HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 23, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

ILLINOIS' UPDATED MEDICAID CARE COORDINATION ROLLOUT

This week, our *In Focus* section reviews an updated rollout plan for Illinois Medicaid's care coordination initiatives. Under a 2011 Medicaid reform law (P.A. 96-1501) passed by the state's legislature and signed by Governor Pat Quinn, the state's Medicaid agency – The Department of Healthcare and Family Services (HFS) – is mandated to transition a minimum of 50 percent of all Medicaid beneficiaries into "care coordination" by January 1, 2015. Shortly after the law was enacted, HFS determined that the state's Medicaid Primary Care Case Management (PCCM) program, one of the largest in the nation at more than 1.6 million enrollees, would not meet the definition of care coordination. Illinois' care coordination transition is notable for both its scope and structure:

- Rather than transitioning fully to a traditional Medicaid managed care program, HFS has, through a series of procurements, engaged provider-led care coordination entities (CCEs) and accountable care entities (ACEs) to operate alongside traditional Medicaid managed care organizations (MCOs).
- Illinois has moved first to transition the most complex recipients – aged, blind, and disabled and dual eligibles – into commercial managed care plans.

- Governor Quinn's FY 2105 budget proposal, released in late March, estimates that only 16.4 percent of Medicaid beneficiaries will be enrolled in coordinated care at the end of FY 2014, compared with more than 71 percent by the end of FY 2015.
- Governor Quinn's budget proposes estimated medical assistance payments to Medicaid MCOs of more than $3.06 billion in FY 2015, more than four times the estimated $738.1 million to be spent in FY 2014.
- All told, more than 2 million Medicaid beneficiaries, including dual eligibles and ABD populations, will be transitioned or transition to care coordination by early 2015.

Integrated Care Program Expansion

HFS awarded Integrated Care Program (ICP) contracts to two health plans – Centene's IlliniCare and Aetna Better Health – to serve the aged, blind, and disabled (ABD) population, known as seniors and persons with disabilities (SPDs), in the Chicago suburbs in 2010. The ICP program, which was implemented in May 2011 in the five counties surrounding Chicago (DuPage, Kane, Kankakee, Lake, and Will counties) and in the portions of Cook County outside the city of Chicago, eventually mandatorily enrolled around 36,000 non-dual eligible SPDs in the two health plans. In February 2013, health plans began coverage of the long-term supports and services (LTSS) benefit package for ICP enrollees.

As part of the mandated push to expand care coordination it was announced that the ICP would expand to four additional regions and into the City of Chicago in 2013 and 2014. The expansion is expected to increase the ICP by roughly 28,000 enrollees outside of the Greater Chicago region and by roughly 69,000 enrollees in the City of Chicago.

Rockford Region – 5,100 non-dual SPDs – Implemented July 2013:
Boone, McHenry, Winnebago counties

- Aetna Better Health
- Community Care Alliance of Illinois (CCAI)
- IlliniCare (Centene)

Central Illinois Region – 12,800 non-dual SPDs – Implemented September 2013:
Knox, Peoria, Stark, Tazewell counties

- Health Alliance
- My Health Care Coordination (CCE)
- Meridian
- Molina

McLean, Logan, DeWitt, Sangamon, Macon, Christian, Menard, Piatt, Champaign, Ford, Vermillion counties

- Health Alliance
- My Health Care Coordination (CCE)
- Molina

Metro East (East St. Louis) Region – 7,800 non-dual SPDs – Implemented Sept. 2013:
Madison, Clinton, St Clair counties

- Meridian
- Molina

Quad Cities Region – 1,900 non-dual SPDs – Implemented November 2013:
Rock Island, Mercer counties

- IlliniCare (Centene)
- Precedence (CCE)

Greater Chicago Region – 105,000 non-dual SPDs – Full Implementation July 2014:
Cook, DuPage, Kane, Kankakee, Lake, Will counties

- Aetna Better Health
- IlliniCare (Centene)

Currently Cook County only
(will expand to DuPage, Kane, Kankakee, Lake, and Will Counties effective July 2014)

- Blue Cross Blue Shield of Illinois
- Cigna Health Spring of Illinois
- Community Care Alliance of Illinois (CCAI)
- Humana Health Plan
- Meridian

Medicare-Medicaid Alignment Initiative (MMAI)

Accepting voluntary enrollment for the first time in March 2014, the state's dual eligible financial alignment demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI), has voluntarily enrolled a total of 192 dual eligible beneficiaries in both Greater Chicago and Central Illinois. Across the two regions, an estimated 111,000 dual eligibles qualify for the demonstration, although total enrollment will likely be lower due to the ability of individuals to opt-out of participating. In the case of an opt-out, dual eligibles requiring LTSS will be mandatorily enrolled into a Medicaid MCO in their region for managed Medicaid benefits. Passive enrollment is set to being on June 1, 2014.

Greater Chicago MMAI Plans:

- Aetna Better Health (excluding Lake County)
- Blue Cross Blue Shield of Illinois
- Cigna-HealthSpring (excluding Kankakee County)
- Humana
- IlliniCare (Centene)
- Meridian (excluding Kankakee County)

Central Illinois MMAI Plans:

- Health Alliance Connect
- Molina

Family Health Program (Children/Families or Caregivers) and ACA Adults

The Family Health programs (existing Medicaid coverage for children and families or caregivers) and the newly eligible ACA adults population will be transitioned to care coordination beginning July 1, 2014 in the same five regions as the ICP: Greater Chicago, Rockford, Central Illinois, Quad Cities, and Metro East. Formal announcements of participating health plans have not yet been made, but comments and public documents from the state provide the following details on likely plan participation:

- All MMAI health plans will be included, meaning 6 health plans in Greater Chicago and 2 in Central Illinois. It is presumed that the MMAI plans participating in the three non-MMAI mandatory care coordination regions under the ICP expansion will be included in their respective regions.

- Existing Voluntary MCOs will be given the opportunity to transition to the new managed care structure, meaning Family Health Network (which owns CCAI), and WellCare's Harmony Health Plan may participate. Meridian Health Plan is already included as a MMAI participating health plan. It is unclear at this time, however, whether these Voluntary MCOs will be given the opportunity to expand their current service areas.
- Newly formed Accountable Care Entities (ACEs) will begin serving the population (pending final approval) as early as July 1, 2014. Some ACEs may not launch until later in the year. The six ACEs given conditional approval to participate include five in the Greater Chicago area and one in Central Illinois.

    1. Accountable Care Chicago – Greater Chicago
    2. ACE Care Services (Presence) – Greater Chicago
    3. Advocate Physicians – Greater Chicago
    4. Health Cura (Access) – Greater Chicago
    5. Loyola University Health System ACE – Greater Chicago
    6. Illinois Partnership for Health – Central Illinois

    Final service areas are to be determined. ACEs in Cook County will be required to have capacity to serve a minimum of 40,000 enrollees, while other Greater Chicago ACEs must have capacity to serve 20,000. ACEs in the rest of the state must have capacity to serve 10,000. ACEs will initially operate under a shared savings model, with the intention of transitioning to full-risk capitation within three years.

CCEs – Adults and Children with Complex Medical Needs

Care Coordination Entities (CCEs) are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. The Adult and Complex Children CCEs were procured through separate RFPs and the following entities were selected by the state to participate. Some CCEs have already begun serving beneficiaries, while others will go live later in 2014.

Adult CCEs and Areas Served:

- Be Well Partners in Health (Chicago area)
- EntireCare - Healthcare Consortium of Illinois (Chicago area)
- My Health Care Coordination-Macon County (Central Illinois)
- Precedence Care Coordination (Quad Cities, add'l counties)
- Together4Health (Chicago area)

Children with Complex Medical Needs CCEs and Areas Served:

- Lurie Children's CCE (Chicago area)
- La Rabida CCE (Chicago area)
- OSF CCE (Central Illinois)

HMA Medicaid Roundup

Arizona

Brewer Vetoes Bill Imposing Limited Coverage and Work Requirements for New Medicaid Enrollees. On April 22, 2014, *AP*/the *News Observer* reported that Governor Jan Brewer has vetoed House Bill 2367, which would have forced able-bodied Medicaid recipients to get a job and would have limited some to a maximum of five years of Medicaid coverage. Brewer said the bill could have dropped up to 210,000 adults from the Medicaid rolls, and an additional 253,000 children when they reached their 18th birthday. House Speaker Andy Tobin, who drafted the bill, argued that the bill provides the state with a means to cut Medicaid enrollment if the government fails to fund the program as promised. Read more

California

HMA Roundup – Alana Ketchel

Over Three Million Sign Up for Coverage In Initial Open Enrollment. On April 17, 2014, Covered California reported that more than three million Californians enrolled in commercial and Medi-Cal insurance plans by April 15. Nearly 1.4 million people selected a private plan via Covered California, with 88 percent of those eligible for a subsidy. Medi-Cal enrolled an additional 1.9 million people through the end of March. The total enrollment over six months exceeded initial projections by more than 800,000. Four out of eleven total insurers – Anthem Blue Cross of California, Blue Shield of California, Health Net, and Kaiser Permanente – account for nearly 94 percent of all enrollments. Read more

State Rules on Denials of Autism Therapy Made Permanent. On April 17, 2014 the *California Healthline* reported the California Department of Insurance approved regulations that clarify policies on authorization of autism treatment. The rule states that if insurers delay or deny autism services, they could face enforcement and penalties from the state insurance commissioner. The rules had previously been issued on an emergency basis, but the new ruling gives them permanent status. Read more

Medi-Cal Eases Access to HIV Pre-Exposure Prophylaxis. On April 18, 2014, the AIDS Project of Los Angeles announced their support of a new Medi-Cal policy that eases access to Truvada, a drug which could prevent HIV infection in at-risk individuals. Medi-Cal lifted a requirement that doctors complete a request for authorization when prescribing the drug for HIV-negative patients. According to the press release, the action is effective immediately and will be published in Medi-Cal's June Provider Bulletin. Read more

Los Angeles to Re-Launch Healthy Way LA. On April 20, 2014, the *Guardian* reported that the Los Angeles Department of Health Services will re-start Healthy Way LA, a program to increase access to care for residents who did not qualify for coverage under the Affordable Care Act. Uninsured residents whose income falls below 138% of the Federal Poverty Level would qualify for the program. The program currently has $55 million in funding. Advocates are pushing the Board of Supervisors to increase funding. Read more

VA Advises Selective Administration of New Hepatitis C Drugs. On April 17, 2014, *Kaiser Health News* reported on a panel held by the California Veterans Administration, which recommended that doctors consider the severity of a patient's hepatitis C before administering newly available treatments for the disease. The highly efficacious new hepatitis C treatments, Sovaldi and Olysio, are also prohibitively expensive, running a single patient between $70,000 and $170,000 when used in combination with interferon or ribavirin. The panel also stressed that there are a limited number of hepatologists with experience using the drugs. Therefore, the VA advises doctors to treat only the sickest patients for the time being, until cheaper and more easily administered options become available. The panels represent the first large-scale attempts since the release of the new drugs to consider which hepatitis C patients should be treated first. Read more

Colorado

HMA Roundup – Joan Henneberry

Connect for Health CO Enrollment Data. On April 21, 2014, *Health News Colorado* reported data on which plans people chose through Connect for Health Colorado, the state marketplace, during the open enrollment period. Nearly three out of four people who bought private health insurance through Colorado's exchange selected non-profit carriers: Kaiser Permanente, Rocky Mountain Health Plans, and the Colorado HealthOP. Forty-six percent of these people - or 58,344 of 127,233 Coloradans - enrolled with Kaiser. Rocky Mountain Health Plans enrolled 16,050 people, or about 13 percent of the market, and the Colorado HealthOP (a new CO-OP developed under the ACA) signed up 15,166 people, or about 12 percent of all enrollees. Anthem Blue Cross and Blue Shield traditionally has been a big player in Colorado's insurance market and has not released sign-up data yet, nor have Cigna, Humana or United. Read more

CO Dept. of Health Care Policy and Financing Appoints HP to Implement New Medicaid Management System. On April 22, 2014, HP Enterprises Services announced that the Colorado Department of Health Care Policy and Financing has signed a $116.9 million contract for HP to implement a new Medicaid management system. Under the five-year agreement, HP will configure and implement a new Colorado interChange Medicaid Management Information System (MMIS) and provide ongoing enhancements and maintenance. HP will also implement its award-winning Medical Assistance Provider Incentive Repository (MAPIR) tool to help track incentive payments for meaningful use of electronic health record technologies. Colorado's Medicaid system serves about 950,000 Coloradans and processes about 44 million medical claims each year. Read more

Florida

Senate President Restarts Discussion of Medicaid Expansion Alternatives with New HHS Secretary. On April 18, 2014, Florida Senate President Don Gaetz wrote to newly-nominated HHS Secretary Sylvia Burwell asking if she might consider restarting discussions regarding the state's alternative plan to Medicaid expansion. According to *Health News Florida,* Gaetz asked Burwell to give the state more authority to design its own program for the Medicaid expansion population, which includes 800,000 low-income adults. State lawmakers previously rejected $51 billion in federal funds for Medicaid expansion as described in the ACA. In the letter to Burwell, Gaetz named three topics that would be "starting points for meaningful improvements":

- Gradual expansion (rather than all at once)
- Permission for the state to ask new enrollees to contribute some money to their coverage
- Reduction of "bureaucratic barriers that block innovation"

Read more

Florida Blue Reports High Enrollment, But Premium Rates May Still Rise Next Year. On April 21, 2014, the *Miami Herald* reported that premium rates for Florida Blue beneficiaries might rise in 2015, despite higher than expected enrollment during the open enrollment period. The insurer cites several reasons for this, including high enrollment of sick, costly individuals and low enrollment of young, healthy ones. While most Florida Blue consumers who signed up for exchange plans have paid their first month's premium, Senior VP of public policy Jason Altmire says that many are still uneducated about the health law. Read more

Georgia

HMA Roundup – Mark Trail

Governor Deal Ensures Teachers Have Say on Health Insurance Plans. On April 15, 2014, WJBF/ABC News reported that Governor Nathan Deal has signed an executive order that requires the Department of Community Health to include a teacher representative in the State Health Benefit Plan (SHBP) invitation for proposals process. Teachers and their dependents make up the largest group of SHBP members. Read more

Georgia Exchange Received Over 220,000 Applications. On April 17, 2014, *Georgia Health News*/The *Albany Herald* reported that Georgia insurers received more than 220,000 applications for health coverage through the ACA exchange during the open enrollment period. Insurance Commissioner Ralph Hudgens said that 107,581 of these applicants have paid their premiums. This figure does not include individuals who signed up for insurance or paid their premiums in April, after the official enrollment deadline of March 31 was pushed back to accommodate consumers who had difficulties with the exchange website. Read more

Board of Regents Select Insurers for University System of Georgia Health Plan. On April 18, 2014, *Georgia Health News* reported that the Board of Regents has approved two insurers to deliver medical services in 2015 to University System of Georgia's 100,000 employees, retirees and dependents. Blue Cross and Blue Shield of Georgia was selected as a statewide health plan, and Kaiser Permanente will offer an HMO alternative in metro Atlanta and in Athens. CVS Caremark was chosen as the pharmacy

benefits manager for the self-insured plans. The plan amendments come in response to complaints from many state employees, teachers, and other personnel earlier this year over choice of plans and high out-of-pocket costs. Read more

Idaho

Kaiser Health News Reports on Idaho Hospital Merger Debate. On April 22, 2014, *Kaiser Health News* reported that a major hospital merger in Idaho has resulted in a legal battle with state and federal regulators and rival hospital systems. In January, a federal judge ruled to dissolve a merger between St. Luke's Health System and the 43-physician Saltzer Medical Group, explaining that the massive consolidation effort could diminish competition and prompt the providers to jack up their prices. The case has received national attention and has resulted in active discussion about whether mergers and acquisitions actually help lower healthcare costs. Read more

Indiana

State Medicaid Director Provides Updates on ABD Managed Care Program. On April 23, 2014, Medicaid Director Joe Moser gave a presentation at a meeting with Aged, Blind and Disabled (ABD) stakeholders about the direction the state is going for managing the ABD population. Two items of note came out of this presentation that were not in the RFI released last week: It appears the state has decided to carve drugs in for the ABD population so that the health plans will manage them (currently, drugs are carved out of risk-based managed care and managed by the state's PBM). Additionally, the state plans to issue its RFP in the late spring, award contracts in August and begin enrollment January 1, 2015. Read more

Kansas

Waitlist Verification Process Delays In-Home Care Services for Nearly 400 Disabled Kansans. On April 21, 2014, the Kansas Health Institute reported that the Kansas Department for Aging and Disability Services (KDADS) is having trouble contacting individuals on the waitlist for in-home services, which is in turn delaying this group's access to care. Earlier this year, KDADS Secretary Shawn Sullivan said the agency was prepared to move nearly 400 people off the 3,074-person waiting list; but the department must confirm who is on this list and whether they are still eligible for in-home services before granting access to care. Advocates for the elderly and disabled fear that this verification process might cause the agency to remove people from the waitlist if it cannot make contact with them. Read more

Kentucky

ACA Enrollment Tops 413,000 in Kentucky. On April 22, 2014, the *Courier-Journal* reported that more than 413,000 people enrolled for health insurance coverage through the Affordable Care Act during the first open enrollment period. Governor Steve Beshear announced the news in a Capitol news conference, lauding implementation of the ACA as an "indisputable success." Beshear said that 75 percent of applicants were previously uninsured. Over 330,600 people qualified for Medicaid through the exchange, while 82,792 purchased private health insurance. Almost 630 businesses have completed applications and are eligible to offer plans for employees. Read more

Louisiana

State Democrats Hold Press Conference to Push for Medicaid Expansion. On April 22, 2014, the *Daily Advertiser* reported on a press conference calling for Louisiana lawmakers to approve Medicaid expansion. Lafayette Consolidated Government Councilman Kenneth Boudreaux, the Louisiana Democratic Party, the Louisiana Consumer Healthcare Coalition and the Louisiana Developmental Disabilities Council joined together to advocate for expansion, warning of the ramifications of not expanding Medicaid. State Governor Bobby Jindal opposes expansion, citing that it is not financially sustainable for the state in the long run. Read more

Michigan

Nursing Homes Develop New Ways to Increase Quality of Care and Profits Simultaneously. On April 20, 2014, *Crain's Detroit Business* discussed the challenge faced by Michigan's nursing homes to provide high-quality care while simultaneously generating profit. Many nursing homes in the state struggle to produce profits because of low reimbursements they receive for Medicaid beneficiaries. To boost their profit margins, nursing homes are resorting to a variety of strategies, all focused on keeping patients healthy, reducing readmissions and increasing their referrals. Read more

Community Health Centers Blame Flaw in Medicaid Expansion for Major Funding Gap. On April 22, 2014, *MLive* reported that flaws in Michigan's Medicaid expansion funding policy have caused community mental health programs throughout the state to turn away thousands of patients. The state estimated that Medicaid expansion through its Healthy Michigan plan would alleviate burden on the state budget by shifting certain healthcare costs to the federal government, including costs for Community Mental Health (CMH) services. But mental health providers say that the federal funds only cover Healthy Michigan patients, creating a funding gap for coverage for non-Healthy Michigan patients. Read more

Missouri

Missouri Hospital Association Official Discusses Need for Medicaid Expansion. On April 22, 2014, the *Daily Journal* reported on the major topics covered by the Farmington Regional Chamber of Commerce in its monthly networking luncheon. Featured presenter Andrew Wheeler, VP for federal finance for the Missouri Hospital Association, focused on the potential economic and healthcare impact should Medicaid expansion not pass in the legislature. Wheeler cited two major studies that estimated 24,000 jobs could be brought to the state if expansion is approved. Wheeler also explained that expanding Medicaid would help dozens of struggling hospitals in the state stay afloat. Read more

New Jersey

HMA Roundup – Karen Brodsky

County Welfare Offices Face Backlog in Processing NJFamilyCare Applications. On April 21, 2014, *NJSpotlight* reported that just 92,000 of more than 276,000 New Jersey residents who were approved for Medicaid in recent months have received their insurance cards to date. The remaining individuals are waiting for their applications to be fully processed and to receive insurance ID cards. While the state has extended

presumptive eligibility to individuals who were approved for Medicaid until their applications are processed, many of these residents are unsure of their status and may delay seeing a doctor for fear of incurring medical expenses. County workers are processing the applications manually due to a delay in implementation of the state's new computer system that will process all human-services applications. The county offices have brought on part-time workers to help with the backlog. Read more

NJ Department of Health (DOH) gives testimony on the State FY15 proposed budget. On April 14, 2014, Health Commissioner Mary O'Dowd gave testimony to the New Jersey Assembly Budget Committee. The proposed DOH budget is $1.8 billion (of which $339 million is the state's share). This represents a total decrease of 4 percent from State FY2014. Commissioner O'Dowd described a number of public health efforts underway:

- Tax parity for e-cigarettes, which have not been approved by the FDA and pose health risks to people exposed to their smoke
- An investment of more than $1 billion in the state's hospitals and Federally Qualified Health Centers (FQHCs), including $650 million in Charity Care, $100 million in Graduate Medical Education funds and $166.6 million for the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP is the first state subsidy program to reward hospitals for improving quality of care.
- A commitment of $135 million for the Early Intervention System, which provides early identification, referral and service coordination for children from birth to age three with developmental delays and disabilities
- An initiative aimed at reducing premature births and improving birth outcomes
- Advancement of Health Information Technology through a Health Information Network, a statewide information exchange that allows providers, hospitals and other health care stakeholders to share patient information securely and in real-time. Read more

New York

HMA Roundup – Denise Soffel

Mandatory Managed Long Term Care. New York continues to expand its mandatory managed long term care program. Since September 2012 the state has required dual-eligible enrollees that require more than 120 days of community-based long term care services to enroll in a managed long term care plan. Expansion was initiated in four additional counties in March: Albany, Erie, Monroe and Onondaga. The mandatory program will begin in Columbia, Putnam, Sullivan and Ulster in April. The intent is to have all counties operating a mandatory program by the end of the calendar year. Expansion in new counties is dependent on CMS approval, based on establishing adequate plan capacity, including a choice of at least two plans.

FIDA Update. Preparation for implementation of New York's dual eligible integration demonstration, Fully Integrated Duals Advantage (FIDA), continues. Plans are undergoing desk reviews, network validation and systems testing. Development of the three-way contract is on-going, and a draft will be circulated on April 25 for review and comment. The Department of Health expects contracts will be signed early in July, with a program start date of January 2015.

Managed Long Term Care Reports. The Department of Health has released two reports on the managed long term care program. The 2013 Managed Long-Term Care Report is a statistical report on plan-specific quality of care. The Managed Long Term Care Plan 2013 Member Satisfaction Survey Summary Report provides information from a 1,800-person survey of managed long term care plan enrollees. Both reports can be found on the Department of Health website.

According to the 2013 Managed Long-Term Care Report, 85 percent of MLTC enrollees are over the age of 64, 28 percent are over 85, and 70 percent are female. Sixty one percent speak a primary language other than English. Fifty eight percent have a cognitive impairment, a rate that is higher among PACE program members. Dual-eligibles make up 87 percent of enrollment. The report includes plan-specific measures of enrollee characteristics; plan performance based on quality of life as well as plan performance over time; utilization and patient safety indicators; member satisfaction; and potentially avoidable hospitalizations. The nursing home admission rate among MLTC enrollees over the last six months was 1.6 percent, with 30 percent of those for long-term placement. Seven percent of MLTC enrollees had a hospital admission in the previous six months, and 1.6 percent had two hospital admissions.

IPRO conducted a member satisfaction survey of MLTC enrollees that was designed to assess satisfaction with quality of health care services, access to primary care and timeliness of access to services; differences between the three models of MLTC plan (partial capitation, PACE and Medicaid Advantage Plus); and changes in member satisfaction since the previous (2011) survey. Satisfaction was high, with 89 percent reporting that they would recommend their plan to others, and 84 percent rating their plan as excellent or good. Complaints and grievances have increased over 2011, with 37 percent of members reporting they had called their plan with a complaint or grievance; 61 percent said they were not satisfied with the response they received from their plan. PACE members were much more likely to report that their plan was good at helping them manage their illnesses, were more likely to give favorable quality of care ratings to their providers, and were more likely to give high ratings for timeliness of care.

Ohio

State's Inmates to Get Medicaid Coverage upon Their Release. On April 20, 2014, the *Columbus Dispatch* reported that newly released prisoners in Ohio are now eligible for Medicaid coverage under Governor John Kasich's expansion of the program. Treatment will also be covered for prisoners requiring hospital stays longer than 24 hours, which will save the state millions of dollars in treatment costs. State Medicaid Director John McCarthy said he hopes the approach will "allow (released prisoners) to have immediate access to much-needed mental health and substance abuse treatment upon release," which will "reduce the recidivism in the state and get these individuals back into the workforce." Read more

Court Votes against Hospital Merger on Antitrust Grounds. On April 22, 2014, The Wall Street Journal reported that a panel from the U.S. Circuit Court of Appeals in Cincinnati has voted down a merger between non-profit hospital ProMedica and community hospital St. Luke's, citing the merger would allow the institutions to jack up rates. The ruling demonstrates that hospital mergers are facing a rougher regulatory path as the Federal Trade Commission and the Justice Department increase their efforts to protect the cost-saving goals of the ACA. ProMedica says it plans to appeal the ruling. Read more

Pennsylvania

HMA Roundup – Matt Roan

Pennsylvania Experiences Increase in Medicaid Rolls during ACA Open Enrollment Period. On April 21, 2014, the *Pittsburgh Post-Gazette* reported that Medicaid enrollment in Pennsylvania is up by more than 18,000 people since the October 1 launch of the Affordable Care Act's online health plan marketplaces. While the state has not approved Medicaid expansion, the increased enrollment represents the "woodwork effect" of individuals previously eligible for Medicaid finally signing up for coverage. A similar effect has been observed in other Republic-led states that have not approved Medicaid expansion. Read more

UPMC Workers Victims of Identity Theft. On April 18, 2014, *AP*/the *Centre Daily Times* reported that the personal information of approximately 27,000 University of Pittsburgh Medical Center (UPMC) employees appears to have been compromised. According to an announcement by UPMC, identity thieves may have used information on 788 employees to file fraudulent tax returns. Federal prosecutors have initiated an investigation into the breach. UPMC noted that no patient information was at risk as part of this incident. Read more

Senator Casey Pushes Tax-advantaged Savings for People with Disabilities. On April 17, 2014, the *Times-Tribune* reported that U.S. Senator Robert Casey visited Scranton this week to promote legislation introduced in February that would create tax incentives for saving for the future financial needs of people with disabilities. The bill would allow people with severe disabilities to establish special savings accounts for qualified expenses including education, transportation, housing, health and wellness, employment support and other financial obligations. Savings deposited into the accounts would be tax-exempt, similar to tax-exempt college savings plans. Read more

UPMC Challenges City of Pittsburgh to Send Tax Bills to Subsidiaries in Non-Profit Status Fight. On April 22, 2014, the *Pittsburgh Post-Gazette* reported that UPMC has introduced a new argument in the ongoing court battle between the health system and the City of Pittsburgh over its non-profit tax-exempt status. Attorneys for UPMC argued that if the city believes that the organization is for-profit, they should send tax bills to the various UPMC affiliates operating within city limits. Each of those entities would then be entitled to separate appeals of the tax charges. UPMC also contended that "UPMC" has no employees; rather, it is just an organizational framework under which affiliates operate. Attorneys for the city responded that state law holds parent companies accountable for the tax obligations of its subsidiaries and that the city is within its rights to settle the question of UPMC's non-profit status before sending out tax bills. Further, city attorneys argue that UPMC does in fact have employees, including senior executives who are paid by UPMC, and therefore the organization should be paying payroll taxes. UPMC is the largest landowner in the city of Pittsburgh, as well as the city's largest employer. Read more

Texas

Privatization of Foster Care to Expand. On April 15, 2014, the *Dallas Morning News* reported that Department of Family and Protective Services (DFPS) Commissioner John Specia told state lawmakers in a hearing that he still intends to expand privatization of foster care. The move would make a single contractor accountable for improving outcomes for children in foster care and for ensuring the full continuum of services in a given area. By promoting a collaborative, community-based approach to service

coordination and delivery, the state hopes to ensure foster homes and treatment beds will be available everywhere they are needed. Shortly after the hearing, the state Health and Human Services Commission released its final RFP to contract with one managed care organization for the State of Texas Access Reform (STAR) Health program, the statewide program that covers a full continuum of health care services for children in foster care. Read more

Utah

"Healthy Utah" Health Care Expansion Plan Moves Closer to Federal Approval. On April 21, 2014, the Salt Lake Tribune reported that Governor Gary Herbert is getting close to gaining federal approval for his alternative plan for Medicaid expansion through a block grant to the state. Herbert's "Healthy Utah" plan would use $258 million in federal funds each year to provide state-subsidized private insurance coverage to up to 111,000 low-income Utah residents. Subsidies would vary based on household income, ability to work, access to other insurance and health care needs. Herbert met with outgoing Health and Human Services Secretary Kathleen Sebelius and White House aides last week and said that his plan was "extremely well" received. Read more

Virginia

Small Business Owners Advocate for Medicaid Expansion. On April 16, *AP*/the *Washington Post* reported that a group of small business owners in Virginia have approached state House Republicans to advocate for the expansion of Medicaid. A member of the group has delivered a letter signed by more than 400 current and former small business owners to House Speaker William J. Howell. The letter serves to demonstrate a statewide interest in Medicaid expansion, the issue that has delayed passage of the state's budget this year. Read more

Governor McAuliffe continues push for Medicaid Expansion in Virginia. On April 21, 2014, the Washington Post reported on a meeting of Virginia state agency heads with Governor Terry McAuliffe in which the governor discussed his progress towards creating jobs and diversifying the state economy during his first 100 days in office. Amongst other issues, McAuliffe reiterated his goal of expanding Medicaid eligibility to as many as 400,000 Virginians, a contentious topic which has delayed passage of the state's $96 billion two-year budget. Read more

Washington

As Medicaid Enrollment Rises, Challenges are Addressed. On April 18, 2014, *Kaiser Health News*/the *Seattle Times* reported that higher than expected Medicaid enrollment in Washington has raised concerns about how new beneficiaries will get access to care. A reported 285,000 Washingtonians newly eligible for Medicaid signed up for coverage, twice as many as originally anticipated. Since Medicaid insurance generally pays doctors at a lower rate than Medicare or private insurance, some worry physicians might turn away Medicaid patients. However, the state is working on several programs and strategies to make the Medicaid system more efficient and to increase access to care. Read more

HCA and DOC in Agreement on Medicaid Expansion for Prisoners. On April 21, 2014, *McClatchy News* reported that the Washington State Department of Corrections (DOC) has agreed with the state Health Care Authority to allow prisons to pre-enroll inmates in Medicaid 30 days before their release. Submitting Medicaid applications at the end of prisoners' sentence will ensure they have access to health coverage as soon as they are released. The process also allows prison officials to help inmates complete their applications accurately. The DOC has hired three new staff to process inmates' Medicaid applications. Ensuring health care coverage should help recently released prisoners, particularly those with mental health issues, access needed care and could even reduce the likelihood that prisoners become repeat offenders. Read more

Wisconsin

Health Officials Ready to Expand Family Care Program. On April 21, 2014, *AP*/the *St. Paul Pioneer Press* reported that Wisconsin health officials are ready to begin expanding the Family Care program, which provides in-home care, to seven additional counties in the state. The expansion would include 2,434 people who use similar county-based care programs, 977 people on waiting lists for county services and anyone else who resides in the counties and meets eligibility requirements. Expansion is contingent on approval from the Joint Finance Committee, which could meet on the issue by the end of this year. A recent state Department of Health Services study found that statewide expansion of the program would be $34.7 million cheaper than the counties continuing their own programs. Read more

Industry Research

Cain Brothers' House Call Replay: Addiction and Substance Use Treatment House. The first in a series of four Cain Brothers' House Calls on the Behavioral Health Sector focused on addiction and substance use. Panelists were asked to share their views on the following, among other topics:

- Why so many individuals are suffering from addictions and substance use disorders, and why historically so few have been able to get treatment.
- How patients find their way to the panelists' clinics and practitioners and how marketing practices have and will change in the future.
- How the panelists' companies are able to achieve high treatment success rates.
- Advocacy and de-stigmatization.
- Reimbursement.
- Organic growth versus mergers & acquisitions.
- How the market may evolve in coming years.

The House Call was hosted by Cain Brothers' Managing Director Todd Rudsenske and included a representative from Marwood Group. Panelists included:

- David Sack, CEO, Elements Behavioral Health
- Rob Waggener, CEO, Foundations Recovery Network
- Jim Dredge, CEO, The Meadows
- Jonathan Wolf, CEO, Pyramid Healthcare

A replay of the conference call, and information on upcoming Cain Brothers' House Calls, are available here.

Industry News

UnitedHealth Group Reports Q1 2014 Results. On April 17, 2014, UnitedHealthcare reported its first quarter results. United reported that its Medicaid membership grew by 395,000 in the past year, including 255,000 people in the first quarter of 2014. The company spent $100 million on coverage for expensive new hepatitis C medications for commercial, Medicaid and Part D coverage recipients. Read more

Centene Corporation Reports Q1 2014 Results. On April 22, 2014, Centene Corporation announced its first quarter financial results for 2014. The company reported a Health Benefits Ratio of 89.3 percent this quarter, compared to 90.2 percent in Q1 2013. Centene reported Health Insurance Marketplace enrollment of 39,700 and Medicaid and CHIP/foster care membership of more than 2.4 million. Additionally, Centene reported relatively limited exposure to costs for Sovaldi. Read more

RFP Calendar

Date	State	Event	Beneficiaries
April, 2014	Puerto Rico	Contract Awards	1,600,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
May 1, 2014	Texas NorthSTAR (Behavioral)	Proposals Due	840,000
May 12,2014	Rhode Island (Duals)	Proposals due	28,000
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 12, 2014	Delaware	Contract awards	200,000
June 13, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 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	Vermont Duals	Implementation	22,000
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
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 7/1/2014 1/1/2015	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	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	MFFS‡	6,380					10/1/2012		
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		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; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.3M Capitated 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 Upcoming Appearances

"Medicaid Health Homes: Best Practices"
2014 Annual Conference
National Council of Community Behavioral Healthcare
Lynn Dierker – Presenter
Juan Montanez – Presenter
Alicia Smith – Presenter
May 5, 2014
Washington, D.C.

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