Health Management Associates

# HMA Weekly Roundup

Trends in State Health Policy

*May 21, 2014*

RFP Calendar

Dual Eligibles Calendar

HMA News

**Edited by:**
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

## This Week


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## In Focus

### Indiana Proposes Alternative Medicaid Expansion

This week, our *In Focus* section reviews the alternative Medicaid expansion proposal and draft waiver unveiled by Indiana Governor Mike Pence's administration. The proposal builds on Indiana's existing Healthy Indiana Plan (HIP), requesting approval from the Centers for Medicare & Medicaid Services (CMS) for HIP 2.0, which would expand coverage to those below 138 percent of the federal poverty level (FPL). Under HIP 2.0, individuals would receive coverage through private insurers, with spending accounts jointly funded by enrollees and the State of Indiana to cover cost-sharing expenses. Governor Pence's administration is planning a public comment period over the next month, with a goal of finalizing the waiver submission to CMS in late June 2014. The State of Indiana estimates that anywhere between 334,000 and nearly 600,000 individuals would be eligible for HIP 2.0. Additionally, Governor

Pence's administration is submitting a renewal waiver for the existing HIP program as a contingency if the new HIP 2.0 waiver cannot be approved before the expiration of the existing waiver.

**Link to HIP 2.0 Waiver (PDF):**
*http://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_Final_Draft_5_14_14.pdf*

**Link to HIP 2.0 Homepage:**
*http://www.in.gov/fssa/hip/2442.htm*

## HIP Background

Since 2008, HIP has enrolled working-age, uninsured adults in one of four health plans. HIP targets non-disabled adults ages 19 through 64, with incomes below 100 percent FPL who are not otherwise eligible for Medicaid. There is no enrollment limit on parents and caretaker relatives in HIP, but non-caretaker enrollment is capped at 36,500. HIP enrollees are required to contribute 2 percent of income to a HSA-like account called a Personal Wellness and Responsibility (POWER) account. The state of Indiana contributes the remaining amount up to the annual deductible.

HIP benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, laboratory services, and other therapies, but do not include non-emergency transport, dental, or vision services. According to the state's draft Waiver proposal, the current HIP benefits do not meet CMS requirements for benchmark-equivalent coverage.

## HIP 2.0

The HIP 2.0 waiver proposes the following eight changes to the HIP program and Indiana's traditional Medicaid program:

1. Eliminate traditional Medicaid and expand HIP to all non-disabled adults ages 19-64 under 138 percent FPL without enrollment caps;
2. Create an optional defined contribution premium assistance program to promote family coverage and private market options over public assistance programs;
3. Augment the POWER account for all HIP members with a new rollover methodology which maintains incentives for preventive care and judicious management of the account;
4. Lower monthly POWER account contribution amounts based on the member's household income level to assure affordability, while maintaining the contribution requirement;
5. Offer a new enhanced benefit plan to include vision and dental services for individuals making consistent POWER account contributions;
6. Offer a basic benefit plan with required co-payments for all services for members under 100 percent FPL choosing not to make POWER account contributions;
7. Adjust non-payment penalties for all members; and
8. Support HIP member self-sufficiency by requiring individuals to be referred to job search and training programs.

Beginning in 2015, although timing is dependent on the approval of the waiver, nearly all Indiana residents with incomes below 138 percent FPL between the

ages of 19 and 64 would be eligible for HIP 2.0, enrolling in either HIP Plus or HIP Basic. Aged and disabled (ABD) Medicaid beneficiaries, along with dual eligible beneficiaries, would be ineligible for HIP coverage as they are today.

**HIP Plus** will be the only option for eligible individuals with incomes between 100 percent and 138 percent FPL, and is optional for individuals with incomes up to 100 percent FPL. Under HIP Plus, enrollees would receive an expanded benefit package beyond what is covered in HIP Basic. Under HIP Plus, enrollees would contribute between $3 and $25 monthly to their POWER account, with the remainder provided by the state. Failure to make contributions would result in disenrollment and a 6-month lockout (reduced from the current 12-month lockout under HIP) from the program for individuals with incomes above 100 percent FPL. Failure to make contributions for individuals with incomes below 100 percent FPL would result in a transfer to the HIP Basic program.

**HIP Basic** will only be available for those individuals with incomes up to 100 percent FPL and provides a more limited benefit package. However, enrollees will not be required to make contributions to their POWER account. Instead, the State of Indiana will fully fund the POWER account, but enrollees will be responsible for co-pays on all non-preventative services that may exceed the POWER account annual amount. HIP Basic cost-sharing will be monitored to ensure individuals do not pay more than 5 percent of annual income in cost-sharing. Additional detail on HIP Plus and HIP Basic covered benefits and POWER account rollover scenarios from year-to-year are included in the draft waiver.

Beginning in 2016, again dependent on timing of waiver approval, HIP 2.0 intends to begin the optional **HIP Link** program for HIP eligible individuals with access to employer sponsored insurance (ESI). Under HIP Link, eligible beneficiaries would receive premium assistance from the state to enroll in ESI, with an adjusted POWER account for out-of-pocket cost-sharing requirements.

### Current HIP Insurers and Enrollment

HIP enrollees currently have a choice among three health plans – WellPoint's Anthem Blue Cross and Blue Shield, Centene's Managed Health Services (MHS), and local non-profit MDwise. Additionally, the HIP Enhanced Services Plan (ESP) is available for certain individuals with conditions like cancers, HIV/AIDS, hemophilia, and others requiring additional support. The ESP plan is administered by Affiliated Computer Systems (ACS). As of April 2014, more than 55 percent of HIP enrollees have selected Anthem as their HIP plan.

| Healthy Indiana Plan (HIP) Health Plan | April 2014 Enrollment | % of Total |
|---|---|---|
| Anthem (WellPoint) | 26,465 | 56.6% |
| MDwise | 11,973 | 25.6% |
| Managed Health Services (MHS) (Centene) | 8,012 | 17.1% |
| Enhanced Services Plan (ESP) | 268 | 0.6% |
| **Total HIP Enrollment** | **46,718** | |

*Source: State Enrollment Data, April 2014.*

# HMA Medicaid Roundup

## Arkansas

**Arkansas Hospitals See Favorable Results from Medicaid "Private Option" Alternative.** On May 15, 2014, *Benefits Pro* reported that Arkansas hospitals are reporting treating fewer patients who are unable to pay their bills. The hospitals report similar trends in the number of uninsured patients admitted to the hospital, with admission rates of uninsured patients decreasing 20 percent to almost 60 percent. Critics say the Arkansas "private option" Medicaid expansion program has still resulted in cost overruns. Read more

## California

### HMA Roundup – Alana Ketchel

**Brown's Budget Adds $1.2 Billion to Medi-Cal.** On May 14, 2014, *California Healthline* reported that Governor Brown's new 2014-2015 budget proposal includes an additional $1.2 billion to cover 800,000 Medi-Cal lives that were eligible prior to Medicaid expansion under the Affordable Care Act. The budget also expands funding for the California Public Employees Retirement System (CalPERS), early childhood education, and increasing In-Home Supportive Services' caseloads. Additional Medi-Cal funds were aimed at expanding mental health and substance misuse programs, increasing managed care rates, and enhancing technology around eligibility determination. The total number of Medi-Cal enrollees is expected to grow to 11.5 million by 2015, representing 30 percent of the population. The plan also allocates $12.4 million to the state's prison medical center. Read more

**Orange County Approves Court-Ordered Mental Health Care.** On May 13, 2014, the *Los Angeles Times* reported that Orange County became the first large California county to adopt Laura's Law, allowing for court-ordered treatment of the severely mentally ill. The county will allocate over $4 million a year in Mental Health Services Act funds towards assessment and treatment of approximately 120 people. Eligible individuals must have a recent history of violence and have been jailed or hospitalized due to their mental illness. Read more

**Diabetics Make Up One Third of Hospitalized Patients Over 34.** On May 15, 2014, *Kaiser Health News* reported on a recent UCLA/CA Center for Public Advocacy study which found that roughly one third of hospitalized patients over 34 years old in California have diabetes. Inpatient stays for diabetic patients cost roughly $2,200 more than for patients without the disease. Diabetes was the primary cause of hospitalization in only 1.7 percent of cases; however, it is

linked to costly conditions such as kidney and heart disease, blindness and limb amputations. Read more

**Covered California Adds Special Enrollment Period for COBRA Policyholders.** On May 15, 2014, Covered California announced that it will create a limited-time special enrollment period for people who are enrolled in COBRA and wish to switch to an exchange plan. COBRA beneficiaries can shop for coverage on Covered California through July 15. Current COBRA policyholders who qualify for subsidies through Covered California may be able to find more affordable coverage than their current plan. Read more

**Advocates Concerned with Medi-Cal Renewal Process.** On May 19, 2014 the California Healthline reported on stakeholder concerns about a form Medi-Cal beneficiaries must complete to renew their coverage. Advocates say the new form requires more effort to complete, is more complex than previous forms, and is only available in English and Spanish. A representative from the Santa Barbara County Department of Social Services responded that the new form will simplify redetermination and that the state will contact beneficiaries who do not complete the form by the deadline before they lose coverage. Read more

**Report Highlights Needed San Francisco Public Health System Reform.** On May 12, 2014, the *San Francisco Business Times* discussed a March 2014 report from the City of San Francisco that highlighted public health system budget concerns that, if left unaddressed, will require General Fund subsidies of unsustainable levels in the next five years. The report, which featured insights from the city's engagement with Health Management Associates, details steps needed to sustain the Department of Public Health in the new era of health reform, including increasing patient care access and improving quality, enhancing care management, and pursuing opportunities to increase revenue and control spending. Read more

**Home Care Workers Worry about Consequences of Proposal to Limit Their Hours.** On May 19, 2014, the *Sacramento Bee* reported on concerns from California's home care workers about a proposal from Governor Jerry's Brown budget, which would limit the amount of time for which the state would compensate home care workers. Brown's budget would bar home care workers from putting in more than 40 hours a week. Care providers argue that limiting their hours will put significant financial strain on them and could jeopardize the quality of care their clients receive. Labor unions believe that Governor Brown's proposal is an attempt to deny home care workers overtime compensation. Read more

# Colorado

### HMA Roundup – Joan Henneberry

**Governor Hicklenlooper Signs Bill for Hepatitis C Screening.** On May 19, 2014, *FOX 31 Denver* reported that Governor John Hickenlooper signed into law a bill that would recommend primary care physicians offer screenings for hepatitis C to all baby boomers (those born between 1945 and 1965) through a simple blood test. It is estimated that some 50,000 people in Colorado may have the disease, but are not aware of it because they are asymptomatic. Read more

**Colorado Insurance Rating Areas Decrease from Eleven to Nine**. On May 19, 2014, the *Denver Post* reported that the State Department of Health and Human Services has approved the proposal submitted by the Colorado Division of Insurance to reduce the number of insurance rating areas in the state from eleven to nine. Insurance Commissioner Marguerite Salazar asked for the change in response to protests from several mountain communities located near ski resorts, where the health care premiums were among the highest in the country. For instance, a 40-year-old resident of Garfield, Eagle, Pitkin, or Summit counties would pay $483 a month for a policy compared to $280 for the same person in Denver. Commissioner Salazar believes that consolidating the higher health cost regions into larger rating areas and spreading the risk will reduce the premiums in those four counties. The proposal also combines two Eastern Plains rating areas consisting of 26 counties. Read more

**Dental Benefits for Kids and Enrollment Efforts.** Community Health Centers played an integral role in educating Coloradans about new coverage options and providing enrollment assistance during this first open enrollment period for new health coverage. Outreach and Enrollment (O&E) staff at Colorado's 19 CHCs helped more than 57,800 individuals enroll in coverage between July 2013 and March 2014 – or about 19 percent of the total individuals enrolled.

**Pediatric Dental Benefit Law Passed**. This week, the Colorado Community Health Network announced that House Bill 14-1053 passed this legislative session. The bill will allow the Commissioner of Insurance to adopt rules that ensure requirements for pediatric dental benefits in Colorado's health benefit plans are consistent regardless of whether a plan is purchased inside or outside of the state's Health Insurance Marketplace. Previously, only plans purchased outside of the Marketplace were required to include pediatric dental benefits. Read more

## Georgia

### HMA Roundup – Mark Trail

**DCH Announces Intent to Award Pharmacy Rebate and Integrated Eligibility System Contracts.** On May 13, 2014, the Georgia Department of Community Health (DCH) announced that it will extend its current contract with Goold Health Services to provide Medicaid Pharmacy Rebates services associated with the Care Management Organizations (CMOs) that deliver health care services on a prepaid, capitated basis to Georgia Medicaid and PeachCare for Kids members. These services are part of DCH's Medicaid Redesign effort, which aims to improve health outcomes for Medicaid members and achieve long-term, sustainable savings. DCH also announced its intent to award an Integrated Eligibility System Contract to Deloitte Consulting, LPP. The contract requires that the vendor design, develop, and implement a system that utilizes a single point of entry that will allow seamless eligibility processing for Georgians requesting assistance. The system will support eligibility for Medicaid and PeachCare for Kids, as well as several other state-administered assistance programs. Read more

**Central Georgia Health System and BCBS Agree to New Contract.** On May 15, 2014, the *Macon Telegraph* reported that the Central Georgia Health System and Blue Cross Blue Shield agreed to a new contract. According to Central Georgia Health System CFO Rhonda Perry, the new contract "assures that we are in

network and business will continue as usual for each of our (BCBS-insured) patients." Blue Cross Blue Shield administers Georgia state workers' health benefit plan, including those of retirees. Central Georgia Health System includes The Medical Center of Central Georgia, The Medical Center of Peach County and Central Georgia Rehabilitation Hospital. Read more

## Illinois

**Governor Quinn Announces New Funding for Community Health Centers.** On May 14, 2014, *AP* reported that Illinois Governor Pat Quinn has allocated $14.5 million in funds towards renovating and building community health centers around the state. The funds are part of the state's $31 billion "Illinois Jobs Now" capital construction program. Quinn said that investing in community health centers is a "critical and essential step" in transforming Illinois' health care system. Read more

## Indiana

**New Medicaid Changes Could Leave Thousands without Coverage.** On May 19, 2014, *NBC/WTHR Indiana* reported that some Indiana families that are covered by Medicaid might lose their coverage when the state ends its Medicaid "spend down" program on June 1, 2014. Last year, state lawmakers voted to set a strict income cap for Medicaid beneficiaries, with the understanding that beneficiaries who earned more than this cap would be moved into Medicare savings programs or into marketplace programs. But thousands of Hoosiers across the state who make too much face the threat of a period with limited to no benefits until their new Medicare or marketplace programs kick in. The state is currently implementing steps to try to keep people from falling through the cracks. Read more

## Maine

**Governor LePage Calls for Increased Nursing Home Funding**. On May 14, 2014, the *AP/Miami Herald* reported that continuing debate in the state Legislature over nursing home funding might jeopardize the financial stability of nursing homes. Governor Paul LePage proposed a bill to use tobacco settlements funds to increase Medicaid reimbursements for the state's nursing homes by $5 million; lawmakers rejected this bill. LePage charges lawmakers with rejecting the bill without coming up with alternative funding for the nursing homes before the end of the legislative session. Read more

**Consultants Recommend Medicaid Program Overhaul in Maine.** On May 15, 2014, the *AP/Greenfield Daily Reporter* reported that consultants hired by Governor LePage's administration have advised the state to seek a Medicaid waiver that would provide it the flexibility to overhaul its Medicaid program. Consultants from the Alexander Group argued that ACA Medicaid expansion would be fiscally unsustainable in Maine; the group believes that Maine needs to create a custom Medicaid program that allows it to maintain healthcare for its most vulnerable populations, most notably the developmentally disabled and the indigent elderly. Democratic lawmakers dismiss the waiver recommendation as political campaign fodder. Read more

# Massachusetts

**Nursing Homes Face Steep Shortfalls, Struggle to Provide Services With Limited Budgets**. On May 19, 2014, the *Boston Globe* reported that low Medicaid reimbursement rates are threatening the solvency of nursing homes across Massachusetts. Medicaid rates have not increased in nearly a decade; this has led to a statewide shortfall of $350 million, or $37 per patient per day. Such low reimbursements have resulted in the closure of 50 nursing homes in the state over the past ten years. State officials argue that rates do not have to be raised because fewer people are using nursing homes now that home care treatment options have been made available. However, with more than half of the remaining nursing homes in the state currently in the red, patients that still rely on nursing home care face the imminent threat of losing their services. Read more

# Minnesota

**Governor Dayton Signs Bill Granting Autonomy to Advanced Practice Registered Nurses.** On May 13, 2014, *Minnesota Public Radio* reported that Governor Mark Dayton has signed a bill that gives advanced practice registered nurses the authority to practice without physician supervision. The licensing change will go into effect on January 1, 2015, and applies to nurse-midwives, nurse practitioners, clinical nurse specialists and registered nurse anesthetists. Minnesota is the ninth state to grant full practice and prescribing autonomy to all four categories of advanced practice nurses. Read more

# Missouri

**Medicaid Expansion Effectively Dead as Session Nears End.** On May 14, 2014, the *St. Louis Business Journal* reported that Medicaid expansion is likely a dead issue in this year's legislative session. Kansas City Senator Ryan Silvey made one last attempt to include expansion as part of a proposed reform of entitlement programs. While Silvey's attempt gained the support of several Republican lawmakers for its unique approach of coupling expansion with entitlement reforms long sought after by Republicans, the proposal was quickly rejected by several adamant opponents of expansion. Read more

# Nebraska

**Nebraska Medicaid Delaying Development of MLTSS Program.** On May 13, 2014, the Nebraska Department of Health and Human Services reported that Nebraska Medicaid will temporarily suspend work on the development of a statewide Medicaid managed care program for the delivery of long-term services and supports (MLTSS). This is necessary to devote Department resources to the application for a Balancing Incentive Program (BIP) grant, which will put in place infrastructure to strengthen access to long-term services and supports statewide. Read more

# Nevada

**Nevada Scraps State-Based Exchange Marketplace in Favor of Federal Exchange.** On May 20, 2014, *POLITICO* reported that Nevada has decided to drop its problematic state-based exchange marketplace and adapt the HealthCare.gov site for at least one year. As of May 10, 2014, 35,000 Nevadans signed up for insurance coverage through the site, far short of the original enrollment goal of 118,000 people. The exchange was plagued with informational inaccuracies, even calculating incorrect subsidy amounts for low-income residents. Nevada is the fourth state that has opted to scrap its exchange in favor of a more functional one. Read more

# New Jersey

## HMA Roundup – Karen Brodsky

**ACA Requires Medicaid Provider Re-enrollments.** The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) will begin re-enrolling all fee-for-service New Jersey Family Care (NJFC) providers on June 1, 2014. This action is in response to a requirement under the Affordable Care Act (ACA) that Medicaid programs will need to re-validate their providers every five years. DMAHS must complete the re-enrollment process by March 2016. Providers who enrolled or re-enrolled in NJFC on or after January 1, 2013 are exempt from re-enrollment at this time. Molina Medicaid Solutions, the fiscal agent for DMAHS, will begin mailing re-enrollment packets by provider type in monthly stages. Read more

# New York

## HMA Roundup – Denise Soffel

**New York State of Health Marketplace.** At a forum sponsored by the New York Academy of Medicine, staff from New York's health exchange provided some observations and information about the experience of the exchange to date:

- While New York had initially wanted to establish their exchange as a public benefit corporation, the decision to house it within the Department of Health actually resulted in some benefits. The state was committed to an integrated enrollment and eligibility process with a single point of entry into the marketplace, and being housed with a state agency facilitated a close integration with Medicaid.
- Enrollment surged on the last days of open enrollment. That happened in December, and again in March. The last two days in December saw 26,000 enrollments, and 2,900 calls per hour to the call center. Seventy-five percent of all enrolments through the marketplace occurred after January 1, 2014.
- The state is preparing a report profiling enrollment, which should be released in the next couple of weeks. They indicated that they have a good distribution across metal levels, although with a preponderance of silver plans. All plans received enrollments; four plans had at least 14 percent of all enrollments. Over one-third of enrollees were between the ages of 18 and 34, and 70 percent were uninsured at the time of

enrollment. About 75 percent of individuals enrolling in a qualified health plan has income below 400 percent of the federal poverty level, and qualify for subsidies. Enrollment numbers and demographics for QHPs tracked with forecasts.

- Medicaid enrollment was much stronger than anticipated. In six months, the state has already passed new Medicaid enrollment that Urban Institute forecasted by 2016. Medicaid enrollment continues to be strong, with an estimated 5,000 new enrollments per day. The state does not know whether these are individuals who are completely new to Medicaid, or whether they are individuals who failed to renew at some point and fell out of the program. They believe that making enrollment easier and faster has made a huge difference. Instead of the usual 30 or 45 day enrollment timeframe, enrollments through the marketplace are generating decisions about Medicaid eligibility in 24-48 hours.

**Health Plans form Strategic Alliance.** CDPHP and Independent Health announced a strategic alliance to explore opportunities to enhance their efforts to further transform health care in their respective communities, while remaining independent. The partnership is intended to benefit key stakeholders, in particular customers and providers, by sharing best practices and expertise, in all areas of each company's respective operations. Independent Health, headquartered in Buffalo, and CDPHP, located in Albany, are non-competing, regional health plans serving different geographic markets. CDPHP operates in 24 counties in the central part of the state; Independent Health operates in 8 counties in Western New York. Both health plans are not-for-profit organizations. As part of the strategic alliance, the two companies will look to:

- Develop innovative tools to help health care providers manage their entire populations and provide patient care in the most efficient manner;
- Partner with physicians through technology and clinical innovation to provide patients the right care, in the right place, at the right time and with the right level of cost;
- Invest in new technology to provide consumers easy access to the information and services they need to navigate the often fragmented health care system;
- Develop new products with the consumer at the center, rather than the delivery system.

**Beneficiary Concerns Cited as Medicaid Shifts Long Term Care Services to Managed Care.** On May 8, 2014, the *New York Times* reported the shift of public spending on long-term services for the aged and disabled to managed care companies has resulted in controversial enrollment tactics on the part of managed care companies. Interviews with patients, patient advocates and industry insiders cited instances in which patients in large adult homes felt harassed by managed care companies to sign up for coverage, and that managed care employees have received proposals to take on enrollees in exchange for money. Read more

# Pennsylvania

## HMA Roundup – Matt Roan

**UnitedHealthcare Community Plan of PA to offer Text Messaging Program to Medicaid Members.** UnitedHealthcare Community Plan of Pennsylvania has announced a new program for Medicaid members in the Commonwealth called Txt4health, which will use text messaging to remind members about key preventive health visits and share information about vaccinations and healthy behaviors. The initiative was driven in part by a recent consumer survey by PricewaterhouseCoopers which found that 79 percent of Medicaid recipients use text messaging as compared to only 43 percent of Medicare recipients and 68 percent of people enrolled in employer-sponsored programs. Read more

**Democratic Candidates for Governor would Scrap Healthy PA, Establish State Run Insurance Exchange.** On May 20, 2014, Pennsylvanians went to the polls in a primary election to choose a Democratic challenger to incumbent Republican Governor Tom Corbett. All four Democratic candidates said that if elected, they would scrap the Governor's Healthy PA proposal and pursue traditional Medicaid expansion. The candidates also agreed that if elected, they would pursue the implementation of a state-based health insurance marketplace and withdraw from the Federally Facilitated Marketplace. Businessman and former State Secretary of Revenue Tom Wolf won the primary with 58 percent of the vote and will face Governor Corbett in the general election in November. Wolf's plan for improving healthcare in Pennsylvania can be found here.

**Pennsylvania Senate Democrats hold Public Hearing on UPMC/Highmark Dispute.** On May 16, 2014, the *Pittsburgh Post-Gazette* reported on last week's Pennsylvania Senate Democratic Policy Committee meeting, in which the Committee received public feedback on the ongoing dispute between western PA healthcare giants UPMC and Highmark. Contract disputes between the two integrated health systems may result in patients insured through Highmark, the local Blue Shield plan, being unable to receive treatment at UPMC facilities. Consumers testified to the Committee that the State government should intervene to prevent potential disruption in patient care. Several area legislators are pursuing legislation that would require integrated delivery systems such as UPMC and Highmark to contract with "any willing insurer," thus preventing the potential practice of shutting down access to facilities as a way to harm a competing health insurer. Read more

**Joint Legislative Report Recommends More Funding for Mental Health Services.** On March 18, 2014, the *Pittsburgh Post-Gazette* reported that a new study by the Joint State Government Commission which recommends increased funding to support a robust community mental health services system in order to prevent unnecessary institutionalization of Pennsylvanians with serious mental illness. The report, which has been developed over the past year, compared the average costs of state mental hospital institutionalization ($144,072) to correctional facility costs ($36,300) and community-based mental health treatment ($2,322). While the report does not make specific recommendations on the amount of additional funding that is needed, the Commission observed that mental health providers are seeking restoration of a 10 percent funding cut that was enacted as part of the 2013-2014 state budget. The report also echoed recent recommendations from the Pennsylvania Medical Society calling for a statewide tracking system to identify available psychiatric beds in community hospitals. Read more

# *Puerto Rico*

## HMA Roundup – Juan Montanez

**Government Health Plan (*Mi Salud*) Managed Care RFP.** The full-risk MCO RFP which called for "full" integration of physical and behavioral health services within the *MI Salud* program was released on February 5-6 and then cancelled on May 9. The reasons given for the cancellation were:

- Triple-S (Blue Cross Blue Shield of Puerto Rico) hoped to negotiate contract provisions regarding the "quality withhold" (5% of premium), the cap on "profits" (1.5% of premium) and the implementation timing which the Health Insurance Administration (Spanish acronym *ASES*) had indicated were non-negotiable.
- Initially Triple-S had submitted a bid that covered all nine program regions; subsequently it amended its bid to only cover several regions. This left one program region without a proposal from any bidder.
- Renewed concerns within the administration and the CMS Regional Office in New York about the transition from the existing system to three plans operating an entirely different model happening over, at most, a four-month period. This was not seen as practical or prudent.
- ASES not wanting or being able to operate a "hybrid" where some regions would be under the new full-risk managed care arrangement while others would be on the current physical health ASO/risk-based BHO system. Both ASES and the Medicaid Office of the Department of Health (which determines eligibility for *Mi Salud*) have major IT and operations challenges.
- One of the bidders, Molina Healthcare, was not able to secure a certificate of authority from the Office of the Insurance Commissioner by the date ASES had set to announce contract awards.

A "new" RFP, which is not expected to be substantially different from the RFP issued in February, is expected sometime in June. The new timeline which the ASES Executive Director announced last week calls for contract awards by September and go-live on April 1, 2015 - plans would have up to six months to implement.

**"Health Care Reform" Pilot.** This much-discussed pilot, which is based on materials released to date, would be based on a patient-centered medical home model and implemented on the northwest region of the island. The pilot is still lacking implementation funding. Officials from ASES and the Department of Health have been working with the CMS New York Regional Office to identify ways to fund the pilot. A grant application submitted to CMS which could have helped fund the pilot was rejected on "technical" grounds.

**"Universal Access" Plan and its Three Components: *Mi Salud*, Basic Health Plan, and Open Enrollment.** Last October, Governor Alejandro Garcia-Padilla announced changes to the *Mi Salud* program that would result in more program beneficiaries being members of the "federal" population within the program (i.e. federal Medicaid or CHIP funds matched with local funds would be used to cover their health costs). This program design change would free up local funds which would be redirected to pay for a "basic health plan" (BHP) program, whereby the government would subsidize 100 percent of the premium for

"bronze-level" plans which would be offered in some type of marketplace. Individuals and families that make too much to qualify for *Mi Salud* but make less than $25,000 per year would qualify for this program.

The State Plan Amendment that would authorize Puerto Rico to make the aforementioned change in the *Mi Salud* program has not yet been approved by CMS. Moreover, details of the BHP program have yet to be announced. That notwithstanding, during his State of the Commonwealth address earlier this month the Governor indicated that the BHP program was going to be implemented by January 2015.

Last October, the Office of the Insurance Commissioner oversaw an "open enrollment" program through which uninsured individuals and families could acquire ACA-compliant health insurance products. The open enrollment program was managed in accordance with Chapter 10 of Puerto Rico's Health Insurance Code. No subsidies are available under this program; on the other hand U.S. territories are exempt from the individual mandate and the Commonwealth opted not to implement such a mandate. It has been reported that this program resulted in approximately 20,000 new subscribers to health insurance plans – mainly plans offered by Triple-S (Blue Cross Blue Shield of Puerto Rico) and First Medical Health Plan.

**Health Care Reform Initiatives**. Despite the attention currently being placed on reorganization of the Commonwealth government and reaching agreement on a truly balanced budget for the upcoming 2014-2015 fiscal year (year begins July 1, 2014), there is legislative activity on the health care reform front. Specifically, a bill to form a "multi-sectorial committee on health reform" is still being debated within the local legislature. The likelihood of this bill passing is unclear.

## *Virginia*

**Virginia Lawmakers Announce $300 Million Budget Shortfall; Lawmakers Still Polarized on Medicaid Expansion Issue.** On May 19, 2014, the *Washington Post* reported that Virginia is facing a $300 million shortfall in revenue collections, which would jeopardize the state's bond rating. House Appropriations Committee Chairman S. Chris Jones said that House and Senate lawmakers must work quickly to revise their budgets to reflect the shortfall; but each group is using the shortfall to bolster its case for or against Medicaid expansion. Senate lawmakers argued that expanding Medicaid, which would initially supply the state with $5 million per day, would go a long way towards coping with the budget shortfall. House lawmakers say expanding Medicaid would result in an even bleaker financial outlook for the state. Governor Terry McAuliffe has urged both the Senate and the House to work together to resolve the budget as soon as possible, as missing the July 1 bond payment date would tarnish the state's financial reputation. Read more

**State Launches Dual Eligible Demonstration.** On May 20, 2014, the *News Leader* reported that dual eligible beneficiaries in several parts of Virginia have received enrollment letters for the state's financial alignment demonstration. The "Commonwealth Coordinated Care" plan is open to around 78,000 dual-eligible Virginians aged 21 and older. Residents in the Staunton-Augusta-Waynesboro area have been sent letters to enroll in the demonstration. Read more

# Wisconsin

**Walker Calls Alternative Expansion Program a Success, Claims His Reforms Leave No Coverage Gap.** On May 19, 2014, the *Milwaukee Journal Sentinel* reported that more than 19,000 more low-income state residents are gaining coverage under Governor Scott Walker's alternative Medicaid expansion plan. Walker turned down federal funds for traditional ACA Medicaid expansion and opted instead to expand the state's BadgerCare Plus Medicaid program. The Walker administration announced that over 81,000 adults below the poverty line signed up for BadgerCare in recent months, while about 62,000 adults just above the poverty line were dropped from BadgerCare by March 31 and told to buy coverage under the federal health care law. Opponents of Walker's expansion plan point out that his administration has not released information about how many of these 62,000 residents were able to sign up in the exchange after being removed from BadgerCare. Read more

# National

**CMS Releases Basic Health Program FAQs.** On May 8, 2014, CMS released Medicaid and CHIP FAQs for the Basic Health Program, an optional health benefits coverage program for individuals between 133 and 200 percent of the Federal Poverty Level. Points of interest include:

- A state can enroll eligible individuals throughout the year - like Medicaid - or can limit enrollment of eligible individuals to open enrollment/special enrollment periods.
- A state must submit a BHP Blueprint to HHS that describes how the state will meet statutory and regulatory requirements in order to implement a BHP.
- The state must have a competitive process when contracting for BHP standard health plans. However, CMS will not be enforcing the competitive contracting process requirements in the event that the state is unable to implement such a process for program year 2015. The state must request the exception and it will only be available in program year 2015.
- While states must include in the contracting process consideration for contracting with managed care plans, they are not restricted from contracting with health plans that do not operate on a managed care basis.
- States can add state dollars to a BHP trust fund, but after deposit, they are subject to the rules applicable to the BHP trust fund and can only be used to lower premiums and cost sharing or to provide additional benefits. Read more

**Federal Regulation Allows Use of Federal Funds to Offset the Potential Losses of ACA Insurers.** On May 21, 2014, the *Los Angeles Times* reported on a recently published ACA regulation which would allow the federal government to tap funds set aside for other health programs to pay insurers if companies providing coverage through the ACA lose money. The provision reflects the Obama administration's efforts to keep insurance premium hikes down in 2015 and stabilize the exchange market, but it has unsurprisingly drawn the ire of ACA critics. Read more

**States Work to Enroll Ex-Prisoners into Medicaid.** On May 15, 2014, *Kaiser Health News* reported on growing Medicaid enrollment amongst recently-released prisoners in 26 states and how this can affect prisoners' health and their return to life outside of prison. Of the population that is newly eligible for Medicaid under ACA Medicaid expansion, experts predict one-third will be former inmates or detainees, many of whom suffer from mental illness, drug addiction and chronic health conditions. Keeping former inmates healthy could substantially reduce the likelihood that they commit additional offenses, thus improving their lives and reducing the financial burden on the prison system. County agencies in several states are currently working to develop systems that will automatically enroll eligible inmates for Medicaid coverage. Read more

# Industry News

**Kindred Healthcare Announces Proposal to Acquire Gentiva Health Services; Gentiva Rejects Proposal.** On May 15, 2014, post-acute care provider Kindred Healthcare, Inc. (NYSE:KND) announced a proposal to acquire all outstanding shares of the common stock of Gentiva Health Services, Inc. (NASDAQ:GTIV) for $14.00 per share in cash and stock in a $1.6 billion transaction. The combined company would operate in 47 states, employ 110,000 people and serve nearly 127,000 patients a day. Kindred's CEP Paul J. Diaz said that the acquisition would allow the company to use its resources and Gentiva's home health and hospice capabilities to provide efficient, cost-effective coordinated care. Gentiva's management board rejected the offer, explaining that Kindred significantly undervalued the company and would limit its future prospects. Despite this response, Kindred has shared the proposal with Gentiva shareholders and discussed the proposal in a live conference call with analysts and investors in an effort to get Gentiva to reconsider its decision. Read more

**Magellan Drops Arizona Behavioral Health Award Appeal.** On May 20, 2014, *Seeking Alpha* reported that Magellan Health Services has dropped its appeal of the Arizona Department of Administration's final decision denying Magellan's protest of the award of the new contract to another bidder. Magellan previously managed the Maricopa County behavioral health system; the company filed a series of protests and appeals when the state failed to renew its contract last year, which the Superior Court dismissed. Read more

**Inovalon Announces New Additions to Executive Leadership Team.** On May 19, 2014, healthcare technology company Inovalon, Inc. announced the appointment of Robert Wychulis as President and Thomas Kloster as Chief Financial Officer. Mr. Wychulis, who previously served as the President of the WellPoint New York government program health plan HealthPlus, will serve as the general manager of the Inovalon. He will be responsible for day-to-day product and service delivery, performance, support and client value achievement. Mr. Kloster, who previously served as the Chief Financial Officer at Algeco Scotsman, will be responsible for the oversight of all financial activities and relationships of the Company. Read more

**IASIS Heathcare and Humana Medical Plan Partner to Serve Florida Medicaid Members Using a Managed Care Program.** On May 19, 2014, the *Wall Street Journal Market Watch* reported that Health Choice, the managed care solutions organization of healthcare services provider IASIS Healthcare LLC, has been selected by Humana subsidiary Humana Medical Plan, Inc. to provide administrative and managed care services to Humana's Medicaid members in Florida. Humana and IASIS have carefully prepared for their new partnership in Florida, demonstrating the growing trend towards collaborating on patient-oriented, cost-efficient population health management models. Read more

**Insurer Highmark Initiates Three Year Deal with NaviHealth.** On May 20, 2014, health insurer Highmark, Inc. announced it has initiated a three-year partnership with naviHealth, a national post-acute care management company, to bring a personalized approach to support its 285,000 Medicare Advantage members across Pennsylvania. The collaboration will ensure that Highmark beneficiaries receive the most appropriate care to facilitate their recovery. Care coordinators from naviHealth will educate Highmark beneficiaries and their providers on the post-acute care options that are available and will coordinate care for the patients. Read more

**PwC US Reports U.S. Health Services Total Deal Value for Q1 2014 Rose 152% Compared to Q1 2013.** On May 20, 2014, *PR Newswire* reported that U.S. Health Services merger and acquisition total deal value rose 152 percent to $12.3 billion during Q1 2014 compared to the same period in 2013. "… having deal value jump 152 percent is an indication of renewed confidence in the industry as the dust settles from the implementation of the Affordable Care Act," said Brett Hickman, partner and PwC's U.S. healthcare deals leader. "Several indicators that we track point to robust M&A activity for the rest of the year. The impetus for greater alignment and size remains unchanged in the hospital sector – and for managed care deals, an increase is likely as these companies work to meet the required ACA milestones. Combined with positive signs we're seeing in the other health services sectors, we're optimistic that there will be heightened deal activity in 2014." Read more

# RFP Calendar

| Date | State | Event | Beneficiaries |
|---|---|---|---|
| Late May, 2014 | Indiana ABD | RFP Release | 50,000 |
| June 1, 2014 | Illinois Duals | Passive enrollment begins | 111,000 |
| June 1, 2014 | Florida acute care (Regions 5,6,8) | Implementation | 811,370 |
| June 6, 2014 | New York Behavioral (NYC) | Proposals Due | NA |
| June 12, 2014 | Delaware | Contract awards | 200,000 |
| June 13, 2014 | Texas STAR Health (Foster Care) | Proposals Due | 32,000 |
| June, 2014 | Washington Foster Care | RFP Release | 23,000 |
| July 1, 2014 | Florida acute care (Regions 10,11) | Implementation | 828,490 |
| July 7,2014 | Rhode Island (Duals) | Proposals due | 28,000 |
| July 16, 2014 | Texas NorthSTAR (Behavioral) | Contract Awards | 840,000 |
| Mid-July 2014 | Texas STAR Kids | RFP Released | 200,000 |
| August 1, 2014 | Florida acute care (Regions 1,7,9) | Implementation | 750,200 |
| September 1, 2014 | Texas Rural STAR+PLUS | Implementation | 110,000 |
| Late October 2014 | Texas STAR Kids | Proposals Due | 200,000 |
| November 3, 2014 | Georgia ABD | Implementation | 320,000 |
| January 1, 2015 | South Carolina Duals | Passive enrollment begins | 68,000 |
| January 1, 2015 | Texas Duals | Implementation | 132,000 |
| January 1, 2015 | Michigan Duals | Implementation | 70,000 |
| January 1, 2015 | Ohio Duals | Passive enrollment begins | 115,000 |
| January 1, 2015 | Washington Duals | Passive enrollment begins | 48,500 |
| 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 |
| September 1, 2015 | Texas NorthSTAR (Behavioral) | Implementation | 840,000 |
| September 1, 2015 | Texas STAR Health (Foster Care) | Implementation | 32,000 |
| September 1, 2016 | Texas STAR Kids | Implementation | 200,000 |

# Dual Eligible Financial Alignment Demonstration Calendar

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

| State | Model | Duals eligible for demo | RFP Released | RFP Response Due Date | Contract Award Date | Signed MOU with CMS | Opt- in Enrollment Date | Passive Enrollment Date | Health Plans |
|---|---|---|---|---|---|---|---|---|---|
| Arizona | | 98,235 | Not pursuing Financial Alignment Model | | | | | | |
| **California** | Capitated | 350,000 | X | 3/1/2012 | 4/4/2012 | 3/27/2013 | 4/1/2014 | 5/1/2014<br>7/1/2014<br>1/1/2015 | Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore) |
| **Colorado** | MFFS | 62,982 | | | | 2/28/2014 | | 7/1/2014 | |
| **Connecticut** | MFFS | 57,569 | | | | | | TBD | |
| Hawaii | | 24,189 | Not pursuing Financial Alignment Model | | | | | | |
| **Illinois** | Capitated | 136,000 | X | 6/18/2012 | 11/9/2012 | 2/22/2013 | 4/1/2014 | 6/1/2014 | Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina |
| **Iowa** | MFFS | 62,714 | | | | | | TBD | |
| 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 | 10/1/2014 | 1/1/2015 | |
| **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 | 132,600 | | | | | | 1/1/2015 | Amerigroup, Health Spring, Molina, Superior, United |
| **Virginia** | Capitated | 78,596 | X | 5/15/2013 | TBD | 5/21/2013 | 3/1/2014 | 5/1/2014 | Humana; Health Keepers; VA Premier Health |
| Vermont | | 22,000 | Not pursuing Financial Alignment Model | | | | | | |
| **Washington** | Capitated | 48,500 | X | 5/15/2013 | 6/6/2013 | 11/25/2013 | 10/1/2014 | 1/1/2015 | Regence BCBS/AmeriHealth; UnitedHealth |
| | MFFS | 66,500 | X | | | 10/24/2012 | | 7/1/2013;<br>10/1/2013 | |
| Wisconsin | Capitated | 5,500-6,000 | X | Not pursuing Financial Alignment Model | | | | | |
| ***Totals*** | **11 Capitated<br>6 MFFS** | **1.3M Capitated<br>520K FFS** | ***12*** | | | ***10*** | | | |

** 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 Medicare ACO: Effective Care Management and its Anticipated Impact"***

**Wednesday, May 28, 2014, 2:00 p.m. EDT.**

**Register here**

Health Management Associates is hosting the second in a three-part webinar series on becoming a Medicare Accountable Care Organization (ACO). "The Medicare ACO: Effective Care Management and its Anticipated Impact" will be presented at 2 p.m. EDT Wednesday, May 28, 2014.

Care management is an important component for meeting the Triple Aim. However, care management alone without the systems, infrastructure, and culture of team work within organizations will lead to limited progress. HMA Accountable Care Institute experts will discuss:

- Lessons learned from the latest Medicare demonstrations
- Characteristics of successful programs
- Care management's return on investment
- Population management and workflows
- Building blocks for care management success

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