HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

LOUISIANA ISSUES BAYOU HEALTH RFP

This week our *In Focus* section reviews the request for proposals (RFP) issued by Louisiana's Department of Health and Hygiene (DHH) on July 28, 2014, to rebid the Bayou Health Medicaid managed care program, which launched in 2012. Bayou Health currently serves around 900,000 Medicaid beneficiaries across 5 health plans – three of which are risk-based MCOs, and two of which are shared savings MCOs.

Bayou Health Changes in Reprocurement

Transition to Full Risk-Based Managed Care. The most significant change under the Bayou Health rebid is the elimination of the shared savings program, which currently accounts for 54 percent of Bayou Health enrollees. These roughly 480,000 lives will be translated to full risk-based managed care in 2015, which could more than double the $960.7 million spent in fiscal year 2013 on capitation payments to Bayou Health MCOs.

New Voluntary Populations Included. Under the new Bayou Health contracts, participants in Louisiana's Medicaid home and community based services (HCBS) waivers may be eligible to voluntarily enroll in a Bayou Health MCO. This includes disabled adults and the intellectual and development disabilities (IDD) population, as well as children on the waiting list for a waiver. However, dual eligibles, individuals residing in a nursing facility or intermediate care facility for IDD, as well as individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), are excluded from Bayou Health MCO enrollment at this time. *A separate RFP for a standalone Medicaid Managed Long Term Supports and Services (MLTSS) program is anticipated later this year.*

Additional Services, Including Behavioral Health. Under the new Bayou Health contracts, hospice and personal care services for individuals ages 0-20 will be carved-in to the MCO benefit package. Additionally, non-emergency medical transportation will be expanded to include all necessary transportation. Finally, Bayou Health MCOs will assume responsibility for all "basic" behavioral health services, which include:

- Drugs not prescribed by behavioral health specialists;
- Professional services not provided by behavioral health specialists (e.g., Psychiatrist, Psychologist, Mental Health Rehabilitation provider);
- FQHC/RHC encounter in which no services were provided by a behavioral health specialist;
- Facility services except those provided in a psychiatric facility or distinct part psychiatric unit; and
- Acute Medical Detoxification services.

"Specialized" behavioral health services will continue to be provided through the Louisiana Behavioral Health Partnership, managed by Magellan Health Services of Louisiana.

RFP Timing and Contract Award

DHH indicates in the timeline below that proposal will be due on September 26, 2014, with awards anticipated less than a month later on October 24, 2014. Implementation is currently set for February 1, 2015.

Timeline	Date
Letter of Intent Due (not required)	August 8, 2014
DHH Responses to Written Questions	August 18, 2014
Deadline for Follow-Up Questions	August 25, 2014
DHH Responses to Follow-Up Questions	September 1, 2014
Proposals Due	September 26, 2014
Anticipated Award Announcement	October 24, 2014
Contract Start Date	February 1, 2015

According to the RFP, DHH intends to contract with at least three and as many as five Bayou Health MCOs. However, the RFP states that DHH does not intend to contract with more MCOs than is necessary to meet capacity and Federal requirements for choice.

Contract terms will extend for three years, through January 31, 2018, with two optional extension years, which would extend into 2020.

Evaluation Criteria

The evaluation criteria in the table below place significant weight on quality management, value added to members and providers, and meeting the requirements of Veteran and Hudson initiatives. Additionally, DHH has indicated that bidders must score a minimum of 25 out of 35 points on the financial requirements section to be considered for a contract award.

Evaluation Criteria	Possible Points	Pct. Weight
Mandatory Requirements	Pass/Fail	
Financial Requirements (Must score min. 25 out of 35)	35	3.5%
Organization Requirements	50	5.0%
Organizational Structure	35	3.5%
Provider Network Development	35	3.5%
Provider Management	35	3.5%
Member Assessment and Care Coordination	15	1.5%
Coordination of Carved Out Services	20	2.0%
Case Management	10	1.0%
Member Transition	20	2.0%
Early Periodic Screening, Diagnosis, and Treatment	10	1.0%
Utilization Management	55	5.5%
Chronic Care Management Program	20	2.0%
Non-Emergency Medical Transportation	10	1.0%
Pharmacy	25	2.5%
Customer Service	25	2.5%
Member Grievances and Appeals	10	1.0%
Marketing and Member Material	30	3.0%
Quality Management	75	7.5%
Program Integrity	60	6.0%
Information Systems	65	6.5%
Claims Management	35	3.5%
Value Added to Members	100	10.0%
Value Added to Providers	100	10.0%
Value Added to Louisiana Employees	25	2.5%
Veteran and Hudson Initiatives	100	10.0%
Total Points Possible	**1,000**	

(Link to full evaluation criteria)

Current Bayou Health Market Overview

Amerigroup, AmeriHealth Caritas, and Centene's LA Healthcare Connections subsidiary comprise the current risk-based MCO market in Bayou Health, each enrolling between 125,000 and 150,000 beneficiaries, and accounting for 46 percent of total enrollment.

Bayou Health Plan	July 2014 Enrollment	Mkt. Share
Amerigroup	127,501	14%
AmeriHealth Caritas	141,963	16%
LA Healthcare Connections (Centene)	148,710	16%
Total Risk-Based Enrollment	**418,174**	**46%**
Community Health Solutions	209,508	23%
United Healthcare	274,239	30%
Total Shared Savings Enrollment	**483,747**	**54%**
Total Bayou Health Enrollment	**901,921**	

Source: State Enrollment Data

Community Health Solutions and United Healthcare comprise the current shared-savings MCO market in Bayou Health, enrolling around 210,000 and 275,000 beneficiaries, respectively, and accounting for 54 percent of total enrollment.

As of July 1, 2014, Centene completed a previously announced transaction with Community Health Solutions, whereby Louisiana Healthcare Connections assumed CHS' Bayou Health shared savings contract. This transaction gives Centene's subsidiary roughly 40 percent of the overall Bayou Health market.

Link to RFP Website

http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/3077

HMA Medicaid Roundup

California

HMA Roundup – Alana Ketchel

Three Health Care Bills Up for Consideration in August. *Capital Radio's KXJZ News* reported on July 21, 2014 about three new health care bills up for consideration once lawmakers return in August:

- SB117: Would require insurers to track and record out-of-pocket costs, and reimburse patients if they go over the limit.
- AB1917: Would reduce the cost of specialty drugs for chronic disease patients
- AB2533: Would require insurers to cover out-of-network care when a participating provider is not available immediately

Read more

Covered California Releases 2015 Plans and Rates. On July 31, 2014, Covered California revealed the 10 health insurers that will offer plans in California's insurance Marketplace in 2015. Insurers include: Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care Health Plan, Molina Healthcare, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. Covered California also reported that premiums would rise an average of 4.2 percent. The release stated that some plans will expand their provider networks in response to customer feedback. Read more

California Uninsured Rate Drops Sharply Post-ACA. Kaiser Family Foundation survey findings released July 30, 2014, reveal that 58 percent of those uninsured prior to the rollout of the Affordable Care Act in California now report having health insurance. This translates to approximately 3.4 million newly insured Californians. Medi-Cal was the most common form of new coverage, followed by private coverage under Covered California. The survey found that the remaining uninsured are more likely to be male, undocumented immigrants, or people who had never had insurance. Read more

Coordinated Care Initiative Changes Enrollment Timeline. On August 1st, 2014, the Department of Health Care Services announced a change to the Coordinated Care Initiative timeline (for the dual eligible demonstration and mandatory enrollment in Medicaid Managed Long Term Services and Supports). Enrollment in Alameda and Orange Counties is adjusted to begin in July 2015. The change was made to ensure those counties were adequately prepared to accept enrollees. Read more

State Allowed to Continue Duals Demonstration. The *California Healthline* reported on August 4th, 2014 that a recent California Superior Court decision allowed the state to continue its demonstration project for dual eligibles. The lawsuit was filed by the Medicaid Defense Fund and the group plans to appeal. Read more

Two Insurers Create Patient Record Database. An August 4th, 2014 report from the *Los Angeles Times* stated that Anthem Blue Cross and Blue Shield of California are partnering to create a database of patient records. This could allow clinicians to access the medical histories of approximately one in four Californians. The new system, called Cal Index, will be funded with $80 million in seed money from the two plans. However, the database still faces technological and privacy concerns. Read more

Colorado

HMA Roundup – Joan Henneberry

Medicare/Medicaid Dual Demonstration Slated to Launch. The state Department of Health Care Policy & Financing will begin enrolling eligible clients into the Accountable Care Collaborative (ACC): Medicare-Medicaid Program. The program will integrate and coordinate physical, behavioral and social health needs for over 50,000 full-benefit Medicare-Medicaid clients. The first group of clients will begin receiving enrollment notices at the end of this month and the program will begin September 1, 2014. Full benefit Medicare-Medicaid enrollees that are not already participating in an integrated system of care will be passively enrolled in the program and are able to opt-out of the program if they wish. Clients who participate in this program keep all their Medicare and Medicaid benefits and services.

Colorado Community Living Plan. On July 30, 2014, the Department of Health Care Policy and Financing, Department of Human Services and Department of Local Affairs unveiled Colorado's Community Living Plan, which calls for community-based, long-term services and supports alternatives and housing for individuals with disabilities living in public institutions. The Colorado Community Living Plan represents years of development and collaboration among stakeholders, advocates and state government to better serve individuals with disabilities following the 1999 United States Supreme Court decision *Olmstead v. L.C.* (Olmstead). The Olmstead decision found that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination based on disability.

Medicaid Policy on Opioids. Colorado has been deliberating various policies to address the growing problem of addiction to prescription medications. The state Medicaid agency announced that effective August 1, 2014, short-acting opioids will be limited to a total of 120 tablets per 30 days, per Medicaid member. If more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. Exceptions will be made for members with a diagnosis of a terminal illness or sickle cell anemia. For members who are currently receiving more than 120 tablets and who do not have a qualifying exemption diagnosis, a grace period can be granted via the prior authorization process for providers to taper utilization. Long acting opioids will be discussed at the upcoming Drug Utilization Board meeting for the institution of quantity limits.

Medicaid Eligibility Goes Smart and Mobile. On July 17, 2014, the Colorado Department of Health Care Policy and Financing reported that clients and applicants can now access PEAK*mobile*, the mobile version of the PEAK eligibility and enrollment website, from a smart phone or other mobile device with a small screen. Anyone who visits the PEAK website from a mobile device will automatically be viewing the PEAK*mobile* website. PEAK*mobile* is equipped with essential tools clients need to effectively manage their benefits, including:

- Create a PEAK Account
- Access *Account Overview*
- Check the Application Status of submitted Medical, Food and/or Cash Assistance applications
- View current Medical, Food and/or Cash Assistance benefit information
- View premium and enrollment fee details
- Make a payment
- View medical cards for each member of a client's household
- Access the *PEAK Mail Center* and benefit letters
- Upload documents needed for eligibility

Read more

Connect For Health CEO Patty Fontneau Leaves for Position with Cigna. On July 24, 2014, the *Denver Post* reported the Connect for Health exchange CEO Patty Fontneau is stepping down to take a job as president of Private Exchange Business for Cigna. Fontneau was one of the first employees to join the exchange, serving as CEO since December 2011. The exchange's board of directors said they plan to name an interim CEO within a week. Read more

Connecticut

Insurance Department Denies Anthem Rate Hike. On July 29, 2014, the *Hartford Business Journal* reported that the state Insurance Department has disapproved Anthem Blue Cross and Blue Shield's proposed rate increase of 12.5 percent for individual health insurance policies and cut ConnectiCare's proposed increase in half, from 12.8 percent to 6.2 percent. Following an actuarial review by the Insurance Department, the department recommended changes to some of the key assumptions and projections Anthem used to calculate next year's rates. Anthem has until August 31 to file a new rate proposal. Attorney General George Jepsen and Healthcare Advocate Victoria Veltri said in a statement that they will continue to pursue public hearings on rate filings when necessary. Read more

Florida

HMA Roundup – Elaine Peters

AHCA Gets Federal Approval to Continue MMA Waiver. On August 1, 2014, the Agency for Health Care Administration (AHCA) announced that the federal government has given approval for the state to continue the 1115 Managed Medical Assistance (MMA) waiver through June 30, 2017. The state expects to save about $2 billion over the three-year life of the waiver. The Statewide Medicaid Managed Care (SMMC) program includes a Long-term Care Program and the Managed Medical Assistance program; AHCA has completed implementation of both components.

Florida unveils 2015 proposed prices for Health Plans. On August 4, 2014, the *Miami Herald* reported that individuals buying health insurance on the individual market will see an average increase of 13.2 percent in their monthly premiums come next year. Eight returning companies have filed rate increases ranging from 11 to 23 percent and three have filed rate decreases ranging from 5 to 12 percent. Florida Blue, the state's largest insurer, has announced that the exchange plan will see an average increase in premiums of 17.6 percent Read More

CMS Network Specialty Plan Goes Live. On August, 1, 2014, the Agency for Health Care Administration reported that the Children's Medical Services Network Specialty Plan (CMSN plan) has begun providing services statewide. The CMSN plan, operated by the Department of Health under the Managed Medical Assistance (MMA) component of the state's new Medicaid program, is a statewide specialty plan for children under the age of 21 with special healthcare needs and chronic conditions. The CMSN plan is unique in that it uses the Medicaid pharmacy benefits management system to authorize and pay pharmacy claims for its enrollees. Read more

Floridians to Receive $41.7 Million in Refunds from Health Insurance Companies Due to the Medical Loss Ratio Rule. On July 23, 2014, the *Health News Florida* reported that more than 981,000 Floridians will receive a refund from their health insurers this summer because of the ACA's "80/20" rule. The rule, also called the medical loss ratio, requires insurers in the individual and small group markets to spend at least 80 percent of premium dollars on patient care; if insurers put too much towards profits and overhead, they must refund consumers. In total, residents will receive a combined $41.7 million in rebates, the highest of any state. Read more

Georgia

Financial, Resource Limitations Continue to Stress Georgia's Hospitals. On July 31, 2014, Georgia Health News reported on the ever-present effects of financial and resource limitations on the stability of Georgia's hospitals. Emory-Adventist Hospital announced it will close its doors in October, marking the fifth hospital in the state to shut down the in past two years. Low insurance reimbursement, fewer inpatient visits, and more pressure to update their technology have put a significant financial burden on hospitals, forcing them to close their doors or partner with other facilities in order to maintain solvency.

Georgians to Receive $11 Million in Refunds from Health Insurance Companies Due to the Medical Loss Ratio Rule. On July 24, 2014, *Georgia Health News* reported that 304,000 Georgians will receive a combined $11 million in rebates from insurance companies this summer as a result of the Medical Loss Ratio rule of the ACA. The rule requires insurers in the individual and small group markets to spend at least 80 percent of premium dollars on patient care; if insurers put too much towards profits and overhead, they must refund consumers. The $11 million refund total is down from $15 million paid last year for 2012 coverage and almost $20 million the year before. Read more

Illinois

Illinois Medicaid Department Medical Director Discuss Sovaldi Criteria. In an interview published August 3, 2014, by the Wall Street Journal, the Illinois Department of Healthcare and Family Services (HFS) Medical Director, Dr. Arvind Goyal, discusses the approval process Illinois is using in the approval of Sovaldi, the hepatitis C drug, which costs around $84,000 for a full course of treatment. Dr. Goyal discusses the state's requirement that patients cannot have abused drugs or been treated for alcohol/drug abuse in the twelve months prior to requesting approval for Sovaldi. Additionally, it is explained that the state will only be approving Sovaldi for patients with advanced stage liver disease. Dr. Goyal tells the Journal that the state was spending $1 million per week prior to implementing the approval controls, and that the state has spent $16 million on Sovaldi as of June 2014. Read more

Indiana

ABD RFP Released. On July 31, 2014, the Indiana Department of Administration (IDOA) released RFP-15-001 to establish risk-based managed care services for Aged, Blind and Disabled (ABD) Medicaid beneficiaries. IDOA will post any subsequent changes to the RFP along with the rest of the solicitation documents for bidders. Read more

CMS asks for Resubmission of Indiana's Medicaid Waiver Request. On August 5, 2014, the *Indy Star* reported that CMS returned Indiana's Medicaid Waiver request. The Pence Administration has been asked to resubmit the waiver application once they have sought input from the Pokagon Band of Potawatomi Indians. Read More.

RFI Released for Advertising and PR Services for HIP 2.0. On August 1, 2014, the Indiana Department of Administration (IDOA) released RFI 15-007 to establish Advertising and Public Relations Services for the Healthy Indiana Plan (HIP) 2.0 Public Education. The HIP 2.0 Medicaid expansion alternative is currently being considered by CMS; this RFI is part of an effort to develop a public education marketing campaign to promote HIP 2.0. Responses are due by Friday, August 15. Read more

State Suspends HIP Enrollment, For Now. On July 24, 2014, the state received permission from the federal government to stop new enrollment for now into the current Healthy Indiana Plan (HIP), which provides healthcare coverage for low-income Hoosiers. Enrollment was temporarily capped because HIP is financed by the state's cigarette tax, which was maxed out due to high enrollment. About 52,000 people are currently enrolled in the program. Read more

CMS Reviews Indiana's Medicaid Enrollment Process after Discovering 80,000-Person Backlog in May. On July 24, 2014, *AP*/the *Greenfield Reporter* reported that federal officials are reviewing Indiana's procedures for enrolling residents into Medicaid after finding that the state had 80,000 residents awaiting approval in May. While state officials have reported that the backlog has been halved since May, CMS aims to learn what specific technical or operational hiccups caused the backlog in the first place. CMS spokeswoman Elizabeth Schinderle said in a statement that Indiana is one of a handful of states being reviewed by the federal government. Read more

Kansas

Over $28 million recovered by Kansas State Medicaid Fraud Unit. On August 1, 2014, *KHI News Service* reported that during Fiscal Year 2014 Kansas Attorney General, Derek Schmidt's, Medicaid Fraud and Abuse Division recovered more than $28.7 million in taxpayer funds. This is the second-highest year of recoveries, following the previous fiscal year's record of $33.7 million. Read More

Louisiana

Louisiana DHH issues Disease Management RFI. On July 31, 2014, the Louisiana Department of Health and Hospitals released a Request for Information (RFI 305PUR-DHHRFI-DM-MVA) related to Disease Management and Disease Management Services for Medicaid recipients with chronic diseases. The services would include identification of eligible participants, participant outreach and engagement, direction, coordination, monitoring and tracking of disease management and disease management related services. The key objective for this disease management program is to improve coordination of care and health outcomes that will result in a reduction in the overall costs. Target populations include dual-eligibles, nursing home and adult home residents, and residents enrolled in Medicaid 1915 Home and Community Based Services (HCBS) waiver services. Read more

Maryland

Health and Human Hygiene Secretary Joshua Sharfstein to Step Down in January. On July 30, 2014, the Washington Post reported that Maryland Secretary of the Department of Health and Mental Hygiene Joshua Sharfstein will step down at the end of Governor Martin O'Malley's term in January to become an associate dean at the Johns Hopkins Bloomberg School of Public Health. Sharfstein has served in the position for nearly four years and previously served as the state's health commissioner. Read more

Montana

State and Xerox Resolve MMIS Contract Issue. On July 23, 2014, *AP*/the *San Francisco Chronicle* reported that Montana state officials have resolved a contract issue with Xerox Corp. over developing a new Medicaid Management and Information System (MMIS). The state Department of Health and Human Services announced in June that Xerox was in breach of its $70 million contract due to missed deadlines and unfulfilled contract obligations; DHHS Director Richard Opper rescinded that statement in a letter to Xerox on July 18. Xerox has developed a revised work plan for a new MMIS system, which should be able to serve the state for 20 years. Read more

New Jersey

HMA Roundup – Karen Brodsky *(email Karen)*

U.S. Rep. Frank Pallone co-sponsors bill to extend CHIP funding through 2019. According to NJ Spotlight, on July 31, 2014 New Jersey U.S. Rep. Frank Pallone (D-6th) co-sponsored a bill that would fund the federal Children's Health Insurance Program (CHIP) through 2019. A report by the Wakely Consulting Group found that New Jersey families with an annual income of $50,085 would experience an increase in annual out-of-pocket costs of $857 if CHIP ended and they enrolled in a subsidized Marketplace plan. This would affect over 107,000 children according to the most recent Division of Medical Assistance and Health Services (DMAHS) Medicaid and CHIP enrollment report. CHIP benefits are currently available under NJ FamilyCare, administered by DMAHS. Read more

New Jersey Medicaid submitting State Plan Amendment to CMS for Health Homes in Mercer County. On July 30, 2013 the Department of Human Services issued a public notice inviting public comment on a Medicaid state plan amendment to implement health homes for adults with SMI who are at risk for high utilization of medical and behavioral health care services, and for children, adolescents and young adults with serious emotional disturbance (SED) and a chronic medical condition. The Division of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families' Division of Children's System of Care, in coordination with the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) are seeking approval from CMS to amend the state plan and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.

Medicaid Shift Will Help Aging Residents Stay in Their Homes Longer. On July 23, 2014, the *New Jersey Business Journal* reported on a new state initiative to help seniors remain at home and out of institutions for as long as they can in order to improve health outcomes and decrease costs to the state's Medicaid program. As part of the new Medicaid managed-care program, seniors will gain access to a wide array of home-based health services, including some services which may not have been covered previously due to program barriers. Insurance companies will begin receiving capitated payments for each patient's care and will thus have incentive to develop less costly home-and community-based care solutions for these patients. Read more

New Mexico

New Mexico to Continue Using Federally-Facilitated Exchange. On July 25, 2014, *AP*/FOX Business reported that New Mexico will use the federally-facilitated exchange for another year to enroll individuals into health insurance plans. Many members of the state's exchange governing board expressed concern that the state would not be ready to switch to a state-run online system for individuals. Small businesses have been using the state system since October. Read more

New York

HMA Roundup – Denise Soffel

DSRIP Update. Jason Helgerson, New York's Medicaid Director, conducted a webinar to alert stakeholders to recent developments in the Delivery System Reform Incentive Payment (DSRIP) program that have been finalized with CMS. His presentation is available on the DSRIP web site. The state has created a new project, a potential 11th project, called Patient and Community Activation. The intent of the project is to do outreach to the uninsured, and to Medicaid enrollees that are non-utilizers or that do not have connection to a primary care provider, and engage them in care. The state will be using a program called Patient Activation Model as a way of measuring patient engagement in care, and will also be tracking changes in primary and preventive care utilization. In order to be eligible, a Performing Provider System (PPS) has to demonstrate the capacity to do 10 other DSRIP projects in addition to the Patient and Community Activation project. PPSs sponsored by public hospitals in a specified region have the right of first refusal.

The state has also created financial incentives that encourage potential PPSs to come together and form a single PPS within a given region, increasing their attribution of Medicaid lives, thus increasing the valuation of their DSRIP projects, and thus the value of their incentive payments. Finally, based on public comment that their proposed attribution method did not accurately identify loyalty patterns for special populations, and that it didn't place enough emphasis on the relationship with a PCP, they have revised the beneficiary subcategories. They will be dividing the Medicaid population into 4 buckets, each of which will have its own attribution logic: developmental disability, in a nursing home, seriously mentally ill, and all other. The state plans to give bonus points in the application scoring to PPSs that do Project 11 - as much as a 10 point bonus (on a score of 0-100). They are also planning bonus points for PPSs that apply as a single PPS for a region, although they didn't indicate the value.

DSRIP Procurements. The Department of Health announced the award of two procurements related to the DSRIP program: an independent assessor, and a support team. Public Consulting Group (PCG) Inc. will serve as an independent assessor of New York State's DSRIP program. The DSRIP independent assessor's tasks include creating an application and application review tool as well as a process for a transparent and impartial review of all proposed project plans; making project approval recommendations to the state using CMS-approved criteria; assembling an independent review panel chosen by the Department of Health based on standards set forth in the DSRIP STCs; conducting a transparent and impartial mid-point assessment of project performance during the third year to determine whether the DSRIP project plans merit continued funding or need plan alterations; and assisting with the ongoing monitoring of performance and reporting deliverables

KPMG, LLP will serve as a Support Team for New York State's DSRIP program for up to a one-year contract period. The DSRIP Support Team's responsibilities include working with providers to strategically think through their potential DSRIP Project Plan applications and work on developing project proposal prototypes and "how to" guides to help providers as they prepare their DSRIP Project Plan applications.

Medicaid Disallowance Being Appealed. New York's Medicaid program has been under review by the Health & Human Services (HHS) Office of the Inspector General, to determine whether to allow specific Medicaid costs for services provided to the Medicaid population in state-operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). The initial review period includes claims for services provided from April 1, 2010 through March 31, 2011, resulting in a disallowance notification from CMS in the amount of $1.26 billion. They also indicated they will be initiating a similar review of the two subsequent fiscal years, with a comparable amount of Federal aid at risk if CMS is successful.

According to the Division of the Budget Quarterly Financial Update, the state plans to request a reconsideration of the disallowance, and will also file a notice of appeal. The Budget update notes that they are not aware of any similar attempts by the Federal government to retroactively recover Federal aid of this magnitude that was paid pursuant to an approved State plan. They note that this could have a sizeable adverse effect on the state's budget. A Moody's analysis of the potential claw-back termed it a "credit negative" for the state.

VNSNY hires restructuring advisory firm. After two rounds of major layoffs in the last year, the Visiting Nurse Service of New York has hired the consulting firm Alvarez and Marsal to help it restructure its operations. In April, VNS eliminated 775 positions, on top of 500 positions eliminated in October. VNS is grappling with the impact of changes in the state's financing of home care services, particularly the move of dual eligibles in need of community-based long-term care services into managed long-term care plans. VNS suffered a blow when the state froze enrollment into their MLTC, VNS Choice, for several months in 2013 due to concerns about the plan fraudulently enrolling individuals that did not meet the state's criteria for managed long-term care services.

According to a report in Crain's, "Alvarez and Marsal will assess VNSNY's administrative costs and related processes and compare them with industry benchmarks, identify best practices and business processes through improved administrative workflows, and help VNSNY implement the recommendations."

North Carolina

Hospitals and Adult Care Homes Lose Out in Senate Budget Proposal. On August 1, 2014, *North Carolina Health News* reported that the Senate's recently-passed budget proposal for next year includes cuts to hospital and adult care homes as part of lawmakers' quest to reign in Medicaid costs. The program currently pays for care for more than 1.6 million low-income and disabled North Carolinians; the Senate budget cuts $135 million from Medicaid, largely in the form of reimbursement reductions to providers. Special assistance providers worry that the cutting funds and restricting program eligibility for the medically needy will severely impede these residents' ability to get the care they need, which could ultimately lead to higher health expenses in the long run. Read more

State Senate Passes Its Own Medicaid Overhaul Bill. On July 24, 2014, the *News & Observer* reported that the North Carolina Senate passed its version of a Medicaid overhaul proposal, one that largely differs from the House proposal. Under the Senate proposal, insurance companies would compete with managed

rate networks run by doctors, hospitals and other health care providers for Medicaid enrollees. The managed care groups would be given a set sum of money for each patient enrolled in their plans. The bill would also create a new state department to run Medicaid, removing that control from the State DHHS. In comparison, the House proposal calls for a system of regional managed care networks and wants only provider-led groups to run them. On July 31, the House rejected the Senate proposal in a unanimous vote. Read more

State DHHS Secretary Wos Promotes House-Backed Medicaid Plan as the Best Choice for North Carolina. On July 24, 2014, the *Times-News* reported that State Department of Health and Human Services Secretary Dr. Aldona Wos is promoting her department's proposed Medicaid reform plan as the State tries to plan way to overhaul its Medicaid system. The plan, which has been backed by Governor Pat McCrory, received approval from the state House and was sent to the state Senate for consideration. Wos says that the Senate's Medicaid overhaul plan would push Medicaid reform and managed care too quickly, while the House's plan revamps the system in a more gradual way that is "patient-focused and doctor-driven." Read more

Ohio

Cleveland's MetroHealth Early Medicaid Expansion Paying off. On August 5, 2014, *Kaiser Health News* reported that Cleveland's public hospital, MetroHealth, is realizing positive results from their own Medicaid expansion program. Prior to Ohio expanding the state Medicaid program, MetroHealth created a program by redirecting $30 million from Cuyahoga County taxpayers to create its own Medicaid Program, in order to help cover the costs of "frequent fliers". The results have been promising, in nine months there has been a 60% drop in emergency room visits, a 50% increase in primary care visits, and MetroHealth is saving an average of $150 on each patient every month. Read More.

Oregon

Oregon Insurance Division releases 2015 health insurance plan rates. On August 1, 2014, the *AP* reported that the 2015 premium prices for individual and small employer health insurance plans will see a much tighter range. Premiums are beginning to converge in the middle, with lower premiums increasing and higher premiums decreasing. Moda, a company that captured two-thirds of the individual market share in 2014 due to their low prices, will see a 10.6 percent rate increase, affecting more than 70,000 enrollees. More information is expected to be released by the Insurance Division, in mid-August, outlining premium estimates for different plans, ages, and locations. Read More

Oregon Medicaid to Limit Access to Hepatitis C Drug Sovaldi. On July 31, 2014, *AP*/the *Miami Herald* reported that Oregon's pharmaceutical review committee have limited access to the highly effective but cost prohibitive hepatitis C drug, Sovaldi, to a narrow subset of Medicaid recipients with late-stage liver damage who have been drug-free for at least six months. The committee reasoned that the extreme cost of the drug makes it financially irresponsible to offer the treatment to all Medicaid beneficiaries with the disease. Read more

Medicaid Enrollment Surge Leads to Unintended Consequences. On July 23, 2014, *AP*/the *Washington Post* reported on the unintended consequences resulting from Medicaid expansion in Oregon. The state added nearly 360,000 new Medicaid enrollees to the rolls this year; the massive growth in the program has prompted some coordinated care organizations to stop accepting new patients, has forced some beneficiaries to wait months for medical appointments and has increased the number of emergency room visits, which the state was hoping to avoid. Read more

Pennsylvania

HMA Roundup – Matt Roan

Philadelphia Start-up Provides On Demand House Calls. A new start-up company in Philadelphia is hoping to change the way people think about going to the doctor. As reported on Philly.com, Curbside Care, a new company started by a Wharton MBA candidate and a graduate of the University of Pennsylvania Medical School, will provide on demand medical services in the form of a house call from a physician or nurse practitioner. Scott Ames, co-founder of Curbside says that the company is looking to disrupt the healthcare industry just as companies like Uber have disrupted the taxi-cab market. The target market for the service includes busy professionals who face challenges with scheduling appointments, and long waits at doctor's offices and business travelers who may need medical assistance in a hotel room. Costs are entirely out of pocket, $149 for a nurse practitioner visit and $249 for a physician. Ames contends that with the proliferation of high deductible health insurance plans, the rates are not that much higher than out of pocket costs for an Urgent Care center visit. Curbside Care has received start-up capital from the Wharton Venture Initiation Program, the University City Science Center's Digital Health Accelerator, First Round Capital's Dorm Room Fund, and a $50,000 grant from the state. Read more

Independence Blue Cross/ Davita Joint Venture Attracts Primary Care Providers. Tandigm Health, a joint venture between Independence Blue Cross and Davita Healthcare Partners has recruited nearly 300 primary care providers to its new accountable care program. According to *Philly.com*, Tandigm will receive capitation payments from IBC and will assume responsibility for managing the health of the population assigned to its providers. Under the model, physicians are accountable for all of their patients, not only those who present at the office for services. Tandigm had set a goal to recruit enough providers to serve 50,000 patients when it is implemented in January 2015, so far they have a network that will serve approximately 71,000 patients. This venture represents a shift in the role of physicians from one of "gatekeeper" to one of "care manager." Read more

Susquehanna Health System Sues Medicare Advantage Plan over Sequestration Cuts. As reported in *Healthcare Finance News*, Susquehanna Health System is suing American Progressive Health and Life Insurance, a Medicare Advantage Plan over rate reductions with American Progressive attributed to sequestration cuts contained in the 2011 Balanced Budget Act. Susquehanna contends that American Progressive unilaterally passed on the rate reductions even though the provider agreement between the hospital system and the health plan contained no provisions allowing such a reduction. Susquehanna lawyers say that the cuts passed by Congress were meant to impact the Medicare Advantage plans, not providers. It is not clear how other

Medicare Advantage plans dealt with the cuts, or whether they passed them along to providers like American Progressive. The American Hospital Association has requested clarification from the Centers for Medicaid and Medicare Services, and while CMS has not prohibited passing on the cuts to providers, they have issued guidance suggesting that reducing provider payments may not be allowed under provider-insurer contracts. Read more

Rhode Island

OIG Audit Finds State Medicaid Program Could Lower Costs of Selected DME Items. On July 30, 2014, *Healio Orthotics/Prosthetics* reported on an audit by the state DHHS Office of the Inspector General (OIG), which sought to determine cost control options for 16 durable medical equipment (DME) incontinence items which account for 42 percent of the state Medicaid agency's DME reimbursements. The audit found that from July 2010 to June 2011, Rhode Island Medicaid reimbursed 234 DME providers either the lesser of the Medicaid fee schedule payment amount or providers' usual and customary charge. The also concluded that Rhode Island Medicaid could have saved $1,014,990, or $608,258 federal share, for the selected 16 DME items if it had reduced the fee schedule payment amounts to match the most frequently reimbursed DME providers' usual and customary charges. Read more

Tennessee

BlueCross BlueShield of Tennessee uses strong market share to offer low premiums. On August 6, 2014, *KHN* reported that Tennessee's largest health insurer BlueCross BlueShield is using its strong foothold in Chattanooga's marketplace to offer low premiums to individuals and families. The company captured 88 percent of the plans for Tennessee individuals and families with only one other insurer, Cigna, offerings plans in Chattanooga. BlueCross BlueShield of Tennessee's current rates place it in 10 least expensive insurer markets in the country and Read More.

Groups Sue State over Medicaid Enrollment Delays. On July 23, 2014, *Kaiser Health News* reported that three consumer advocacy groups filed a class-action lawsuit accusing Tennessee officials of adopting policies that are depriving thousands of Medicaid coverage. The lawsuit alleges that the state has created an overcomplicated and confusing enrollment process, leading to delays in processing Medicaid applications. Tennessee is the first state to be sued over Medicaid enrollment problems since the passage of the ACA. Read more

Vermont

Vermont to end Relationship with CGI. On August 4, 2014 the *New York Times* reported that amidst continued issues with the Vermont Health Connector website, the state is ending its relationship with CGI. Lawrence Miller, the state's chief of health care overhaul, stated that the website was still failing many individuals trying to navigate their health insurance via the online marketplace. Optum has been hired by the state to continue work on the website. Read More.

Washington

RFP issued for Foster Child and Adoption Assistance Populations. On July 31, 2014, the Washington State Health Care Authority (HCA) issued a RFP for managed care for the foster care, adoption assistance, and foster alumni populations. A 2013 law was passed requiring HCA to transition all Medicaid children into managed care, and the foster care population will complete that transition. The RFP covers an estimated 23,000 child and young adult lives. Interested bidders must submit a mandatory letter of intent by Tuesday, August 12, 2014 to be considered. Final bids are due on September 10, with anticipated award announcements on September 29, 2014. Implementation is scheduled for January 1, 2015. The initial contract term will run for two years, through the end of 2016, with two optional extension years. Read more

Inslee Submits Grant Application for Healthier Washington to HHS. On July 28, 2014, *State of Reform* reported that Governor Jay Inslee submitted the state's "Healthier Washington" project as part of a $92.4 million grant application to the U.S. Department of Health and Human Services to support innovation in the state's health care system. The project aims to increase access to preventive care, integrate physical and behavioral health care delivery, and to reward quality health care over quantity. The proposal builds on health-related innovations generated by the State Health Care Innovation Plan, which the Washington Health Care Authority implemented last year. Read more

West Virginia

West Virginia Family Health to Provide Services in 53 WV Counties. On July 31, 2014, the *West Virginia State Journal* reported that West Virginia Family Health (WVFH) is entering the Medicaid managed care market in 53 counties to deliver services to Medicaid members eligible for managed care. WVFH will begin enrolling members for services effective September 1, 2014. WFVH is a collaboration between a group of FQHCs and Highmark Blue Cross Blue Shield West Virginia. Read more

National

NAMD Gives CMS Recommendations for Medicaid Managed-Care Regulations. On July 23, 2014, the National Association of Medicaid Directors submitted a letter to CMS regarding the states' interest in how the MMC regulations should be done. Their specific recommendations are as follows:

- CMS should issue guidelines specifying the underlying elements of rate development that states must include in their submission to CMS, including the assumptions made, data sources used, and methodological approach to the rate build up.
- To accommodate innovations in rate setting, as well as the maturity of state managed care programs, CMS should establish a two-tiered approach to rate review.
- Regardless of whether the state must go through a Level 1 or 2 review, states need more consistency in the timeframes for rate development and approvals.
- CMS must support innovation in rate setting methodologies.

- CMS should work with states to ensure any federal efforts to align Medicaid with Medicare and federal Marketplace rules address the unique characteristics of the Medicaid program.
- CMS should work with states to develop a standardized reporting approach for data collection while ensuring there is a clear purpose, both for the state and CMS, for each data element reported.
- Risk-based arrangements and rate setting issues are increasingly complex and require regional and central office staff with sophisticated skill sets.
- The policy direction provided by CMS regional offices is often inconsistent with the direction provided by the central office.

A more complete explanation of each is contained in the letter. Read more

Six States and D.C. Extending Medicaid Pay Raise Next Year to PCPs. On July 31, 2014, *Kaiser Health News*/the *Washington Post* reported that six states – Alabama, Colorado, Iowa, Maryland, Mississippi and New Mexico - and the District of Columbia will use their own money in 2015 to sustain the federal Medicaid pay raise to primary care physicians (PCPs). Alaska and North Dakota paid PCPs in Medicaid above the Medicare levels even before the ACA provision to raise Medicaid payments to PCPs. The other 42 states will let the Medicaid pay rates revert back to their 2012 levels. Read more

HHS Awards $54.6 Million in ACA Mental Health Services Funding. On July 31, 2014, the *Hill* reported that the US DHHS will distribute $54.6 million to 221 community health centers in 47 states to support mental healthcare. The funding demonstrates the ACA's goal of using community health centers to improve access to health care services nationwide. Over five years, the centers will receive $11 billion in funding under the ACA. Read more

Hospitals, Insurers and Consumers See Benefits from Implementation of the ACA. On July 30, 2014, *Bloomberg* reported that hospitals, insurers and consumers are seeing positive returns, both in terms of finances and healthcare quality and access, after implementation of the Affordable Care Act. According to the Obama administration, 8 million Americans signed up for private plans through the law's health insurance exchanges, and another 6 million were added to Medicaid. Hospital chains are reporting higher profits and lower uninsured volumes, and the country is experiencing slower growth in its healthcare spending. Read more

CMS Releases Letter to States Regarding Health Care-Related Taxes. On July 25, 2014, CMS released a letter providing states with information regarding the treatment of health care-related taxes (provider taxes) and their effect on Federal matching funding under Medicaid and the Children's Health Insurance Program (CHIP). It would appear from the guidance that there may be confusion among states as to what would or would not be considered a health care-related tax. Read more

Industry News

Molina Healthcare Names New Chief Medical Officer. Molina Healthcare, Inc. announced on August 4, 2014, that Keith Wilson, M.D., has been named chief medical officer for the Company. In this role, Dr. Wilson will be responsible for establishing clinical policy and oversight of medical management functions of all the Company's health plan subsidiaries, including utilization management, quality improvement, pharmacy and risk management activities. He was previously the vice president of clinical services for the Molina Medical Group clinics and American Family Care. Read more

Florida Medicaid Managed Care Rollout Impacts WellCare Medical Expenses. On July 25, 2014, *Health News Florida* reported that Florida's transition to a Medicaid managed care (MMC) model had a significant impact on medical expenses for WellCare Health Plans, Inc. During the insurer's second quarter 2014 call with analysts, company executives reported that the Florida's MMC program, which almost all Medicaid beneficiaries are required to join, led to $75 million in losses for the company, mostly from prescription drug expense. Chief Financial Officer Tom Tran also said that medical expenses are consuming a majority of the premium for new participants, leaving little behind to cover the administrative ramp-up costs for expansion. Read more

Gentiva Announces Entry into Nondisclosure Agreement. On July 24, 2014, Gentiva Health Services, Inc. announced that it has entered into a nondisclosure agreement with a recognized owner, operator and investor who previously delivered a proposal to Gentiva's Board of Directors to acquire all outstanding shares of Gentiva common stock for $17.25 per share in cash. The Board has also received a conditional proposal from Kindred Healthcare, Inc. The Board intends to provide to Kindred a nondisclosure agreement substantially similar to the agreement it entered into with the other party. If and when Kindred executes such nondisclosure agreement, the Board will provide Kindred with the same level of due diligence that will be made available to the other party. Kindred's access to due diligence will be conditional on the termination of its partial tender offer for 14.9 percent of Gentiva's shares. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
August 11, 2014	Puerto Rico	Proposals Due	1,600,000
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
September 10, 2014	Washington Foster Care	Proposals due	23,000
September 12, 2014	Indiana ABD	Proposals Due	85,000
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 24, 2014	Louisiana	Proposals Due	900,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
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	Washington Foster Care	Implementation	23,000
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
January, 2015	Georgia	RFP Release	1,250,000
February 1, 2015	Washington Duals	Implementation	48,500
February 1, 2015	Louisiana	Implementation	900,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
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	2/1/2015	4/1/2015	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 5 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 WELCOMES…

Karen Duncan, Principal – Atlanta, Georgia

Karen comes to HMA most recently from Grady Health System where she worked for almost 30 years. Her latest role was as Senior Vice President of Ambulatory Services. In her responsibilities she teamed with senior executives to create ambulatory strategies and organizational goals by improving ambulatory performance metrics and patient experience scores. Karen also helped lead the implementation of the EPIC system as well as helped lead the ambulatory JCAHO accreditation team.

Prior to her role as Senior VP, Karen served as the Medical Director of Community Medicine for 5 years. Here she led the PCMH Level 3 certification process and presented the vision and strategy for a new ambulatory care site. Karen was a practicing Pediatrician with Grady for 21 years while also serving as an Assistant Professor in the Department of Family and Preventive Medicine with Emory School of Medicine.

Karen received her M.D. from Emory University School of Medicine. She attended medical school at Case Western Reserve School of Medicine and completed her BA in Biochemistry at Smith College. Additionally, Karen just completed the Executive MBA Program at Georgia State University. She is a Member of the Morehouse ACO Board and a Fellow with the American Academy of Pediatrics.

Carl Mercurio, Principal – New York City

Carl comes to HMA most recently from the Corporate Research Group, Inc. where he has worked for the past 18 years in various capacities. His most recent role was that of President. As President, Carl was responsible for the editorial and operational oversight for the leading producer in healthcare research reports, newsletters, online content, conferences, webinars, and consulting projects. He is the Author/Editor of Insurance Exchange Strategies for Health Plans; Managed Medicaid: New Growth, New Challenges; Outlook for Managed Care; The Consumer-Drive Healthcare Revolution; and several more. The conferences that Carl has created include Managed Healthcare Industry Forum on New Product Development; Emerging Technologies in Healthcare; The Pharmacy Benefit Forum; The Dual Eligibles Opportunity; and Insurance Exchanges: Life After the Launch. Prior to his role as President he was the Vice President for Editorial Development.

Carl has also worked for Communications Trends/Simba Information Inc. initially as their Managing Editor for five years and then as the Editorial Director for five more years. Here he had editorial oversight for media industry research, reports, newsletters, and informational products such as Professional Publishing Report; Book Publishing Report; and Computer Publishing and Advertising Report. Carl was the author of The Media Book; State of the Newspaper Industry; and Professional Publishing Market Forecast.

He received his BA in Liberal Arts (American Literature) from the University of Connecticut where he graduated cum laude.

Kuliva Wilburn, Senior Consultant – Chicago, Illinois

Kuliva comes to HMA most recently from The Chicago Community Trust where she has been serving as a Senior Program Officer (Health) for the past 3 years. In this role, Kuliva led the development, implementation, and management of an $8MM charitable giving portfolio for the largest health-funding foundation in Chicago. She provided leadership for public/private partnerships in the local public health sector consisting of public health leaders, public health advocates, and philanthropy. Her additional responsibilities included facilitating the awarding of grants to support public/private partnerships promoting health and improving care delivery systems within metropolitan Chicago; representing the foundation in the Governor's Alliance for Health Task Force, the Cook County Court's Justice and Health Initiative, the Donor's Forum of Chicago, and the Patient Centered Outcomes Research Institute/Chicago Collaborative; facilitating the development of a 10-year strategy to reduce obesity in Chicago; and directing her team in the coordination/execution of the quarterly grant making and monitoring process.

Prior to her role with the Trust, Kuliva worked for Access Community Health Network for 4 years as a Manager of Planning and Development. Here she provided oversight to all aspects of the management of a $2MM portfolio for community health projects/grants; supported operations and initiatives for the nation's largest network of Federally-qualified health care centers; and led the community assessment process working with operations, medical leadership, and health center staff.

Kuliva's other previous roles include Assistant Researcher for the University of Illinois at Chicago, Institute for Health Equity; Science and Technology Editor for NASA; Science Policy Associate with the American Association for the Advancement of Science; and Protein Biochemist with MERK & Co.

Kuliva is currently finishing her Doctorate in Public Health Management and Leadership at the University of Illinois at Chicago. She received her Master of Public Health Degree from the University of Illinois at Chicago and her Bachelor of Science degree in Biochemistry from Drexel University.