensure that patients or their families are involved in care planning and in the discharge process. Read More

CMS Administrator, Andy Slavitt, Nominated as Head of Agency. On July 9, 2015, *Reuters* reported that Andy Slavitt, administrator of the Centers for Medicare and Medicaid Services, was nominated as head of the agency. Slavitt joined CMS last year to oversee the HealthCare.gov website, following the resignation of Marilyn Tavenner as head. Read More

Long Term Care Facilities Concerned About Updated Requirements. Long-term care providers are voicing concerns over the new rules released by the Department of Health and Human Services. During the first year, the industry will need to pay over $729 million to meet the new requirements during the first year, and approximately $638 million per year after that. Providers are opposing the unfunded mandates and consumer advocates want more requirements in the rule, including specific rations of staff per patients.

INDUSTRY NEWS

Molina to Acquire Preferred Medical Plan's Florida Medicaid Business. On July 14, 2015, Molina Healthcare announced that its subsidiary, Molina Healthcare of Florida, has entered a definitive agreement to acquire Preferred Medical Plan's Medicaid business in Florida. Molina will assume the Medicaid contract in Miami-Dade and Monroe Counties and acquire assets related to the operation of the Medicaid business. The transaction is expected to close during the third quarter of 2015. Read More

Marilyn Tavenner Named AHIP President and CEO. On July 15, 2015, it was announced that Marilyn Tavenner, formerly the head of CMS, has been appointed as the America's Health Insurance Plans (AHIP) president and CEO. Tavenner served as the Administrator of CMS until the end of February of this year. She follows Karen Ignagni, who left AHIP for New York's EmblemHealth after 22 years.

RFP Calendar

Date	State/Program	Event	Beneficiaries
July 31, 2015	Iowa	Contract Awards	550,000
August 3, 2015	Michigan	Proposals Due	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September, 2015	Georgia	Contract Awards	1,300,000
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Montana Expansion (TPA)	Contract Awards	70,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (Phase I)	450,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care (*exiting demo*); Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Progress

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

State	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
California	122,908	123,079	124,239	122,520	122,798	122,846
Illinois	63,731	64,199	60,684	58,338	55,672	53,328
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705
Michigan					9,216	14,867
New York	17	406	539	6,660	7,215	5,031
Ohio	68,262	66,892	65,657	63,625	63,446	62,958
South Carolina		83	1,205	1,398	1,366	1,317
Texas			58	15,335	27,589	37,805
Virginia	27,333	26,877	27,765	27,349	30,877	29,970
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,827**

HMA News

New this week on the HMA Information Services website:

- **Florida** Medicaid MCO Market Share, June, 2015
- **New York** Releases Behavioral Health Carve-in RFQ (non-NYC)
- **Arizona** Medicaid Managed Care Enrollment Up 6 Percent
- Plus public documents including the **Pennsylvania** MMIS RFP, **Kentucky** Medicaid MCO Award Announcement, and the **Louisiana** RFI for the Management of Behavioral Health Services and HCBS Waivers

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

HMA Welcomes…

Barbara Edwards, Principal – Columbus, Ohio

Barb comes to HMA most recently from BCE Health Policy LLC where she served as a Principal. In this role, Barb was a national expert in Medicaid policy and operations, with experience in senior leadership at both state and federal program levels, providing services to public and private sector clients who sought to create increased value for Medicaid consumers, administrators, contractors, and providers. Prior to her role with BCE, Barb was the Director of the Disabled and Elderly Health Programs Group with the Centers for Medicare and Medicaid Services. Here Barb was responsible for a wide array of national Medicaid program policies and oversight to include Home and Community Based long term services and supports waivers; state plan options; and grant programs, including Money Follows the Person and the Balancing Incentives Program. Her additional responsibilities included directing policy development and oversight of all Medicaid integrated service models including managed care plans, health homes, and PACE; Medicaid pharmacy coverage and pricing; the application of essential health benefits to Medicaid expansion populations under the ACA; and the development of a strong focus on behavioral health care within the national Medicaid program.

Additional roles that Barb has served in include Principal with Health Management Associates; Medicaid and CHIP Director, Office of Ohio Health Plans, OH Department of Job and Family Services; Deputy Medicaid Director, OH Department of Human Services; Manager, Enterprise Medical Cost Containment Council, Nationwide Insurance; Chief, Office of Health Policy and Analysis, OH Department of Health; and Analyst, Michigan Insurance Bureau, MI Department of Licensing and Regulation.

Barb received her Master of Public Policy degree from The University of Michigan and her Bachelor of Science degree in Journalism from Bowling Green State University.

Tina Edlund, Managing Principal – Portland, Oregon

Tina Edlund comes to HMA most recently from the Governor's office for the state of Oregon with her most recent role as Federal Liaison for Healthcare, Office of Governor John Kitzhaber and Office of Governor Kate Brown. In this role Tina was responsible for representing the Governor's office in discussions with CMS to ensure efficient federal/state coordination. She was also responsible for representing the Governor's office in developing framework for the next Medicaid 1115 demonstration extending health system transformation in Oregon. Just prior to this, Tina served as the Cover Oregon Transition Project Director for the Office of Governor John Kitzhaber. Here she led the transition of all eligibility and enrollment functions of Oregon's health insurance exchange from Cover Oregon to the federally facilitated marketplace.

Prior to her work with the Governor's office, Tina also served as the Acting Director and the Chief of Policy for the Oregon Health Authority. As the Acting Director, Tina was responsible for leading the agency with 3,800 employees and a $15 billion biennial budget to consolidate all of Oregon's health care purchasing in a single agency. This also included the responsibility for implementation of the Affordable Care Act in OHA and serving as a member of the Governor's five-member executive leadership team for his health policy agenda. As the Chief of Policy, Tina was responsible for all policy development and implementation for the OHA during a time that included creation and implementation of Oregon's Healthy Kids program, major improvements in the Medicaid delivery system, creation of the coordinated care model, and preparation for the implementation of the ACA. She also led the team that negotiated terms and conditions for the Medicaid 1115a demonstration that resulted in a $1.5 billion federal investment in Oregon's health system transformation.

Additional roles that Tina has held include Deputy Administrator, Office for Oregon Health Policy and Research; Research and Data Manager, Office for Oregon Health Policy and Research; Associate Director for Research, Oregon Health Policy Institute, Center for Disability Studies, Oregon Health and Science University; Senior Research Analyst, Center for Outcomes Research and Education, Providence Health System; Research and Evaluation Coordinator, Medical Assistance Programs; Sole Proprietor, Edlund Research; and Research Analyst, David M. Dornbusch and Company.

Tina received her Master of Science degree in Urban Affairs from Portland State University and her Bachelor of Science degree in Sociology from the University of Oregon.

Cathy Kaufmann, Principal – Portland, Oregon

Cathy comes to HMA most recently from Families USA where she served as the Enrollment Program Director. In this role, Cathy was responsible for developing and implementing the enrollment program for a national advocacy organization; providing technical assistance to states and state-based consumer advocates; writing policy briefs, blogs, and funding proposal concepts; and developing strategic plans.

Prior to her work with Families USA, Cathy served in several roles with the Oregon Health Authority. Her most recent role was Executive Director, Transformation Center. Here she was responsible for developing and implementing a new state office to support the Governor's health systems

transformation initiative through Oregon's Coordinated Care Organizations and other health system payers/systems; directing strategic plans and initiatives; and managing 22 staff members and overseeing a $40M biennial budget, including $27M in statewide grants to spur innovation within CCOs and their communities. Cathy also served as the Medicaid Alignment Director/Director's Office where she was responsible for directing the agency's implementation of the ACA, including policy alignment with Cover Oregon's fast track enrollment plan that led to 140,000 more Oregonians gaining Medicaid health coverage within three months. Additionally, Cathy served as the Administrator, Office of Client and Community Services, Healthy Kids where she was responsible for directing outreach and eligibility for all medical assistance programs, including OHP standard and the Healthy Kids program; establishing Healthy Kids as a new office within OHA; creating and directing an outreach and enrollment campaign that enrolled over 100,000 more children into health coverage in two years; bringing in over $60M in federal bonus awards for exceeding enrollment targets that now serves as a national model; and setting the agency's eligibility policies as well as directing the overall eligibility system.

Additional roles that Cathy has held include Policy and Communications Director, Children First for Oregon; Communications Director, Healthy Kids Oregon – Yes on Ballot Measure 50 Campaign; several roles with the Child Welfare Partnership at Portland State University to include Project Manager – Children's Justice Act Child Neglect Study, Research Assistant – Children's Investment Fund Evaluation, Project Manager – Moves in Care Project, Project Coordinator – Northwest Quality Improvement Center, Project Manager – Safety Net Program Pilot Evaluation, and Research Assistant – FACIS Training Development and Evaluation; and Communications and Projects Coordinator, Oregon Children's Foundation.

Cathy received her Master of Social Work degree from Portland State University and her Bachelor of Arts degree in English Literature and Political Science from the University of Tampa.

Steve Fitton, Principal – Lansing, Michigan

Steve comes to us most recently from the Michigan Department of Community Health where he served as the Medicaid Director over the past six years. In this role, Steve helped guide the program through a period of unprecedented state budget issues, rebuilt the Medicaid organization after a long period of hiring freezes, implemented a new Medicaid Management Information System, expanded Medicaid through the Healthy Michigan Plan, and implemented a dual eligible demonstration.

Prior to his work as the Medicaid Director, Steve served as the Director of the Bureau of Medicaid Policy and Actuarial Services within the Michigan Department of Community Health. Here he was responsible for the oversight of Medicaid policy and critical rate-setting as well as financial analysis functions; taking a lead role in the state/federal Medicaid relationship with direct oversight of the State Plan; developing federal waivers; and overseeing the managed care rate-setting function and maximization of federal Medicaid revenue through the Actuarial Division.

Additional roles that Steve has held include Director, Actuarial Division, Michigan Department of Community Health; Acting Director, Division of Children's Special Health Care Services, Michigan Department of Community Health; Research Analyst, Bureau of Finance, Michigan Department of Social

Services; Policy Analyst, Bureau of Medical Assistance, Michigan Department of Social Services; and Employment Counselor, Shiawassee County District Office, Michigan Employment Security Commission.

Steve received his Bachelor of Arts degree from Michigan State University and also completed graduate course work in public administration there.