HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

VIRGINIA GOVERNOR UNVEILS "HEALTHY VIRGINIA" COVERAGE EXPANSION PLAN

This week our *In Focus* section comes to us from HMA Principal Barbara Markham Smith of our Washington, DC office. Barbara provides an overview on Virginia Governor Terry McAuliffe's limited coverage expansion proposed this week after months of speculation on whether Virginia would expand Medicaid.

The "Healthy Virginia" Initiative

After months at loggerheads with the Virginia General Assembly over the Medicaid expansion and a June budget agreement that failed to include the expansion, Governor Terry McAuliffe, a Democrat, appears to have abandoned an effort to adopt the Medicaid expansion without legislative approval. Instead,

on September 8, 2014, he unveiled a more limited plan to expand coverage to targeted populations for specific services. In an initiative named "Healthy Virginia," these targeted expansions are designed to address Virginia's most salient health needs and will affect more than 200,000 people, roughly half the number of people who would have been eligible for health coverage under the expansion.

Occurring under existing programs and statutory authorizations, four emergency regulations by the Department of Medical Assistance Services (DMAS) and one executive order will implement the initiatives. They will be funded through existing revenue streams and grants. Healthy Virginia, therefore, will not require legislative approval when the General Assembly returns for a special session on September 22 to again debate the Medicaid expansion. That debate likely will be affected by a revenue shortfall revealed in August that will require an additional $882 million in the next two-year budget.[1] The Medicaid expansion would bring $2.14 billion into the state by 2022.[2]

While the details of Healthy Virginia are still forthcoming, the governor outlined a ten-point plan to:

- ***Provide additional coverage to 20,000 uninsured mental health patients through the Governor's Access Plan or GAP.*** Staff will begin the emergency regulation process and work with CMS to obtain a waiver to provide the coverage.
- ***Develop health homes for patients with serious mental illness.*** The Department of Medical Assistance Services (DMAS) will issue regulations for the formation of health homes for the seriously mentally ill.
- ***Expand outreach with existing and new federal funds and increase enrollment of people currently eligible for assistance through the Marketplace, Medicaid, and FAMIS.*** Leveraging federal and state resources, the governor expects that 160,000 additional people will enroll in the Marketplace and 35,000 additional children will enroll in FAMIS (the Commonwealth's CHIP program). Virginia will invest in improvements in its Cover Virginia website to facilitate the more aggressive outreach. It will use $4.3 million already awarded by CMS for outreach, and has requested an additional $10 million for the increased effort.
- ***Expand FAMIS to include eligible children of state employees.*** DMAS will accomplish this through emergency regulations. This initiative will provide coverage to 5,000 children while shifting some the cost of their coverage from state payroll costs to the federal Medicaid match.
- ***Provide dental services to 45,000 pregnant women.*** DMAS will issue emergency regulations to enable this coverage in Medicaid and FAMIS.

[1] http://www.timesdispatch.com/news/state-regional/projected-revenue-shortfall-rises-to-billion/article_8b8a381c-248b-11e4-8947-0017a43b2370.html?mode=print

[2] http://www.washingtonpost.com/blogs/govbeat/files/2013/12/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf

- ***Develop systems to improve access to care for veterans by facilitating access to non-VA facilities.*** Based on an inter-departmental collaboration between the Virginia Department of Health and Human Resources, the Virginia Department of Veterans and Defense Affairs, and the federal Veterans Health Administration, Virginia will draw on some of the $10 billion in federal funds to provide health services outside the VA health system for those veterans experiencing barriers to care.
- ***Reduce abuse of prescription drugs and related deaths.*** The specific details of this initiative will likely devolve to a new governor-created Task Force to Combat Prescription Drug and Heroin Abuse.
- ***Aggressively pursue additional Federal grants.*** The governor's staff will apply for "every federal grant currently available for health care and innovation." Collaborating with the Virginia Center for Health Innovation, a non-profit organization composed of employers, providers, the pharmaceutical industry, consumers, and government, the Commonwealth has already applied to CMS for a $2.6 million SIM grant.[3]

The *HMA Weekly Roundup* will continue to report developments in Virginia, particularly as events unfold in the General Assembly special session commencing on September 22, 2014.

[3] https://governor.virginia.gov/news/newsarticle?articleId+6347.

HMA Medicaid Roundup

Alaska

Insurance Rates in Alaska to Increase in 2015. On September 5, 2014, *Alaska Public Media* reported that rates on Alaska's health insurance exchange will see steep increases in 2015. The two insurers offering individual plans on the marketplace – Premera Alaska and Moda – will increase rates by an average of 37 percent and 27 percent, respectively. Premera spokesperson Eric Earling says the insurer took on a disproportionate share of high risk residents, causing their medical costs to skyrocket. In light of these rate increases, the federal government points out that individual policyholders will qualify for federal subsidies to purchase these plans; almost 90 percent of consumers qualified in 2014. Read more

California

HMA Roundup – Alana Ketchel

Covered California Consumers Report Being Dropped from their Health Plans or Transferred to Medi-Cal Without Notice. On September 9, 2014, *KCRA* reported that some Californians who purchased individual health coverage through the Covered California health insurance marketplace are suddenly being dropped or transferred to Medi-Cal. Officials at the exchange acknowledged that some people's coverage is shifted during income checks and eligibility updates, but some consumers are reporting having their coverage altered even when their income and eligibility have not changed. Assemblyman Richard Pan, who chairs the Assembly Health Committee, said he will hold a hearing later this month to discuss, among other things, why people are losing their coverage. Read more

State Holds First Stakeholder Meeting to Discuss New Autism Coverage Under Medi-Cal. On September 8, 2014, the California Healthline reported on the first stakeholder meeting to review California's new autism coverage under Medi-Cal, the state's Medicaid program. On August 3, the Department of Health Care Services (DHCS) announced their intent to include treatment for Autism Spectrum Disorder as a covered Medi-Cal benefit. The state has set a tentative date of September 30 to submit an autism coverage state plan amendment to CMS. At the stakeholder meeting, DHCS officials said that many details of the coverage rollout, including licensing criteria and what the reimbursement rates will be, have not yet been worked out. Details on rates will be revealed during the next stake holder meeting on October 16. Read more

Counties' Costs Rising from Influx of Inmates. On September 8, 2014, the *Sacramento Bee* reported on the increasing financial burden counties are facing due to the transition of lower-level prison offenders to county jails starting three years ago. According to state data, spending on medicine has increased 21 percent and out-of-jail visits have increased 32 percent between the fiscal year ending in 2011 to last fiscal year. Lawsuits over county jail health care services are also on the rise. Read more

Stanford Cancels Anthem Contract. On September 8, 2014, the *California Health Report/KQED Blog* reported that Stanford terminated its contract with Anthem Blue Cross after failing to negotiate a contract renewal. Anthem made public a letter it sent to the president of Stanford Health Care citing higher than average prices for services like an MRI. Read more

Injunction Filed to Halt Duals Demonstration. On September 4, 2014, the *California Healthline* reported that a group of senior advocates filed a lawsuit on August 29 to block the rollout of the duals demonstration project, Cal MediConnect. Advocates are hoping for a quick hearing to halt the demonstration in advance of notices to be sent to potential enrollees at the end of the month. Their lawsuit argues that passive enrollment can put frail seniors at risk, since the transition period could cause a brief gap in care. A previous lawsuit was judged in favor of the continuation of the duals project implementation. Read more

Covered CA to Help Individuals Prove Legal Residency. On September 4, 2014, Covered California announced that it will contact approximately 98,000 families that must submit citizenship and immigration documents to prove eligibility for insurance coverage due to insufficient or inconsistent 2014 enrollment documents. These individuals must demonstrate that they are lawfully in the United States by September 30, 2014 to ensure that their coverage renews into 2015. If the documents are not received, Covered California must terminate insurance along with any federal tax credits for monthly premiums. Read more

Hill Physicians Ownership Shifts to Health Plans. On September 3, 2014, the *San Francisco Business Times* reported that the owners of Hill Physicians Medical Group's management company, PriMed, sold their stakes to a new group of investors, including Anthem Blue Cross of California, Blue Shield of California, Dignity Health, and the medical group itself. The insurers now own a third of PriMed, with Dignity and Hill Physicians each holding the remaining third. Read more

Florida

Enrollment into Medicaid Managed Care Plans Leads to Coverage Drops for Some Beneficiaries. On September 4, 2014, *AP*/the *Miami Herald* reported that Florida's transition of 3 million Medicaid recipients into private managed care plans has caused some patients to be cut off from their current physicians. While the Agency for Health Care Administration released statements from stakeholders indicating the transition to managed care had gone smoothly, local physicians told *AP* that privatization caused many of their current patients to be enrolled into plans they do not cover. While beneficiaries are given 90 days to switch health plans, some were not able to switch to a plan accepted by their current providers. Read more

Georgia

Recent Medicaid Reimbursement Hike for Doctors Could Disappear if State Does Not Come Up With Funding. On September 4, 2014, *Georgia Health News* reported that a budget recommendation from the Georgia Department of Community Health (DCH) to the governor and the Legislature could remove the Medicaid reimbursement increase recently won by physicians. The DCH's budget proposal, which was approved by the DCH Board on August 28, did not include the estimated $50 to $70 million in annual state funding to pay for the physician reimbursement hike for treating Medicaid beneficiaries. The rate hike is currently funded by the federal government, but will end in December. Doctors say that if the state does not come up with a way to fund the reimbursement hike, it is likely that fewer of them will accept new Medicaid patients. Read more

Iowa

State Begins Paying for Sovaldi. On September 8, 2014, the *Des Moines Register* reported that the state of Iowa has begun using the expensive but highly efficacious new hepatitis C drug Sovaldi to treat infected individuals, including two inmates. Corrections Department Medical Director Dr. Harbans Deol said that the prison system has budgeted about $1.5 million for Sovaldi in the current fiscal year. The state's Medicaid program expects to spend $7.4 million on the drug in the current fiscal year and $12.7 million next year. Read more

Kansas

KanCare in its Second Year, but MCOs Continue to Lose Money. On September 9, 2014, the Kansas Health Institute reported that the three managed care organizations (MCOs) administering the Kansas Medicaid Program under KanCare lost $72.6 million in the first half of 2014. The private insurers running the MCOs – Amerigroup, UnitedHealthcare Community Plan, and Sunflower Health Plan – are just coming off a $110 million loss in 2013. Governor Sam Brownback called for almost all Medicaid beneficiaries to be transitioned into managed care beginning January 1, 2013, stating that the switch would save the state $1 billion over five years without cutting eligibility, services, or provider payments. Read more

Maine

Shrinking Medicaid Program has Consequences for Low-Income Mainers. September 4, 2014, *Kaiser Health News* reported on the consequences of shrinking the Medicaid program in Maine. Governor Paul LePage elected to shrink the program rather than expand it in order to save the state money; but the decision has left thousands uninsured and led to declining government reimbursements for uncompensated care, significantly stretching resources available to care for low-income Mainers. Read more

New York

HMA Roundup – Denise Soffel

Department of Financial Services Announces Health Insurance Premiums. The NYS Department of Financial Services announced health insurance rates for 2015, including rates for coverage offered through the health benefits exchange (NY State of Health). The Department reports that a substantial influx of new, previously uninsured customers has helped drive down overall premium rates in the individual direct pay market.

NYS reintroduced prior approval for health insurance premiums in 2009. Health plans are required to submit proposed rates, which are reviewed by the Department. Overall, in both the individual and small group markets, DFS cut the average proposed premium rate increases that health insurers requested for 2015 by more than half. On average, insurers requested a 12.5 percent increase in health insurance rates for 2015 in the individual market. DFS reduced the average increase by more than half to 5.7 percent, which is below the approximately 8 percent average increase in health care costs. On average, insurers requested a 13.9 percent increase in health insurance rates for 2015 in the small group market. DFS reduced that average increase by more than half to 6.7 percent, which is also below the approximately 8 percent increase in health care costs. A summary chart of each company's requested rate increases and DFS approved rates can be found on the DFS website.

Capitol NY published this infographic that tracks insurance rate changes by plan and by plan market share.

Managed Long-Term Care Transition. The state announced the next step in the transition from fee-for-service community-based long-term care services to mandatory enrollment in managed long-term care for Broome, Dutchess, Fulton, Montgomery, and Schoharie counties. The transition will begin in October 2014. It is the intent of the state Department of Health that the mandatory program is established in every county by the end of the year.

Cardiac Readmission Rates. As part of its quality improvement initiatives for cardiac procedures, NYS released reports on readmission rates in an August 21 press release. NYS has been publicly reporting mortality outcomes for percutaneous coronary interventions (PCI) and cardiac surgery for over 20 years, and now looks at risk-adjusted 30-day readmission rates for PCI and coronary artery bypass grafts (CABG) as well. Approximately 11 percent of patients undergoing PCI and 15 percent who have CABG surgery are readmitted to the hospital within 30 days, according to two new reports.

Across New York, the 30-day hospital readmission rate for PCI was 11.08 percent. The hospital risk-adjusted readmission rates, which measure hospital performance, range from 4.06 percent to 17.52 percent. Seven hospitals had risk-adjusted readmission rates that were significantly higher than the statewide average, and an equal number had risk-adjusted readmission rates that were significantly lower.

Across New York, the 30-day readmission rate for CABG was 14.96 percent. The hospital risk-adjusted readmission rates range from 9.52 percent to 24.06 percent. Three hospitals had risk-adjusted readmission rates that were significantly higher than the statewide average, and two hospitals had risk-adjusted readmission rates that were significantly lower. Read more

North Carolina

State Could Pay $10 Billion by 2022 Without Seeing a Return on Investment if it Continues to Opt Out of Medicaid Expansion. On September 3, 2014, *Kaiser Health News*/the *Charlotte Observer* reported on the financial consequences of North Carolina opting out of Medicaid expansion. According to an analysis by McClatchy Newspapers using data from the Urban Institute, the state could spend more than $10 billion by 2022 to provide care for low-income residents in other states, while getting none of that money in return. As many as 689,000 North Carolinians could enroll in Medicaid if the state expanded the program. Read more

Oklahoma

Hospitals Feel Financial Pressures Due to State's Opting Out of Medicaid Expansion. On September 8, 2014, the *Tulsa World* reported that Tulsa hospital executives are frustrated at losing out on federal funds because their state has opted out of expanding Medicaid. According to a recent report by the Urban Institute, hospitals in the state stand to lose more than $4 billion between 2013 and 2022 because the state is not expanding Medicaid for some 182,000 uninsured Oklahomans. Some Tulsa hospitals have had to lay off staff to offset their lost revenue. Read more

Pennsylvania

HMA Roundup – Mike Nardone

PA Prepares for HealthyPA Medicaid Expansion. On September 4, 2014, *AP*/the *Centre Daily News* reported on the efforts of the state and participating health insurers to get the HealthyPA Medicaid expansion system ready to go in the next three months. The state feels confident it will be ready to start on December 1, 2014 when enrollment begins for the new Private Coverage Option. The program will rely on systems already in place, including the county assistance offices and current enrollment broker, and insurers that will administer the new coverage plans are largely the same MCOs that administer benefits to three-quarters of the 2.2 million people already on Pennsylvania's Medicaid program. However, insurers must assemble provider networks given the geographic regions in which the plans operate will be different, benefit packages will be finalized, and a new screening system to identify individuals for the newly created Medicaid high risk and low-risk plans will be created. Likewise, extensive outreach to Pennsylvanians eligible for coverage will be needed to spread the word about HealthyPA. The *Philadelphia Inquirer*/*Kaiser Health News* reported that in addition to outreach planned by the state and PA advocacy organizations, the national advocacy group Enroll America plans to ramp up its telephone outreach efforts to remind people in Pennsylvania about enrolling in health insurance coverage.

PA Insurance Department Makes Highmark's Transition Plan Available. On September 2, 2014, the *Pittsburgh Post-Gazette* reported that the Pennsylvania Insurance Department has posted the final transition plan to assist consumers as the contract between Highmark and UPMC Health System expires at the end of the year. The filing of the plan follows a consent decree brokered and announced in late June by Governor Tom Corbett and Attorney General

Kathleen Kane, outlining a preliminary transition agreement between UPMC, the largest health system in Western PA, and Highmark, the region's largest health insurer. The transition plan articulates in greater detail information on Highmark's provider network, member access to care, and continuity of care. As part of the transition plan, Highmark announced a new Community Blue product —Community Blue Flex — a tiered benefit plan that will provide in-network access to certain UPMC providers but at different prices and benefit levels. Read more

Highmark Sues UPMC Over Cancer Treatment Billing. On September 3, 2014, the Pittsburgh Post-Gazette reported that Highmark Inc. filed suit in the Allegheny County Court of Common Pleas charging that UPMC had engaged in "pricing manipulation" related to billing practices for oncology and cancer-related treatments. The lawsuit represents another in a series of disagreements between Highmark and UPMC over cancer billing. Earlier this year, Highmark announced that it would no longer pay certain markups and facilities fees to UPMC for cancer treatment. The "manipulation," Highmark says, comes by way of UPMC charging higher rates for chemotherapy infusions by billing them on a "hospital outpatient basis." Medicare rules and the hospital's own contract with Highmark allow UPMC to claim higher reimbursements when the chemotherapy is provided in an outpatient hospital setting, rather than in a doctor's office. Highmark also has objected to UPMC's decision to designate two of its cancer clinics as outpatient clinics as of June 1. UPMC says Highmark is the one breaching agreements — its own payment agreements with UPMC, as well as the June consent decree which stipulates that Highmark and UPMC are supposed to settle their billing differences by way of arbitration. Read more

ACO Activity in Pennsylvania. On September 3, 2014, the *Philadelphia Business Journal* reported that Doylestown Hospital and nearly 50 primary-care physicians on the Bucks County hospital's medical staff have reached an agreement to join Delaware Valley ACO, the region's largest Medicare Accountable Care Organization. Doylestown Hospital will join four other hospitals and health systems — Main Line Health, Jefferson Health System, Holy Redeemer Health System, Magee Rehab — as an owner of the accountable-care organization, which began participating in the Medicare Shared Savings Program at the start of this year. More than 30,000 Medicare fee-for-service beneficiaries have been assigned to the ACO since the start of the year. Meanwhile, another Bucks County Pennsylvania hospital, St. Mary's Medical Center, and a group of 250 affiliated physicians announced September 9th that they would be joining together to form the Quality Health Alliance ACO and participate in the Medicare Shared Savings Program. According to the *Philadelphia Business Journal*, The ACO has reportedly filed its application with CMS and expects to become operational in January of next year. Read more

New Study of Impact of Nurse Practitioners with Full Practice Authority. On September 4, 2014, the Pennsylvania Coalition of Nurse Practitioners reported on a new study which found that states like Pennsylvania lag in terms of key health care quality indicators, compared to states where Nurse Practitioners have full practice authority. Researchers looked at hospital admission rates among Medicare or Medicare-Medicaid beneficiaries including: potentially avoidable hospitalizations, readmission rates after inpatient rehabilitation, and nursing home resident hospitalizations, comparing rates in states with full practice authority to states, like Pennsylvania, without full practice authority.

The full findings of the study were published on line on the **Nursing Outlook** webpage. Read More

Utah

Governor Herbert Makes Progress in Gaining Federal Approval for the Healthy Utah Medicaid Expansion Plan. On September 9, 2014, the Salt Lake Tribune reported that the federal government has agreed, in concept, to Governor Gary Herbert's Healthy Utah proposal, an alternative to ACA Medicaid expansion. Herbert and the Utah Department of Health have been negotiating the Plan with the federal government for months. Under Healthy Utah, the federal government would give the state $258 million to provide subsidies to those in the coverage gap so that they can buy private health insurance. The Plan would also offer recipients a "work effort" option in which the state would help them seek employment so that they would not need a subsidy in the future; however it is not yet clear if HHS will allow residents to take such assistance from the state. Read more

Vermont

State Hires IT Director for Vermont Health Connect Exchange. On September 3, 2014, *VT Digger* reported that the Vermont Health Connect exchange has hired Robert Skowronski as the Department of Vermont Health Access' interim deputy commissioner for the exchange. Skowronski most recently worked as project manager for United Healthcare's northeast regional leadership team, where he led the company's participation in the New York exchange and worked on several other exchanges. After learning more about Vermont Health Connect's IT issues, he wrote the state offering his services. Skowronski will help the exchange fix defunct website tools and complete some of the 2,500 "nonfunctional deliverables" that former IT contractor CGI did not complete. Read more

Washington

Update on HealthPath Washington Duals Demonstration. On September 4, 2014, the Community Catalyst Dual Agenda gave an update on the upcoming HealthPath Washington (capitated) duals demonstration in Washington State. Regence BlueShield has withdrawn from the duals demonstration, which leaves only one other health plan, UnitedHealthcare of Washington, in the demonstration. The State is now working to develop a partnership with health plans that originally responded to the Request for Application in the spring of 2013. Because of this change, voluntary enrollment for HealthPath Washington will now be delayed to July 2015, followed by three phases of passive enrollment in September, 2015, November, 2015, and January, 2016. HealthPath Washington will be implemented in King and Snohomish counties. Read more

National

Colorado Hospital Association Study Finds Increased ER Utilization in Medicaid Expansion States. On September 8, 2014, *AP*/the *Washington Post* reported on a recent study by the Colorado Hospital Association which finds that ER utilization has increased in Medicaid expansion states compared to non-expansion states. Using data reported by 450 hospitals in 25 states (13 of which have expanded Medicaid), the study finds that the average number of ER visits in expansion states increased by 5.6 percent in Q2 2014, compared to the same quarter in 2013. That increase was more than three times larger than that observed in non-expansion states. The study also found that Medicaid expansion beneficiaries were sicker than traditional Medicaid beneficiaries, and that hospital charity and self-pay charges are decreasing in expansion states. Read more

Industry News

Clearview Capital Completes Two More Add-on Acquisitions for Active Day/Senior Care. This month, Clearview Capital, LLC announced that its portfolio company, Active Day/Senior Care, has acquired Family Matters, LLC of Clifton Heights, PA and Holland Health, Inc. d.b.a. Home Health Mates of Hingham, MA. With the acquisition of Family Matters, the company now operates 11 adult day health centers in Pennsylvania. The acquisition of Holland Health expands the company's growing Active Home Care division. Read more

RFP CALENDAR

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
September 12, 2014	Indiana ABD	Proposals Due	85,000
September 16, 2014	Washington Foster Care	Proposals due	25,500
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 24, 2014	Louisiana	Contract Awards	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	25,500
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	Louisiana	Implementation	900,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
July 1, 2015	Washington Duals	Implementation	48,500
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		9/1/2014	
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	7/1/2015	9/1/2015 11/1/2015 1/1/2016	UnitedHealth; Regence BCBS/AmeriHealth (Withdrew)
	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 News

Governing Article Draws on HMA's Expertise

Governing's Chris Kardish tapped the expertise of HMA Managing Principal Joan Henneberry for his article, "States Making Long-Term Contraception More Accessible. The Governing article examines how and why states are making Long-Acting Reversible Contraception more accessible to patients and doctors. Read more

HMA Upcoming Appearances

Community Healthcare Care Association of New York State (CHCANYS) Statewide Conference and Clinical Forum 2014

Vern K. Smith, PhD – Keynote Speaker

October 19, 2014

White Plains, New York

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