HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

QUARTERLY MEDICAID MANAGED CARE ENROLLMENT UPDATE – Q3 2014

This week, our *In Focus* section reviews recent Medicaid enrollment trends in capitated risk-based managed care in 20 states. Many state Medicaid agencies elect to post monthly enrollment figures by health plan to their websites for their Medicaid managed care population. This data allows for the timeliest analysis of enrollment trends across states and managed care organizations. Many of these 20 states have released monthly Medicaid managed care enrollment data through much of the second quarter (Q2) and third quarter (Q3) of 2014. This report reflects the most recent data posted.

Ten of the states in the table below – Arizona, California, Hawaii, Kentucky, Maryland, Michigan, New York, Ohio, Washington, and West Virginia – expanded Medicaid and have seen increased Medicaid managed care enrollment throughout 2014.

- As of August 2014 enrollment data, these 10 states have seen combined Medicaid managed care enrollment increase by more than 3.6 million beneficiaries since December 2013.
- Combined managed care enrollment in these ten states has increased more than 30 percent since September 2013.

Monthly Enrollment by State – April 2014 through September 2014

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Arizona	**1,204,520**	**1,244,317**	**1,281,531**	**1,321,026**	**1,354,335**	**1,378,827**
+/- m/m	63,027	39,797	37,214	39,495	33,309	24,492
% y/y	8.4%	11.8%	14.9%	18.2%	21.4%	22.7%
California	**7,185,407**	**7,393,171**	**7,725,374**	**7,842,275**	**7,953,433**	
+/- m/m	163,768	207,764	332,203	116,901	111,158	N/A
% y/y	64.0%	65.6%	71.3%	73.6%	74.8%	
Florida	**1,562,161**	**1,876,243**	**2,206,442**	**2,629,459**	**2,950,812**	**2,737,467**
+/- m/m	(21,744)	314,082	330,199	423,017	321,353	(213,345)
% y/y	6.1%	27.5%	49.9%	78.6%	100.5%	86.0%
Georgia	**1,183,852**	**1,248,223**				
+/- m/m	30,593	64,371	N/A	N/A	N/A	N/A
% y/y	4.1%	10.0%				
Hawaii	**340,569**	**332,981**	**325,510**	**323,167**	**321,329**	**318,427**
+/- m/m	8,116	(7,588)	(7,471)	(2,343)	(1,838)	(2,902)
% y/y	18.3%	15.1%	12.9%	12.1%	11.0%	10.0%
Illinois	**328,296**	**352,911**	**360,031**	**385,672**	**401,503**	
+/- m/m	9,856	24,615	7,120	25,641	15,831	N/A
% y/y	21.8%	30.6%	30.5%	36.1%	39.8%	
Indiana	**755,245**	**758,987**	**772,629**	**759,265**	**759,820**	**766,020**
+/- m/m	(12,857)	3,742	13,642	(13,364)	555	6,200
% y/y	N/A	N/A	1.1%	-0.6%	-0.3%	0.1%
Kentucky	**943,111**	**927,825**	**927,211**	**957,521**	**956,428**	
+/- m/m	85,799	(15,286)	(614)	30,310	(1,093)	N/A
% y/y	N/A	N/A	38.1%	42.6%	42.9%	
Louisiana	**884,762**	**890,661**	**896,262**	**901,921**	**906,663**	**910,711**
+/- m/m	3,569	5,899	5,601	5,659	4,742	4,048
% y/y	-1.6%	-0.9%	0.0%	1.0%	1.5%	3.6%

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Maryland	**1,043,248**	**1,087,969**	**1,103,834**	**1,083,933**	**1,068,184**	
+/- m/m	36,909	44,721	15,865	(19,901)	(15,749)	N/A
% y/y	29.3%	34.3%	36.9%	33.7%	31.2%	
Michigan		**1,363,273**	**1,500,937**	**1,548,764**	**1,479,675**	
+/- m/m	N/A	91,532	137,664	185,491	(69,089)	N/A
% y/y		9.3%	20.6%	23.8%	19.3%	
Missouri	**382,585**	**387,104**	**398,857**			
+/- m/m	(7,569)	4,519	11,753	N/A	N/A	N/A
% y/y	-9.1%	-7.4%	-4.0%			
New York	**4,200,417**	**4,307,165**	**4,365,186**	**4,394,935**	**4,422,298**	**4,480,875**
+/- m/m	101,754	106,748	58,021	29,749	27,363	58,577
% y/y	5.7%	7.8%	9.2%	9.0%	9.4%	10.5%
Ohio	**1,730,975**	**1,751,889**	**1,773,350**	**1,791,529**	**1,801,541**	**1,811,926**
+/- m/m	46,884	20,914	21,461	18,179	10,012	10,385
% y/y	4.3%	5.6%	6.1%	5.7%	5.7%	6.3%
Pennsylvania	**1,650,848**	**1,653,556**	**1,661,343**	**1,668,071**	**1,668,554**	
+/- m/m	5,817	2,708	7,787	6,728	483	N/A
% y/y	2.0%	1.9%	2.5%	2.9%	3.0%	
Tennessee	**1,240,744**					
+/- m/m	17,848	N/A	N/A	N/A	N/A	N/A
% y/y	4.7%					
Texas	**3,342,047**	**3,373,362**	**3,408,120**			
+/- m/m	38,809	31,315	34,758	N/A	N/A	N/A
% y/y	-6.0%	-5.4%	-4.6%			
Washington	**1,113,553**	**1,183,203**	**1,204,901**	**1,223,543**	**1,237,231**	
+/- m/m	50,777	69,650	21,698	18,642	13,688	N/A
% y/y	39.7%	47.3%	50.4%	51.7%	53.1%	
West Virginia	**205,885**	**202,109**	**203,157**	**203,288**	**207,584**	**201,931**
+/- m/m	2,571	(3,776)	1,048	131	4,296	(5,653)
% y/y	20.4%	17.8%	18.3%	19.3%	21.7%	18.6%
Wisconsin	**681,284**	**685,682**	**689,585**	**699,251**	**714,665**	
+/- m/m	(44,509)	4,398	3,903	9,666	15,414	N/A
% y/y	-6.0%	-6.6%	-7.5%	-5.8%	-3.9%	

In the discussion below, we describe recent enrollment trends in the 20 states where we track data.

It is important to note the limitations of the data presented. First, not all states report the data at the same time during the month. Some of these figures reflect beginning-of-the-month totals, while others reflect an end-of-the-month snapshot. Second, in some cases the data is comprehensive in that it covers all of the state-sponsored health programs for which the state offers managed care; in other cases, the data reflects only a subset of the broader managed Medicaid population. This is the key limiting factor in drawing direct ties between the data described below and figures reported by publicly traded Medicaid MCOs. Consequently, the data we review in Table 1 and throughout the *In Focus* section should be viewed as a sampling of the enrollment trends across these states, as opposed to a comprehensive comparison, which cannot be developed based on monthly data.

State Specific Analysis

Arizona

Medicaid Expansion Status: Expanded January 1, 2014

Enrollment in Arizona's ALTCS (Arizona's Managed Long Term Care) program, has remained stable over the past year. However, the Medicaid expansion continues to drive increased enrollment in the state's Acute Care managed care program. Through Q3 of 2014, Arizona's MCO enrollment has increased by more than 260,000 lives, up 22.7 percent from September 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Acute Care	1,149,556	1,189,215	1,226,237	1,264,527	1,298,724	1,322,888
ALTCS	54,964	55,102	55,294	56,499	55,611	55,939
Total Arizona	**1,204,520**	**1,244,317**	**1,281,531**	**1,321,026**	**1,354,335**	**1,378,827**
+/- m/m	*63,027*	*39,797*	*37,214*	*39,495*	*33,309*	*24,492*
% y/y	*8.4%*	*11.8%*	*14.9%*	*18.2%*	*21.4%*	*22.7%*

California

Medicaid Expansion Status: Expanded January 1, 2014

Medi-Cal managed care enrollment data through August 2014 appears to show significant enrollment increases due to the Medicaid expansion, up roughly 1.9 million so far in 2014. As of August 2014, enrollment in managed care topped 7.9 million, a nearly 75 percent increase over the previous year. Additionally, California saw its first duals demonstration enrollments in the Cal MediConnect program in April 2014, with enrollments topping 42,000 in August 2014.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Two-Plan Counties	4,661,516	4,758,111	4,930,934	4,979,152	5,126,798	
Imperial/San Benito	52,483	54,186	57,861	57,895	59,330	
Regional Model	174,192	179,309	208,545	207,898	215,092	
GMC Counties	723,878	747,795	780,036	791,552	817,870	
COHS Counties	1,569,893	1,638,448	1,747,998	1,766,047	1,691,870	
Duals Demonstration	3,445	15,322	17,846	39,731	42,473	
Total California	**7,185,407**	**7,393,171**	**7,725,374**	**7,842,275**	**7,953,433**	
+/- m/m	*163,768*	*207,764*	*332,203*	*116,901*	*111,158*	
% y/y	*64.0%*	*65.6%*	*71.3%*	*73.6%*	*74.8%*	

Florida

Medicaid Expansion Status: Not Expanded

Although not electing to expand Medicaid at this time, Florida began to roll-out its statewide Medicaid managed care program (MMA) in Q2 2014, adding an estimated 1.3 million new enrollees in through September 2014, and bringing final Q3 enrollment above 2.9 million, an 86 percent increase in managed care enrollment since September 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
MMCP	1,035,739	860,401	507,307	312,444	0	0
Reform Pilot	154,359	91,014	86,577	0	0	0
MMA		559,501	1,254,314	1,961,957	2,599,992	2,653,393
SMMC LTC	82,959	83,446	83,576	83,391	83,304	84,074
FL Healthy Kids	289,104	281,881	274,668	271,667	267,516	209,722
Total Florida	**1,562,161**	**1,876,243**	**2,206,442**	**2,629,459**	**2,950,812**	**2,947,189**
+/- m/m	*(21,744)*	*314,082*	*330,199*	*423,017*	*321,353*	*(3,623)*
% y/y	*6.1%*	*27.5%*	*49.9%*	*78.6%*	*100.5%*	*86.0%*

Georgia

Medicaid Expansion Status: Not Expanded

As of publication, Georgia has not reported Medicaid managed care enrollment numbers beyond May 2014, when total managed care enrollment stood at nearly 1.25 million, up 10 percent from the previous year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Georgia	**1,183,852**	**1,248,223**				
+/- m/m	*30,593*	*64,371*				
% y/y	*4.1%*	*10.0%*				

Hawaii

Medicaid Expansion Status: Expanded in 2014

Hawaii's managed care enrollment in both the QUEST managed Medicaid and QUEST Expanded Access (QExA), which provides managed Medicaid to the aged, blind, and disabled (ABD) populations, increased by a total of nearly 40,000 over the first four months of 2014. While enrollment has declined in each of the past five months, September 2014 enrollment at more than 318,000 still increased by 10 percent from September 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total QUEST	287,526	282,644	275,178	272,134	269,895	266,636
Total QExA	53,043	50,337	50,332	51,033	51,434	51,791
Total Hawaii	**340,569**	**332,981**	**325,510**	**323,167**	**321,329**	**318,427**
+/- m/m	*8,116*	*(7,588)*	*(7,471)*	*(2,343)*	*(1,838)*	*(2,902)*
% y/y	*18.3%*	*15.1%*	*12.9%*	*12.1%*	*11.0%*	*10.0%*

Illinois

Medicaid Expansion Status: Expanded January 1, 2014

Illinois enrollment across the state's three managed care programs topped 400,000 as of August 2014. Enrollment in the Integrated Care Program (ICP), which serves Medicaid aged, blind, and disabled (ABD) recipients, continues to increase as the phased-in geographic managed care expansion progresses. Additionally, enrollment in Illinois' duals demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI) surpassed 42,000 in August 2014. Significant Medicaid expansion impacts should begin to appear in Q4 2014 and early 2015 data, as mandatory managed care enrollment expands to the majority of the state.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Family Health Program	256,287	254,363	251,760	247,152	252,897	
Integrated Care Program	68,564	83,226	90,425	98,789	106,133	
Duals Demonstration	3,445	15,322	17,846	39,731	42,473	
Total Illinois	**328,296**	**352,911**	**360,031**	**385,672**	**401,503**	
+/- m/m	*9,856*	*24,615*	*7,120*	*25,641*	*15,831*	
% y/y	*21.8%*	*30.6%*	*30.5%*	*36.1%*	*39.8%*	

Indiana

Medicaid Expansion Status: Not Expanded, Debate Pending

This is the fifth consecutive quarter we have presented Indiana managed care enrollment across three programs: Hoosier Healthwise, Care Select, and Healthy Indiana Program (HIP). As of September 2014, Indiana enrolled more than 766,000 across these three programs, up 0.1 percent from September 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Hoosier Healthwise	674,553	682,677	688,410	671,431	669,002	671,651
Care Select	33,974	32,860	36,638	35,892	34,785	34,429
HIP	46,718	43,450	47,581	51,942	56,033	59,940
Indiana Total	**755,245**	**758,987**	**772,629**	**759,265**	**759,820**	**766,020**
+/- m/m	*(12,857)*	*3,742*	*13,642*	*(13,364)*	*555*	*6,200*
% y/y			*1.1%*	*-0.6%*	*-0.3%*	*0.1%*

Kentucky

Medicaid Expansion Status: Expanded January 1, 2014

This is also the fifth quarter we have been able to present managed care enrollment in Kentucky. As of August 2014, Kentucky enrolled more than 956,000 beneficiaries in risk-based managed care. Kentucky has added nearly 290,000 new Medicaid enrollees to managed care in 2014, with total enrollment up 42.9 percent from August 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Kentucky	**943,111**	**927,825**	**927,211**	**957,521**	**956,428**	
+/- m/m	*85,799*	*(15,286)*	*(614)*	*30,310*	*(1,093)*	
% y/y			*38.1%*	*42.6%*	*42.9%*	

Louisiana

Medicaid Expansion Status: Not Expanded

Despite not expanding Medicaid at this time, Medicaid managed care enrollment in the state's Bayou Health program has steadily increased in 2014, adding nearly 30,000 total lives. September 2014 data shows total managed care enrollment at more than 910,000, up 3.6 percent from the previous year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Louisiana	**884,762**	**890,661**	**896,262**	**901,921**	**906,663**	**910,711**
+/- m/m	*3,569*	*5,899*	*5,601*	*5,659*	*4,742*	*4,048*
% y/y	*-1.6%*	*-0.9%*	*0.0%*	*1.0%*	*1.5%*	*3.6%*

Maryland

Medicaid Expansion Status: Expanded January 1, 2014

Since expanding Medicaid as of January 1, 2014, Maryland Medicaid managed care enrollment has increased by more than 240,000 beneficiaries despite declining enrollment in Q3 2014. August 2014 enrollment of nearly 1.07 million is up 31.2 percent over the previous year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Maryland	**1,043,248**	**1,087,969**	**1,103,834**	**1,083,933**	**1,068,184**	
+/- m/m	*36,909*	*44,721*	*15,865*	*(19,901)*	*(15,749)*	
% y/y	*29.3%*	*34.3%*	*36.9%*	*33.7%*	*31.2%*	

Michigan

Medicaid Expansion Status: Expanded April 1, 2014

Michigan Medicaid managed care enrollment has increased by more than 372,000 beneficiaries so far in 2014, despite the delay until April 1, 2014 in the launch of its Medicaid expansion, known as the Healthy Michigan Plan. As of August 2014, managed care enrollment was at just under 1.5 million, up 19.3 percent from the previous year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Michigan		**1,363,273**	**1,500,937**	**1,548,764**	**1,479,675**	
+/- m/m	N/A	*91,532*	*137,664*	*47,827*	*(69,089)*	
% y/y		*9.3%*	*20.6%*	*23.8%*	*19.3%*	

Missouri

Medicaid Expansion Status: Not Expanded

Missouri managed care in both the Medicaid and CHIP programs saw their first consecutive months of enrollment increases compared to previous months in May and June 2014, after more than a year of steady declines. The net enrollment for 2014 as of June of just under 400,000 is down 4 percent from the previous year. As of publication, Missouri has not made Q3 enrollment data available.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Medicaid	339,851	344,355	357,147			
Total CHIP	42,734	42,749	41,710			
Total Missouri	**382,585**	**387,104**	**398,857**			
+/- m/m	*(7,569)*	*4,519*	*11,753*			
% y/y	*-9.1%*	*-7.4%*	*-4.0%*			

New York

Medicaid Expansion Status: Expanded January 1, 2014

New York's Medicaid managed care programs collectively enrolled more than 4.48 million beneficiaries as of September 2014, up 10.5 percent over the previous year. Enrollment gains of more than 600,000 in the mainstream MCO program have been partially offset by continued declining enrollment in the Family Health Plus program, likely due in part to outmigration to the state's Exchange.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Mainstream MCOs	3,747,724	3,876,986	3,964,905	4,022,935	4,080,173	4,178,416
Family Health Plus	313,668	289,476	258,485	228,700	197,916	156,954
Managed LTC	123,063	124,549	125,416	126,819	127,840	129,203
Medicaid Advantage	10,772	10,814	10,953	10,921	10,724	10,512
Medicaid Advantage Plus	5,190	5,340	5,427	5,560	5,645	5,790
Total New York	**4,200,417**	**4,307,165**	**4,365,186**	**4,394,935**	**4,422,298**	**4,480,875**
+/- m/m	*101,754*	*106,748*	*58,021*	*29,749*	*27,363*	*58,577*
% y/y	*5.7%*	*7.8%*	*9.2%*	*9.0%*	*9.4%*	*10.5%*

Ohio

Medicaid Expansion Status: Expanded January 1, 2014

Ohio's Medicaid managed care enrollment has seen significant growth, due to the Medicaid expansion and the launch of MyCare Ohio. As of September 2014, enrollment in the state's managed care programs is more than 2.24 million, up 31.6 percent from September 2013.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
CFC Program	1,556,077	1,576,866	1,597,078	1,614,862	1,625,047	1,635,559
ABD Program	174,898	175,023	176,272	176,667	176,494	176,367
Group 8 (Expansion)	59,298	114,839	190,308	244,337	287,327	332,327
MyCare Ohio (Duals)		15,338	58,166	97,462	98,289	99,013
Total Ohio	**1,790,273**	**1,882,066**	**2,021,824**	**2,133,328**	**2,187,157**	**2,243,266**
+/- m/m	*78,624*	*91,793*	*139,758*	*111,504*	*53,829*	*56,109*
% y/y	*7.9%*	*13.4%*	*21.0%*	*25.9%*	*28.4%*	*31.6%*

Pennsylvania

Medicaid Expansion Status: Expansion Waiver Approved, Yet to Implement

2013 brought significant growth in the Pennsylvania HealthChoices program due to its previously planned phased-in expansion into the New East and New West regions. Enrollment through much of Q3 2014 has shown modest month-to-month increases, with net new enrollments of 42,000 so far in 2014. August 2014 enrollment sits at nearly 1.67 million, up 3 percent from the prior year. Pennsylvania is set to expand Medicaid in the coming year through the Healthy PA Waiver program.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Pennsylvania	**1,650,848**	**1,653,556**	**1,661,343**	**1,668,071**	**1,668,554**	
+/- m/m	*5,817*	*2,708*	*7,787*	*6,728*	*483*	
% y/y	*2.0%*	*1.9%*	*2.5%*	*2.9%*	*3.0%*	

Tennessee

Medicaid Expansion Status: Not Expanded

Tennessee's TennCare Medicaid managed care program had roughly 1.24 million total enrollees as of April 2014, up 4.7 percent from the previous year, amounting to 56,000 new enrollees since January 1. As of publication, no data beyond April has been made available. This delay in releasing data is consistent with past practice; Tennessee typically delays enrollment data by at least three months.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Tennessee	**1,240,744**					
+/- m/m	*17,848*					
% y/y	*4.7%*					

Texas

Medicaid Expansion Status: Not Expanded

Through June 2014, Texas reports total enrollment of just over 3.4 million beneficiaries across the four managed care programs detailed below, down 4.6 percent from the prior year. As of the time of publication, Q3 2014 enrollment data was not publicly available.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
STAR	2,404,892	2,462,876	2,515,340			
STAR+PLUS	411,196	411,063	411,943			
STAR HEALTH	30,772	30,827	31,087			
CHIP	495,187	468,596	449,750			
Total Texas	**3,342,047**	**3,373,362**	**3,408,120**			
+/- m/m	*38,809*	*31,315*	*34,758*			
% y/y	*-6.0%*	*-5.4%*	*-4.6%*			

Washington

Medicaid Expansion Status: Expanded January 1, 2014

As of December 2013, Washington Medicaid managed care enrollment stood at 818,400. Over the first three quarters of 2014, enrollment has increased by nearly 419,000, bringing August 2014 total enrollment up to nearly 1.24 million, a 53.1 percent increase over the previous year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total Washington	**1,113,553**	**1,183,203**	**1,204,901**	**1,223,543**	**1,237,231**	
+/- m/m	*50,777*	*69,650*	*21,698*	*18,642*	*13,688*	
% y/y	*39.7%*	*47.3%*	*50.4%*	*51.7%*	*53.1%*	

West Virginia

Medicaid Expansion Status: Expanded January 1, 2014

West Virginia managed care enrollment has grown significantly from Q4 2013 and through Q3 2014. As of September 2014, managed care enrollment is nearly 202,000, an increase of 18.6 percent over the prior year, with roughly 17,000 new enrollees so far in 2014.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total West Virginia	**205,885**	**202,109**	**203,157**	**203,288**	**207,584**	**201,931**
+/- m/m	*2,571*	*(3,776)*	*1,048*	*131*	*4,296*	*(5,653)*
% y/y	*20.4%*	*17.8%*	*18.3%*	*19.3%*	*21.7%*	*18.6%*

Wisconsin

Medicaid Expansion Status: Not Expanded

Across the state's three managed care programs, August 2014 enrollment totals more than 714,500, down 3.9 percent from the year before.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
BadgerCare+	605,747	609,912	613,216	622,445	637,829	
SSI	33,972	34,109	34,682	34,826	34,801	
LTC	41,565	41,661	41,687	41,980	42,035	
Total Wisconsin	**681,284**	**685,682**	**689,585**	**699,251**	**714,665**	
+/- m/m	*(44,509)*	*4,398*	*3,903*	*9,666*	*15,414*	
% y/y	*-6.0%*	*-6.6%*	*-7.5%*	*-5.8%*	*-3.9%*	

HMA Medicaid Roundup

Arizona

Arizona Medicaid Limits Coverage of Sovaldi. On October 6, 2014, *AP*/the *Charlotte Observer* reported that the Arizona Health Care Cost Containment System (AHCCCS) is using a stringent screening process for permitting treatment with the effective but highly expensive hepatitis C drug, Sovaldi. The state's criteria dictate that patients must be in late stages of liver scarring from hepatitis and must be drug free in order to have access to the treatment. AHCCCS estimates the drug will increase state spending by $7.7 million in the current fiscal year. So far, the state has approved coverage for just 180 people. Read more

Arizona's Top Hospital Providers Report Increase in Suicide and Behavioral Health Emergencies. On September 30, 2014, the *Arizona Republic* reported that two of Arizona's largest hospital providers have experienced an increase in suicide and behavioral health emergencies in recent months. Banner Health and Abrazo Health Care's West Valley Hospital are taking several steps to accommodate the increase, including training more one-on-one patient supervisors. Mental health advocate Elizabeth Singleton explained that the lack of psychiatric services and housing available through the Arizona Health Care Cost Containment System might be contributing to the rise in emergencies. Read more

California

HMA Roundup - Alana Ketchel (Email Alana)

L.A. Care to Accept Passive Enrollment into its Health Plan. On September 30, 2014, L.A. Care Health Plan announced it will be able to accept passive enrollment for people who qualify for Cal MediConnect beginning in January 2015. Read more

Covered California Plan Rates Deemed Actuarially Sound. On October 3, 2014, the *Los Angeles Times* reported that California's insurance regulators signed off on premium increases from plans participating in the state exchange. The regulators say they will further explore the plans' provider networks in the future to confirm patient access to care given the trend of narrow provider networks. Read more

Dental Providers Dropping Some Special Needs Medi-Cal Patients, Citing High Costs and Low Reimbursements. On October 2, 2014, the *California Health Line* reported that some special needs patients are so scared of being at a

dentist's office that it is difficult for providers to diagnose them. Some patients must be anesthetized for exams and procedures, a process that requires money and additional coordination. As a result, fewer facilities across the state want to deliver dental care to special needs patients. Providers say that in order to accommodate the needs of special needs patients, Medi-Cal reimbursements must be increased. In a statement, the Department of Health Care Services reported that it is "currently assessing the rates for general anesthesia for dental services." Read more

Advocates Drop Lawsuit Against Duals Demo. On October 2, 2014, the *California Healthline* reported that advocates have dropped plans to seek a preliminary injunction against the duals demonstration. So far, the state has issued enrollment notices to almost half of the 456,000 Californians eligible for the program. The opt-out rate so far is 36 percent. Read more

Community-Based Adult Services Future Uncertain. On October 1, 2014, the *California Healthline* reported that the Governor vetoed a bill that would require Community-Based Adult Services (CBAS) to be a Medi-Cal benefit. The veto does not necessarily mean that the adult day health program will not be covered, only that the state and CMS now have to agree to a waiver amendment for CBAS to remain a covered benefit. The state now has the opportunity to change the benefit if it so desires and CMS approves. Read more

LA County Launches Program to Cover Undocumented Immigrants. On September 30, 2014, South California Public Radio reported on the launch of My Health LA. Beginning October 1, 2014, My Health LA will provide health insurance to an estimated 400,000 to 700,000 undocumented immigrants in the county. The $61 million program assigns enrollees to a "medical home," one of approximately 164 community clinics in the state. The clinic receives a set monthly payment rate per patient. Qualifying participants must earn below 138 percent of the Federal Poverty Level and be ineligible for Medi-Cal or ACA subsidies. Read more

Governor Signs Final Bills into Law. On September 29 and 30, 2014, Governor Brown signed the following health care bills into law:

- **SB1299:** Requires hospitals to develop comprehensive safety plans to address violence in the workplace. Read more
- Four new laws that address prison psychiatric care, including a requirement that county courts find suitable mental health facilities for those referred to state hospitals. Read more
- **SB 964:** Requires the California Department of Managed Health Care to review Medi-Cal managed care plans and plans participating in Covered California for compliance with standards around access, network adequacy, continuity of care, and quality measurement. Read more

Idaho

Supreme Court to Hear Idaho's Challenge to Medicaid Reimbursement Lawsuit. On October 2, 2014, *AP/ABC News* reported that the Supreme Court will hear Idaho's appeal to overturn a lower court decision ordering the state to increase Medicaid reimbursement to providers. A 2009 lawsuit filed by several private sector health care providers claimed that the state was unfairly keeping

Medicaid reimbursement rates at 2006 levels, even though cost of care has risen since then. A federal judge ruled in favor of the lawsuit; this cost Idaho an additional $12 million in 2013. The state argues that it is the responsibility of federal government, not private companies, to assess state compliance with reimbursement rules. Read more

Indiana

Pence Writes to President Obama, Asks for Support in Gaining Approval for HIP 2.0 Medicaid Expansion Plan. On October 2, 2014, Governor Mike Pence wrote a letter to President Obama expressing his commitment to moving forward with the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion plan as soon as possible. The Governor restated his previous commitment to providing a state-specific alternative to traditional Medicaid expansion, stating that his administration "will not support efforts to remove or water down the Healthy Indiana Plan's core principles." Pence also greeted the President on his visit to Indiana last week and reiterated the points in his letter. This week, the Governor met with HHS Secretary Burwell in Washington, D.C. "to make clear our expectation that the State of Indiana must retain the necessary flexibility to support any expansion of the Healthy Indiana Plan through HIP 2.0." According to a report by the *Indianapolis Star*, Burwell and Pence did not resolve all issues during their meeting. Pence said that his administration "will continue in good faith regarding (HIP 2.0) to cover more low-income Hoosiers the Indiana way."

Maryland

MCO Rates to Decline in 2015. According to industry sources, MCO rates in Maryland can be expected to decline significantly for 2015, based on a reduction in the services covered. Specifically, substance abuse services will be carved out of MCOs for both the expansion and traditional Medicaid populations. Mental health services were carved out previously. For the expansion population (which is priced separately), MCO rates can be expected to be reduced by more than 20 percent to account for the reduction in benefits and the high base rate provided in 2014 that appears to have overstated risk among the expansion population. For the traditional population, rates will decline by a similar but somewhat smaller order of magnitude. The actual rate reduction for traditional Medicaid was not specified. Virtually all of the rate reduction is attributed to the carving out of MH/SA services that will be managed by an ASO, ValueHealth. In the expansion population in Maryland, it is estimated that 42,000 people suffer from behavioral health problems, roughly half the total expansion population.

Maryland Health Connection Releases September Enrollment Figures. On October 3, 2014, the Maryland Health Connection exchange reported that nearly 22,000 new people enrolled into Medicaid last month. To date, 376,850 people have gained Medicaid coverage since the exchange launched a year ago. The exchange also saw 2,425 new enrollees in private insurance plans last month. To date, 81,091 people have purchase private coverage on the exchange. Read more

Massachusetts

HMA Roundup - Rob Buchanan (Email Rob)

EOHHS Releases Latest One Care Duals Enrollment Figures. This month, the Massachusetts Executive Office of Health and Human Services released the state's latest One Care duals enrollment numbers. As of September 1, 2014, the total number of enrollees is 17,739. The total number that opted out is 25,228. *Community Catalyst* reported that while the planned October 2014 passive enrollment has been canceled, MassHealth and CMS will explore the plans' capacities to accept passive enrollees in 2015.

Renee Kessler Named COO of Cambridge Health Alliance. On October 5, 2014, the *Boston Business Journal* reported that Renee Kessler has been appointed chief operating officer at Cambridge Health Alliance. Kessler previously served as chief operating officer at Saint Thomas Midtown Hospital in Nashville, Tennessee; under her leadership, the hospital's operating margins grew more than 3 percent from 2011 to 2013. Prior to that role, she served as chief operating officer and administrator at Mountainside Hospital in Montclair, New Jersey, helping the facility achieve break-even cash flow two years ahead of schedule. Cambridge Health Alliance has operated at a net loss for 12 out of the last 14 fiscal years. Kessler will replace Allison Bayer, who worked as Executive Vice President and COO for the nonprofit hospital from 2006 through April 2014. Read more

State and Feds Negotiate Over MassHealth Medicaid Program Waiver Extension. On October 2, 2014, the *Eagle Tribune* reported that state officials are nearing a deal with the federal government to expand the state's waiver extending Medicaid benefits beyond the guidelines dictated by the ACA. The waiver, initially approved in 1997, gives the state the ability to extend funding to safety net hospitals and coverage to more low-income patients. Topics of discussion in the current negotiations include the length of the waiver extension, support for Designated State Health Programs, and support for safety net hospitals. The state will also have the propose initiatives to promote better coordination of care and services for beneficiaries. The current waiver is set to expire on October 10. Read more

Missouri

State Releases MMIS and Fiscal Agent Services RFI. On September 24, 2014, the Missouri Department of Social Services issued a Request for Information (RFI) for its Medicaid Management Information System (MMIS) and its Fiscal Agent Services. The state aims to obtain information regarding available MMIS solutions that could support the program management needs of the Missouri Medicaid Enterprise (MME) for the next decade and beyond and Fiscal Agent services to assist with program administration. Specifically, MME is interested in MMIS solutions and FA services that would reduce the overall cost of MMIS and FA operations, support Medicaid program changes, and provide a web portal for providers and patients for managing claims. Responses are due on October 24, 2014. Read more

New Hampshire

Next Step in State's Medicaid Managed Care Implementation Postponed. On October 3, 2014, the *Concord Monitor* reported that state officials are postponing the second phase of managed care for the state's Medicaid program. The state has contracted with Well Sense and New Hampshire Healthy Families to oversee coordination of care for Medicaid beneficiaries. Step 1 of the program began the transition of select Medicaid populations from fee-for-service to managed care. Step 2 would continue this transition with other groups, including mandatory enrollment of the long-term care population, able to opt-out of managed care enrollment under Step 1. But problems were detected after the Step 1 rollout, including the denials by some managed care plans of certain treatments and prescriptions. Delaying the next step of managed care implementation will allow the state to resolve issues identified in the first phase of the initiative. A new implementation timeline will be presented at the next meeting of the Governor's Commission on Medicaid Care Management, set to take place on November 6. Read more

New Jersey

HMA Roundup - Karen Brodsky (Email Karen)

Providers and Insurers Disagree on Cause of High Out-of-Network Costs. On October 3, 2014, *NJ Spotlight* reported that providers and insurers are debating why New Jersey residents pay some of the highest bills in the country for out-of-network healthcare. Insurers argue that bills submitted by out-of-network hospitals are unreasonably high, forcing the insurers to increase premiums. Providers argue that reimbursement rates offered by insurers are unsustainably low, forcing providers to not participate in insurance plans and instead submit more costly, out-of-network claims in order to receive fair compensation. Read more

Two Out of Three Dual Special Needs Plans (D-SNP) Exiting New Jersey Market. Horizon Medicare Blue TotalCare and HealthFirst NJ Maximum D-SNP each recently mailed letters to their D-SNP enrollees to notify them that their D-SNP plans will close on December 31, 2014. This change will affect 13,000 Horizon members statewide, and 5,500 Healthfirst members in Bergen, Essex, Hudson, Middlesex, Passaic, Somerset and Union counties. If the Horizon D-SNP members take no action, they will be automatically enrolled in Horizon NJ Health's NJ FamilyCare/Medicaid program. Healthfirst D-SNP members who take no action will be auto-enrolled into WellCare's Medicaid health plan. In addition, members of both D-SNP plans will be returned to original Medicare, and auto-enrolled into a $0 premium Part D Drug Plan. Further, if these members do not select another D-SNP, beginning January 1, 2015 they will no longer have $0 copays for their medications, a D-SNP benefit. They will be charged a copayment of $1.20 for generic and $3.60 for brand name prescription drugs, with the exception of people on the Community Care Waiver, who will continue to have a $0 copayment for Part D drug plan medications. Members have the option of selecting another D-SNP.

Just two D-SNPs will be operational in New Jersey in 2015: 1) Amerivantage Specialty + Rx, which currently serves 4,000 D-SNP members and will be operating in Bergen, Burlington, Essex, Hudson, Middlesex, Monmouth, Ocean,

Passaic, Somerset and Union counties; and 2) UnitedHealthcare Dual Complete ONE, a new D-SNP that will be operating in Essex, Monmouth, Ocean and Union counties. The following counties will not have a D-SNP option in 2015: Atlantic, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Morris, Salem, Sussex and Warren.

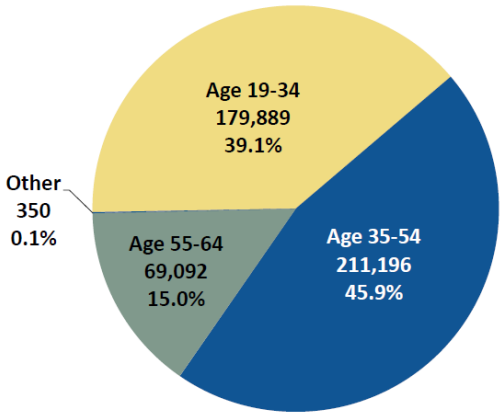
Qualified Income Trust (QIT) Template and Frequently Asked Questions (FAQ) now available. In continuation of the Roundup update on September 17, 2014, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has posted a QIT template to its website that individuals can use to establish income eligibility for Managed Long-Term Services and Supports (MLTSS). The QIT is irrevocable and terminates when the primary beneficiary ceases to receive Medicaid benefits from the State of New Jersey. DMAHS is seeking a State Plan Amendment (SPA) from CMS to use trust devices in nursing facility, assisted living and home-based settings. The SPA will remove the nursing facility benefit from the Medically Needy program, which has been the only vehicle Medicaid applicants could use to spend down their resources to obtain Medicaid benefits. Once the QIT SPA is approved, it will serve as the sole spend-down vehicle, which will enable trust devices for individuals in nursing facilities, assisted living and home-based settings. Approximately 3,500 individuals currently on Medicaid and living in nursing facilities established their coverage under New Jersey's Medically Needy program rules and will be grandfathered in; they will not be required to establish a QIT as long as they are in a nursing facility setting. DMAHS is working with the banking industry to alert them to the implementation of QITs. DMAHS will announce a start date once they receive CMS approval of the SPA. QIT training for stakeholders is being planned for late October 2014. Questions about the QIT may be sent to MAHS.QIT@dhs.state.nj.us. A copy of the QIT template and FAQs can be found here.

Medicaid Expansion Increases NJFamilyCare Enrollment to 1.6 Million. On October 6, 2014, Medicaid Director Valerie Harr presented the September 2014 enrollment figures for NJFamilyCare to its quarterly Medical Assistance Advisory Counsel (MAAC). NJFamilyCare is the state's program for Medicaid and CHIP beneficiaries. Total Medicaid and CHIP enrollment exceeds 1.6 million, and includes:

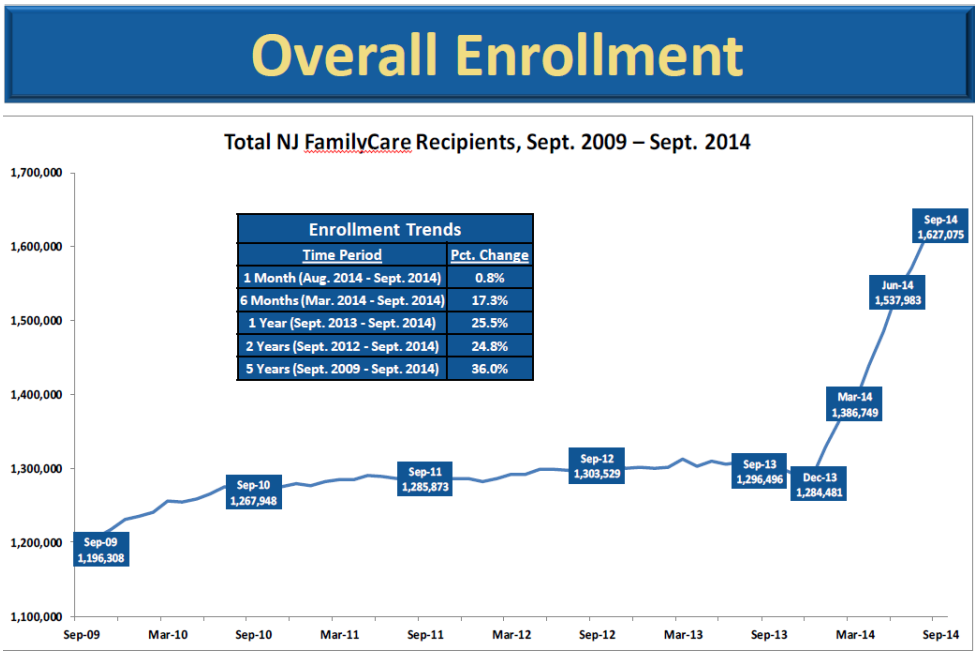
Enrollment attributed to Medicaid Expansion*	Description
159,915	Enrolled adults who maintained Medicaid eligibility due to Medicaid Expansion rules
279,560	Adults newly eligible for Medicaid who would have qualified prior to Medicaid Expansion but did not apply (woodwork effect)
66,571	Children and parents who were previously eligible for Medicaid
506,064	

**Source: DMAHS, Office of Research, September 2014*

The Medicaid Expansion enrollment is distributed by the following age groups:



Overall enrollment trends in NJFamilyCare show major increases in 2014:



**Source: DMAHS, Office of Research, September 2014*

In addition, the State's supplemental nutritional assistance program (SNAP) identified over 20,000 uninsured single adults who were sent a Medicaid application through the express lane eligibility process. Of those, 6,921 returned the application and were determined eligible for Medicaid. New Jersey is one of six states that use the streamlined Medicaid enrollment process for SNAP recipients. Further, its presumptive eligibility population has quadrupled in 2014, which is largely attributed to Medicaid expansion. New Jersey is one of 11 states that makes presumptive eligibility available to all Medicaid eligibles. It limited presumptive eligibility to pregnant women and children before Medicaid expansion began.

Non-Emergency Transportation RFP update. On October 6, 2014, Director Valerie Harr announced that DMAHS received 125 comments from organizations in response to its July 9, 2014 release of the Transportation Broker

RFP. Most of the comments have been used to revise the RFP contents. DMAHS expects the final RFP will be released by the end of December 2014.

Managed Long Term Services and Supports (MLTSS) update. The Department of Human Services, Division of Aging Director, Nancy Day, provided DMAHS MAAC members with an update on the July 1, 2014 MLTSS implementation at the MAAC's October 6, 2014 quarterly meeting. The Division of Aging Services (DoAS) has partnered with DMAHS to implement and monitor MLTSS. Under MLTSS, the State transferred 11,138 1915c waiver participants being managed by more than 100 community-based care management agencies to four Medicaid managed care organizations (MCO). To ease the transition, DoAS provided the MCOs with a database on all participants that included demographic information, identification of high risk individuals, authorizations and hours in place at the time of the transition, and the names of provider agencies serving each participant. The database will serve as a benchmark for quality assurance audits on the MCO plans of care.

The MCOs must provide face-to-face assessments of all participants whose home and community based benefit they now manage. High risk members must be assessed within 90 days and all remaining members must be assessed within 180 days (by December 31, 2014). More than half of the participants have been assessed to date. The number of face-to-face assessments conducted as of September are provided below.

MCO Re-evaluation Assessments Performed to Date	
Month	**Number of Face-to-Face Assessments Performed**
July	1,983
August	2,542
September (as of 9/22/14)	1,424
TOTAL	5,949

MCOs have processed 93,828 MLTSS-related claims since the program began of which 74 percent have been paid and the rest are pending. Some of the top reasons for denied claims have been attributed to needing primary carrier information (the majority of MLTSS participants are dually eligible), filing of duplicate claims, needing an Explanation of Benefit from a commercial carrier, providing incorrect billing, failing to define place of service, or providing codes not in the fee schedule.

Personal Care Assessment Tool (PCA) update. In HMA's April 16, 2014 and June 18, 2014 Roundups, we reported on New Jersey's plans to implement a common PCA tool for use by its four contracted Medicaid MCOs. Carol Grant, Chief of Managed Care and Maribeth Robenolt from the DMAHS Office of Quality Assurance provided an update to MAAC members on the draft PCA tool beta test. The beta test on the draft PCA tool is complete and DMAHS will update the draft tool based on the variations and inconsistencies discovered in assessments that resulted from the new draft tool. The MCOs will test the revised PCA assessment tool in November through December 2014. A final PCA assessment tool with instructions will be prepared by DMAHS in January 2014 and released for MCO use in February 2014.

Medicaid Accountable Care Organization Update. On October 6, 2014, Director Harr announced that DMAHS has completed its review of the eight ACO applications it received this summer and will soon send all of the applicants a follow-up request for information (RFI). The ACOs will have 60 days to respond to the RFI. In addition, the Rutgers Center for State Health Policy is scheduled to

begin the ACO evaluation in January 2015. It will evaluate the extent to which Medicaid ACOs improve healthcare quality and control healthcare spending for Medicaid beneficiaries. It will also document specific changes to care management processes developed by the Medicaid ACOs.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Counties Getting Out of Pricey Nursing Home Business. On October 2, 2014, *Bloomberg* reported that New York counties are getting out of the nursing home business, citing high costs. In addition to the high cost of care provided at nursing homes, municipalities are also responsible for the pension costs of unionized nursing home workers, which are climbing faster than Medicaid reimbursements. According to the Center for Governmental Research, the state's municipally owned homes reported a combined $201 million net loss. Read more

Capital Restructuring Financing Program. The Department of Health in conjunction with the state Dormitory Authority announced the availability of funds under the Capital Restructuring Financing Program (CRFP), a state grant program. Awards totaling up to $1.2 billion over seven years will support capital projects that help strengthen and promote access to essential health services including projects that will improve infrastructure, promote integrated health systems and support the development of additional primary care capacity. The grant program is intended to complement awards granted through the Delivery System Reform Incentives Payment program, DSRIP. In its original waiver request to CMS, NYS had requested funding for capital restructuring, but that request was denied. The CRFP is meant to fill in for the lack of federal support. The state plans to release a competitive RFA shortly. According to the program description, "Capital grant projects include but are not limited to closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects."

Financial Stability Test. As part of the DSRIP application process, institutions that wish to be lead providers of a Performing Provider System (PPS) must pass a financial stability test. The Department of Health posted a draft of the PPS Lead & Financial Stability Test on the DSRIP web site for public review and comment. All PPS Lead Providers will be required to pass the Financial Stability Test in advance of the submission of the DSRIP Project Plan Application. The financial stability test asks for the PPS lead's organizational capabilities. It also reviews the PPSs performance on standard financial metrics including operating margin, current ratio, days cash on hand, cash flow to total debt, debt ratio, fixed asset financing ratio, return on total assets, total asset turnover, and operating cash flow margin. The threshold for passing the financial stability test has not been finalized, but a lead PPS will have to fall within one or two standard deviations from statewide average performance. If the lead fails to pass the test, that entity will not be able to serve as the PPS lead. The PPS would then need to identify another lead or become members of another PPS, in order to continue participation in DSRIP.

Public hospitals may be exempt from the financial stability test if they can document the commitment of the governmental entity of which they are a part to support the hospital during the five year DSRIP period.

North Carolina

Lawmakers Consult with Ohio, Florida, and Virginia State Medicaid Directors as They Contemplate Medicaid Reform in North Carolina. On October 7, 2014, *North Carolina Health News* reported that lawmakers are studying three other state Medicaid programs in order to better inform their strategies for reforming North Carolina's Medicaid program. Lawmakers met this week with Medicaid directors from Ohio, Florida, and Virginia to learn more about their recent Medicaid program reforms. One commonality featured in the three state reforms is the use of managed care organizations to run their Medicaid programs. The Medicaid directors also stressed the importance of having all stakeholders – from lawmakers to providers – in agreement before instituting a reform. This past summer, House and Senate lawmakers disagreed about the organization of the Medicaid program, as well as over whether to pull Medicaid out of DHHS. Read more

Pennsylvania

HMA Roundup – Matt Roan (Email Matt)

Provider Networks Pose Challenge for New Healthy PA Plans. On October 6, 2014, Modern Healthcare reported that health insurers gearing up for a January 1 launch of the Healthy PA Private Coverage Option for the Medicaid expansion population are having difficulty attracting providers to their network. The health plans report that providers expected reimbursement rates to be closer to commercial insurance, while the health plans are offering reimbursement only slightly above the Medicaid rates. The plans also say that the Department of Public Welfare has not been forthcoming about the funding available for the program and that they too were expecting higher payments from the state for offering plans that resembled commercial insurance coverage. DPW has said that in its initial waiver application to CMS they proposed rates that were more aligned to the commercial market but that the version of the waiver that CMS approved limited payments to the health plans to an amount closer to Medicaid reimbursement. Federal law requires that Medicaid waivers such as the one approved for the Healthy PA program meet a "budget neutrality" test, meaning that the proposed program cannot cost more than traditional Medicaid coverage. Concerns have been raised that the plans will not be able to build networks sufficient to meet state certification requirements, but DPW remains optimistic that as provider contracting efforts continue, the plans will be able to meet an October 17 deadline for network certification. Read more

State Regulators say that New Highmark Plan Violates State Consent Decree. On October 6, 2014, the Pittsburgh Post-Gazette reported that Pennsylvania regulators believe Highmark's new Medicare plan offering, known as Community Blue, violates a consent decree that Highmark entered into earlier this year as state officials brokered a deal in the ongoing dispute between Highmark and UPMC. Community Blue is being marketed by Highmark as a new plan option for 2015; it includes a narrow network of providers which excludes UPMC facilities and has a $0 monthly premium. The terms of the

consent decree suggest that UPMC facilities will continue to contract with Highmark plans serving vulnerable populations including those over 65 years of age, but it is not clear that the provisions of the decree prohibit Highmark from offering new plans with narrow networks. UPMC has said that they are contemplating emergency legal action. State officials have responded with a letter stating that pursuit of legal action would also violate the consent decree by circumventing the enforcement provisions of the agreement. Read more

Texas

HMA Roundup – Dianne Longley & Lisa Duchon (Email Dianne/Lisa)

Sunset Advisory Commission Releases Review of HHSC, Calls for Changes. On October 3, 2014, the *Texas Tribune* reported on the Sunset Advisory Commission's recent review of the state's Health and Human Services Commission (HHSC). In its report, the Sunset Commission identified 15 systemic issues with HHSC. The *Tribune* highlighted five key areas from the report:

1. The Sunset Commission recommended consolidating the state's five current health agencies into a single agency in order to lower costs.
2. HHSC's transition of Medicaid beneficiaries into managed care programs has been shaky and must be addressed before additional populations are transitioned.
3. The state's current services for women's health are too fragmented due to disagreement over certain reproductive health services. The report stated that "constant changes in the state women's health policies over the past four years have made stakeholders weary of revisiting an issue so fraught with controversy and emotion."
4. HHSC's ineffective case management system, poor communication and lack of staff training have caused costly errors. For example, officials overseeing Medicaid contractor Xerox did not ensure that its workers were following Medicaid guidelines for approving dental claims, leaving the state on the hook for millions of dollars in false claims.
5. The state has the ability to place mandatory holds on Medicaid payments to providers suspected of fraud. Providers claim that the state is abusing this power, putting providers under financial stress.

The report also offered recommendations for fixing the state's health services. Lawmakers will take the report's recommendations into consideration in the upcoming legislative session, which begins in January. Read more

West Virginia

State Contracts With Medical Transportation Management for Non-Emergency Transports. On October 5, 2015, *AP*/the *News & Observer* reported that West Virginia will contract with St. Louis-based Medical Transportation Management to handle non-emergency medical transport needs for Medicaid beneficiaries, a move that could save the state up to $2 million next year. Previously, Medicaid patients called the Department of Health and Human Resources (DHHR) to request a driver. DHHR deputy secretary Jeremiah Samples said that the new arrangement will allow DHHR employees to focus on

their other duties. The contract does not include ambulance transport; therefore, local EMS and ambulance squads will not lose revenue with this arrangement. Read more

National

CMS Releases FAQ Document Regarding the ACA's Health Insurance Provider Fee. This week, CMS released a "Frequently Asked Questions" document regarding the Health Insurance Providers Fee for Medicaid Managed Care Plans. Read more

Minimum Wage and Overtime Protections Delayed for Home-Care Workers. On October 7, 2014, the *New York Times* reported that the Obama administration will postpone enforcement of its plan to extend minimum wage and overtime protections to the nation's nearly two million home-care workers. The Department of Labor rule would allow home-care workers to receive the federal minimum wage of $7.25 an hour and time and a half when they work more than forty hours per week. Several states have requested a delay in the rule's implementation, citing high cost. Read more

CMS Reopens Submission Period for Hardship Exception Applications. On October 7, 2014, CMS announced its intent to reopen the submission period for hardship exception applications for eligible professionals and eligible hospitals that can't demonstrate meaningful use of Certified Electronic Health Record Technology (CEHRT). The hardship exception would enable eligible providers to avoid the 2015 Medicare payment adjustments for failing to achieve meaningful use standards. The new application deadline will be November 30, 2014. Read more

Industry News

American Addiction Centers Raise $75 Million in IPO. On October 1, 2014, American Addiction Centers, Inc. announced the pricing of its initial public offering of 5,000,000 shares of common stock at a price to the public of $15.00 per share. The shares began trading on the New York Stock Exchange (NYSE:AAC) on October 2, 2014. The company has raised $75 million in its IPO. American Addition Centers operates six substance abuse treatment centers in the US with over 450 beds. Read more

CVS to Pay $6 Million to Settle Medicaid Reimbursement Lawsuit. On September 29, 2014, *Kaiser Health News* reported that Caremark LLC (a unit of CVS) will pay $6 million to settle allegations that it knowingly failed to reimburse Medicaid for prescription drug costs paid on behalf of patients who were also covered by private plans it administered. By law, private insurers must cover the health care costs for dual eligibles. The company denied any wrongdoing. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
Mid-October, 2014	Puerto Rico	Contract Awards	1,600,000
October 24, 2014	Louisiana	Contract Awards	900,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
December, 2014	Georgia	RFP Release	1,250,000
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
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
January 1, 2016	Georgia	Implementation	1,250,000
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	UnitedHealthcare
	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

HMA Upcoming Webinar: *"The Missing Link: Stable Housing as a Key Determinant of Health in Medicaid Populations"*

Tuesday, October 21, 2014
10:00 AM Eastern
Register Here

HMA's Mike Nardone will discuss the link between housing and Medicaid-financed health care. John Lovelace, president of UMPC for You, will offer a case study of his organization's growing three-year-old Shelter Care Plus program for the homeless. William C. Kelly, Jr., strategic advisor of Stewards of Affordable Housing for the Future (SAHF), will discuss the Medicaid business case for housing as a platform to serve the health needs of other low-income populations.

HMA Upcoming Webinar: *"Managed Care and Individuals with Intellectual and Developmental Disabilities: Innovative Approaches to Care Coordination"*

Tuesday, November 4, 2014
1:00 PM Eastern
Register Here

There is a growing focus among states on improved care coordination for Individuals with Intellectual and Developmental Disabilities (I/DD). Strategies vary, from traditional managed care arrangements to accountable care organizations and innovative partnerships involving physicians, hospitals, developmental disability and behavioral health providers, nursing homes, and others. During this webinar, HMA's Shane Spotts, a leading expert on trends in managed care and I/DD, will provide an overview of the most recent initiatives, including an assessment of what's working and why.

HMA's Accountable Care Institute Launches Quarterly Case Studies

As part of its effort to share experiences related to the development of community-specific integrated delivery systems that provide a better patient experience, control costs, and provide vehicles for the integration of medical, behavioral, and social approaches to maintaining and enhancing health status, the Accountable Care Institute (ACI) has launched an initiative to send and post relevant case studies on a quarterly basis that describe a specific health care challenge, solution, and the subsequent results. To receive these quarterly case studies, please sign up here. To see the first ACI case study that was released last week on Cook County Health and Hospital System, please click here.

HMA Upcoming Appearances

Community Health 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

HMA WELCOMES

Jean Glossa, M.D., Principal – Washington, D.C.

Jean comes to HMA most recently from Molina Healthcare of Virginia where she has served as the Medical Director for the Community Health Care Network of Fairfax County for the past seven years. In this role, Jean was the executive leader for all aspects of the $10M medical management contract with Fairfax County. She was the physician champion for technology solutions including the implementation of EMR and PM systems, telemedicine program, patient portal, integrated medical devices, scanning programs, interfaces with pharmacy and lab programs, vaccine registry, and county enrollment database. Jean was also in charge of executive oversight for all workflow changes, customizations, upgrades, and system enhancements for three sites and over 100 end users; leader for NCQA PMCH Level 3 Recognition which includes novel multidisciplinary care team model and chronic disease management programs; creator and director of integrated primary care/behavioral health program with proven outcomes; medical lab physician director for moderate complexity COLA labs; and physician pharmacy director for in-house independently licensed high volume pharmacies that provide an extensive formulary and pharmaceutical assistance programs.

Also, while at Molina, Jean served in several different roles over the last few years to include providing medical leadership for Molina's American Family Care Division where she provided medical oversight for Medicaid primary care clinics in Florida; Molina (MHI) Telehealth workgroup; and Molina Business Development.

Additional positions that Jean has held include Medical Director for Community Healthcare Network in Fairfax County, VA; Assistant Professor of Medicine – Internal Medicine Residency Program, Medical Director of the Center for Women's Health, and Practicing Internist as the USA Knollwood Physicians Group at the University of South Alabama; Vice Chief of Medical Staff and Chief of Service Department of Medicine at Sitka Community Hospital in Alaska; Practicing Internist at Moore Clinic in Alaska; Associate Medical Director of Community Healthcare Network in Fairfax County; Practicing Internist with Tampa General Hospital Family Care Center; and Assistant Professor with the University of South Florida Department of Internal Medicine.

Jean received her MBA with a concentration in healthcare from Auburn University College of Business. She completed medical school and her Internal Medicine residency at the University of South Florida and she received her BS in Biology (magna cum laude) from Jacksonville University. Jean is certified through the American Board of Internal Medicine.

Lee Repasch, Principal – Denver, Colorado

Lee comes to HMA most recently from CMS in Denver where she has worked for the past four years. In her most recent role as a Health IT Specialist, Lee served as Regional Coordinator for the Medicaid Health Information Technology for Economic Health (HITECH) Program where she served as the point of contact for technical assistance for four regions relating to the development, implementation, and maintenance of the HITECH programs to include review of State Medicaid Health IT Plans, Advanced Planning Documents, RFPs, and subsequent contracts between states and vendors. Lee

served as the lead/point of contact for Arkansas, Colorado, Utah, Wyoming (co-lead for Montana, North Dakota, South Dakota) in regard to the development of Medicaid Eligibility and Enrollment Systems in order to become compliant with the ACA.

Prior to joining CMS, Lee worked for George Washington University in several roles over her 14 years with them. She began as a Research Associate for several years and transitioned into a Research Scientist. Lee became a Senior Research Scientist and ultimately a Lead Research Scientist. In her role as Lead Research Assistant Lee developed and managed multiple proposals and wrote/edited white papers, issue briefs, policy briefs, and project summations. Key projects included Health Information Technology Adoption Initiative; Secure Messaging; Privacy and Security Whitepapers; and Medicaid and CHIP managed care contracting practices.

Other positions that Lee has held include Editorial Assistant for Congressional Quarterly and Information Specialist for The Library of Congress, Congressional Research Service.

Lee received her Master of Arts degree from the Korbel School of International Studies at the University of Denver and her Bachelor of Arts degree in International Affairs from Lock Haven University.

Ian Randall, Senior Consultant – Olympia, Washington

Ian comes to HMA most recently from the Veterans Health Administration where he has been a Research Specialist in the Health Services R & D Division for the last few years. In this role he investigated the impact of the VHA patient-centered medical home-based Patient Aligned Care Team (PACT) model on utilization as well as cost and quality outcomes. Additionally, he conducted analytics and support development of a medical home implementation index using administrative and survey data.

He recently finished up his work as a Project Consultant for Public Health – Seattle King County where he designed a system to monitor the impact of the ACA on cost, utilization, quality, population health, and workforce capacity in King County. While there he helped coordinate with the WA Health Benefit Exchange to calibrate PH-SKC outreach efforts based on dynamic enrollment patterns. Ian also served as a Project Consultant for the Washington Office of the Insurance Commissioner where he helped develop the Risk Adjustment and Reinsurance programs for the WA HBE.

Ian was also a Consultant with the Strategy & Operations division of Deloitte Consulting for several years. In this role he led a clinical effectiveness assessment and implementation at a $1.3B health system. Other projects that he worked on included performing supply chain contract assessment project at a health system; developed ICD-10 analytics framework and co-authored a transition issue CMS report from health insurance industry consortium; and spearheaded a strategic planning project analysis for one of the nation's largest not-for-profit health systems.

Ian is currently finishing his Ph.D. in Health Services Research (Health Finance Concentration) at the University of Washington School of Public Health. He received his Master of Health Services Administration degree from the University of Michigan School of Public Health and his Bachelor of Arts (with honors) in International Relations from Michigan State University.

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

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