HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 28, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

TEXAS AND CMS FINALIZE DUAL ELIGIBLE DEMONSTRATION MOU

This week, our *In Focus* section reviews the finalized Memorandum of Understanding (MOU) between Texas and the Centers for Medicare and Medicaid Services (CMS) on the state's dual eligible financial alignment demonstration. Texas is the tenth state to finalize a capitated model MOU, behind Massachusetts, Ohio, Illinois, California, Virginia, New York, South Carolina, Washington, and Michigan. The Texas demonstration will serve full dual eligibles ages 21 and older in six counties—Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant. Below, we review the Texas demonstration and highlight key elements of the MOU. (Link to Texas MOU)

Texas Financial Alignment Demonstration Overview

Texas' Health and Human Services Commission (HHSC) has announced that existing STAR+PLUS Medicaid managed care plans in the six counties will serve the duals demonstration population as STAR+PLUS Medicare-Medicaid Plans (MMPs). As in other states, participation in the demonstration is dependent on completing the three-way contracting process with Texas HHSC and CMS, as

well as a readiness review process. The table below details the current STAR+PLUS health plans by region that Texas intends to contract with as STAR+PLUS MMPs and the number of eligible beneficiaries in each region. As a note, these estimated eligibles numbers are from March 2014, when the state estimated around 132,000 duals eligible for the demonstration. As of the release of the MOU, HHSC's accompanying press release indicates the state now believes 168,000 will be eligible.

Texas Duals Demonstration Counties, Estimated Eligibles as of March, 2014, and Current STAR+PLUS Plans by County

Duals Demonstration County	Total Dual Eligibles	Intended STAR+PLUS MMPs
Bexar County	21,400	Amerigroup Superior (Centene) Molina
Dallas County	21,100	Superior (Centene) Molina
El Paso County	16,600	Amerigroup Molina
Harris County	38,400	Amerigroup Molina UnitedHealthcare
Hidalgo County	23,600	Superior (Centene) HealthSpring Molina
Tarrant County	11,500	Amerigroup HealthSpring
Total Dual Eligibles	**132,600**	

Eligible Populations

The Texas duals demonstration will be open to all dual eligibles in the six counties above ages 21 or older, with exception of following:

- Duals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IIDs)
- Duals receiving services through the following section 1915(c) waivers:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities Program (DBMD)
    - Home and Community-based Services (HSC)
    - Texas Home Living Program (TxHmL)

Additionally, dual eligibles currently enrolled in a Medicare Advantage (MA) plan operated by a parent organization that is not participating in the demonstration will only be able to participate if they elect to disenroll from their current MA plan. The Texas MOU indicates that only 8 percent of STAR+PLUS enrollees are covered by STAR+PLUS and MA plans operated by the same parent organization.

Enrollment Timing

STAR+PLUS MMPs will begin receiving opt-in (voluntary) enrollments as of January 2015, with passive enrollment set to begin on March 1, 2015. As with all dual eligible demonstrations, enrollees will be able to opt-out of enrollment at any time, effective on the first day of the following month.

In all six counties, enrollment will be phased in over a six-month period, with enrollments not to exceed 5,000 per month in Harris County, and not to exceed 3,000 per month in Bexar, Dallas, El Paso, Hidalgo, and Tarrant counties.

Payments to STAR+PLUS MMPs

As with other capitated dual eligible demonstrations, rate setting will occur between CMS and the State of Texas. Medicare and Medicaid will each contribute to the capitation rate, consistent with projected baseline spending projections. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Part A and B components of the capitation rate. Additional quality withhold percentages will be deducted from the capitation rate to be earned back based on a set of quality measures.

The demonstration years, aggregate savings, and quality withhold percentages for participating ICOs are detailed in the table below. Texas is the first state to carry the duals demonstration out into 2018.

Texas Duals Demonstration Aggregate Savings and Quality Withhold Percentages by Demonstration Year

	Demonstration Year	Aggregate Savings	Quality Withhold
1.a.	Mar. 1, 2015 – Dec. 31, 2015	1.25%	1.0%
1.b.	Jan. 1, 2016 – Dec. 31, 2016	2.75%	1.0%
2	Jan. 1, 2017 – Dec. 31, 2017	3.75%	2.0%
3	Jan. 1, 2018 – Dec. 31, 2018	5.50%	3.0%

The aggregate savings percentages in the Texas demonstration are notably higher than with those of other states with finalized MOUs. Massachusetts, Michigan, Ohio, California, South Carolina, and Virginia have set aggregate savings of 2 percent in year two and 4 percent in year three, while Illinois set savings at 3 percent in year two and 5 percent in year three. The larger savings in Texas may be due, in part, to the extended length of the Texas demonstration.

The Texas demonstration will utilize experience rebates to limit the profits of STAR+PLUS MMPs based on the tiers in the table below. STAR+PLUS MMPs will retain all net income before taxes up to 3 percent of revenues. Between 3 percent and 12 percent, MMPs will rebate a percentage of net income to Medicare and Medicaid. All net income beyond 12 percent of revenues will be rebated to the state and federal governments.

Additionally, a cap on administrative expenses will be implemented in Demonstration Year 2 (2017).

Net Income Before Taxes as % of Revenues	STAR+PLUS MMP Share	Medicare/ Texas Medicaid Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

Current STAR+PLUS Enrollment in Demonstration Counties

The table below details December 2013 STAR+PLUS enrollment by health plan in the six demonstration counties. These enrollment totals include non-dual eligible STAR+PLUS enrollees and others that will not be included in the demonstration.

December 2013 STAR+PLUS Enrollment by Health Plan for the Six Demonstration Counties

Current STAR+PLUS	Total Enrolled	Amerigroup	Centene	HealthSpring	Molina	United
Bexar County	48,959	9,873	30,458		8,628	
Dallas County	58,550		25,733		32,817	
El Paso County	24,717	12,936			11,781	
Harris County	102,356	44,525			13,391	44,440
Hidalgo County	73,753		38,450	18,238	17,065	
Tarrant County	33,837	27,293		6,544		
Total	**342,172**	**94,627**	**94,641**	**24,782**	**83,682**	**44,440**

HMA Medicaid Roundup

Arkansas

Over 170,000 Arkansan's Deemed Eligible for State's "Private Option" Medicaid Expansion Alternative. On May 28, 2014, the *Times Record/Arkansas News Bureau* reported that more than 170,000 Arkansans have applied and been found eligible for the state's "private option" Medicaid expansion alternative program. The State Department of Human Services estimates that 225,000 Arkansans qualify for the program. Read more

California

HMA Roundup – Alana Ketchel

DHCS Releases Cal MediConnect Enrollment Update. On May 19, 2014, the California Department of Health Care Services (HCS) released a Cal MediConnect dual-eligible enrollment update. As of May 1, 2014, 15,322 Californians were enrolled in the program. HCS projects a fourfold increase in enrollment by July 2014, with the largest enrollment gains anticipated in LA Care and Health Net plans. Read more

Many Community Clinics Unprepared for Health Reform. On May 21, 2014, the UCLA Center for Health Policy Reform published a study that assessed Los Angeles community clinics' readiness to accept and manage the care of newly insured and existing uninsured populations. The study found that at least 62 percent of community health centers were at some stage of readiness, but the smallest clinics lacked resources to adopt a "medical home," leverage information technology, increase managed care participation, and engage in quality initiatives. Read more

Covered CA Encourages Plans to Expand Networks. To address consumer complaints, Covered California's Executive Director announced at its board meeting on May 22, 2014, that the Exchange is encouraging participating insurers to expand their provider networks. Since January, approximately 200 complaints have been filed with the Department of Managed Health Care citing lack of access to care. Both Anthem and Health Net have said they have already expanded their networks. Read more

Funds Allocated to Ease Medi-Cal Application Backlog. On May 23, 2014, the *California Healthline* reported that the California Assembly budget committee voted to approve $73 million to improve the state's eligibility and enrollment system, CalHEERS. The system upgrade aims to help address the backlog of approximately 900,000 Medi-Cal applications. Read more

Bill to Cover Undocumented Immigrants Stalls in Committee. On May 23, 2014, the *Sacramento Bee* reported that the State Senate Appropriations Committee shelved a bill (SB1005) that sought to extend Medi-Cal coverage to undocumented immigrants. The Committee is giving sponsoring senator Ricardo Lara the summer to come up with a funding mechanism for the expansion. Read more

Alameda Alliance for Health Contests State Takeover in Court. On May 27, 2014, the *California Healthline* reported that the Alameda Alliance for Health, a local initiative health plan, is contesting its conservatorship in court. The Department of Managed Health Care took over operation of the health plan earlier this month due to concerns about the plan's financial viability. The court hearing will be held on June 2, 2014 which will determine whether the Berkeley Research Group will become the state's conservator of the Alameda Alliance. Read more

District of Columbia

Specialty Hospital of America Files for Bankruptcy, Plans to Sell DC Facilities to Hedge Fund. On May 22, 2014, the *Wall Street Journal* reported that Specialty Hospital of America LLC filed for bankruptcy protection with plans to sell its Washington, D.C., health care facilities to hedge fund Silver Point Capital. The deal will allow Specialty's two long-term acute-care hospitals in Capitol Hill and Southwest D.C., as well as two nursing homes, to remain open and continue caring for over 300 patients. Read more

Georgia

HMA Roundup – Mark Trail

DCH Officially Awards Integrated Eligibility System Contract to DeLoitte Consulting. On May 23, 2014, the Georgia Department of Community Health (DCH) officially awarded the contract for its Integrated Eligibility Systems contract to DeLoitte Consulting, LLP_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.

DCH to Extend Contract with Navigant Consulting for Medicaid/CHIP Redesign Effort. This week, DCH announced its intent to extend its contract with Navigant Consulting, Inc., to provide continued support for the state's Medicaid/CHIP redesign effort. The project extension for Navigant entails a one-year extension, with one additional twelve-month option to renew, at a total cost of $3 million through June 30, 2016. Read more

DCH Disputes Avalere Health Estimate of Medicaid Enrollment in Q1 2014. On May 27, 2014, *Georgia Health News* reported on a DCH study on state Medicaid enrollment which refutes previous estimates by consulting firm Avalere Health. Avalere estimated that 98,800 Georgians enrolled for Medicaid or PeachCare in the first three months of 2014, but recent DCH estimates put enrollment at 37,047. Avalere Vice President Caroline Pearson said the company based its analysis on enrollment reports the state gave to the federal government and cannot explain the discrepancy between the two estimates. Read more

Florida

HMA Roundup – Elaine Peters

Governor Scott Receives 2014-2015 Budget, Largest in Florida's History. On May 20, 2014, the *Florida Current* reported that Governor Rick Scott formally received the 2014-2015 fiscal year budget (HB 5001). The $77.1 billion budget is the largest budget in the state's history and is 3.5 percent larger than the 2013-2014 budget. Scott has until June 4 to make a decision on the budget. Read more

Legislature Approves Personal Spending Increase for Medicaid Patients in Long-Term Care. On May 26, 2014, the *Herald Tribune* reported that the State Legislature has approved a $35.4 million increase to raise the monthly personal spending allowance for 40,000 Medicaid patients in long-term care facilities from $35 to $105. This cost-of-living allowance has not been changed in over 25 years. The budget also contains spending increases for programs that help elders remain at home by supporting their family caregivers. Governor Rick Scott must act on the budget before June 4. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

Illinois House Passes Revised Budget Without Income Tax Increase, Medicaid Bill Advancing as End of Session Approaches. After it was announced by Illinois House Speaker Michael Madigan that the votes were not there to extend the state's income tax increase, the House passed a revised budget bill that, according to Democrats, uses budget tricks like special funds and overestimated future revenues. The expiration of the temporary income tax increase is expected to lead to a drop of $1.8 billion in revenue in 2015. According to Crain's Chicago Business, the income tax increase renewal could be revisited after November elections. Additionally, there is a bill, SB 741, advancing through the legislature that would adjust nursing home per diem rates under Medicaid, as well as restore dental and podiatry service benefits that were cut from the program several years prior. The current legislative session ends at the end of the month. Read more

Indiana

Public Hearings Held to Discuss Governor Mike Pence's HIP 2.0 Plan Proposal. This week, the Indiana Office of Medicaid Policy and Planning will hold public hearings on Governor Mike Pence's Health Indiana Plan (HIP) 2.0 proposal, which would expand the current HIP program to cover all non-disabled adults between the ages of 19 and 64 with household income below 138 percent of the federal poverty limit. Both public hearings will be accessible by web conference. Top officials from the Pence administration will also hold public events this week to teach Hoosiers about HIP 2.0 prior to finalizing the waiver submission in late June. A draft of the waiver and other related documents are posted on the Healthy Indiana Plan website. Read more

Kansas

KanCare Insurers Lose $110 Million During First Year of Program. On May 21, 2014, the *Wichita Eagle* reported that the three companies that provide health care services to the state's KanCare Medicaid program reported a collective $110 million in net losses during the first year of the program. While these companies are contractually obligated to provide services for three years (beginning in 2013), some politicians are concerned that the companies will eventually pull out of the state if they keep experiencing losses. Read more

Louisiana

Medicaid Expansion Dead in Louisiana, Jindal's "America Next" Plan Advances. On May 22, 2014, the *Advocate* reported that the Louisiana House Health and Welfare Committee killed three separate bills proposing Medicaid expansion in the state. On the same day, the Senate voted to advance SB 682, under which the state health agency would develop a health care plan using Governor Bobby Jindal's "America Next" outline. Senator Ben Nevers, who sponsored the bill, said he would not allow the bill to be used to resurrect Medicaid expansion. Read more

Maine

LePage Suspends Contract with Alexander Group Over Allegations of Plagiarism. On May 23, 2014, *AP*/the *San Francisco Gate* reported that the administration of Maine Governor Paul LePage has suspended payments to the Alexander Group due to concerns that the consulting group plagiarized parts of a report on the state's welfare and Medicaid programs. A plagiarism expert who examined the report identified several areas that were not properly cited. LePage said that the state may terminate the contract or even ask the Alexander Group to return past payments. Read more

Michigan

Legislature Votes to Reinstate Use Tax to Address HICA Shortfall. On May 27, 2014, the *Michigan Gongwer News Report* reported the State Legislature passed SB 893 and SB 913, which would bring back the decade-old 6 percent use tax on the state's Medicaid health maintenance organizations. The legislation is meant to resolve the deficit in the Health Insurance Claims Assessment (HICA), which provides funding for Medicaid. The use tax was originally used to obtain more federal money for the state's Medicaid program and increase provider participation. Resolving the issue also clears the way for next year's state budget, which Governor Snyder hopes to have squared away by this summer.

Healthy Michigan Plan Medicaid Enrollment Reaches Half of Total-Year Goal in First Six Weeks. On May 15, 2014, *Crain's Detroit Business* reported that 237,329 Michigan residents have enrolled in Medicaid since the state began its Medicaid expansion initiative on April 1, 2014. Healthy Michigan Plan administrators set a goal of signing up 458,790 uninsured people this year. The strong enrollment is good news for hospitals in the state, which have reported a 20 percent rise in uncompensated care in recent years. Read more

Missouri

House Majority Floor Leader Diehl Remains Unconvinced of the Need for Medicaid Expansion in Missouri. On May 22, 2014, the *Springfield News-Leader* reported that Missouri House Majority floor leader Rep. John Diehl is unconvinced by Governor Jay Nixon's efforts to promote Medicaid expansion in the state. As the expected next Speaker of the House, Diehl will be influential in determining what bills are given the opportunity to advance. But Diehl recently stated that he believes the prospect of expansion is still "pretty far away from actually occurring." Read more

New Jersey

HMA Roundup – Karen Brodsky

Statewide survey shows significant reduction in uninsured. A recent statewide survey shows that number of New Jersey residents between the ages of 18 and 65 who were without health insurance dropped from 21.2 percent in September 2013 to 13.2 percent in March 2014. The Robert Wood Johnson Foundation and the Ford Foundation funded the Health Monitoring Survey which was conducted by The Urban Institute nationwide. This change is similar to the national experience and may be attributed to the federal health-insurance marketplace and Medicaid expansion. Federal figures say 162,000 people in the state registered for the Exchange, and the state experienced 140,000 successful Medicaid applicants. The report indicates that New Jersey's marketplace enrollment as a share of eligible residents at 26 percent was slightly lower than New York's experience at 28 percent but better than Pennsylvania's 22 percent. Read more

Division of Medical Assistance and Health Services releases 2013 NJFamilyCare Annual Report. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) recently released an annual report that includes the quality results of its Medicaid managed care program, health plan best practices, eligibility and enrollment experience, infrastructure and fiscal reports, and background on key initiatives from 2013. Medicaid enrollment remained steady in 2013 at about 1.3 million. Four health plans provided services to 90 percent of total enrollment. All of the health plans demonstrated strong compliance with health plan operations based on a review by an external quality review organization (see table below).

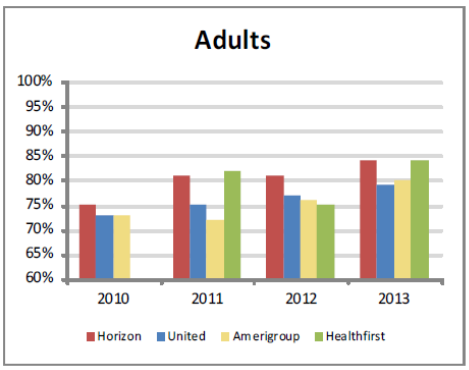
Results of External Quality Review Organization Assessment of Health Plans' Performance in Implementing Contractual Requirements

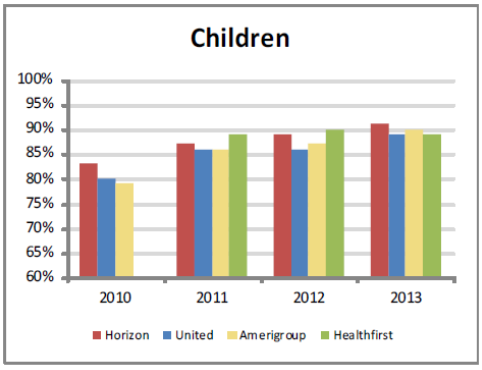
Assessment of Health Plan Operations					
Health Plan	**Elements Reviewed**	**Elements Met Year 1**	**Elements Met Year 2**	**Elements Unmet Year 2**	**% Elements Met After Year 2**
Horizon	171	164	6	1	99.4%
United	171	160	8	3	98.2%
Amerigroup	171	157	11	3	98.2%
Healthfirst*	169	151	11	7	95.9%

*Two standards were considered not applicable for Healthfirst in the partial review as the plan had not yet received results of a contractor survey.

The latest Consumer Assessment of Health Care Providers and Systems (CAHPS) survey found that recipients were generally satisfied with their health plan, and there were improvements seen from the previous year. The report provides trends over a four year period.

CAHPS Survey Results on Percent of Beneficiaries Satisfied Overall with their Health Plan





Health plan performance on measures of care and service under the 2013 HEDIS report were above the national Medicaid average for well visits, lead screening in children, breast cancer screening, prenatal care, immunization for adults, access to primary care physicians, adult asthma medication management, and a few diabetes care measures. Complete HEDIS scorecards by health plan are available in the annual report.

The report also found that New Jersey's NJFamilyCare spending grew at a rate well below the national trend between 2006 and 2012. The state's cumulative spending growth was less than half of the Medicaid/CHIP growth rate, and it was the second lowest in the region for the same period. The report attributes the controlled spending to the state's continuous migration of medical services into managed care.

Managed Long Term Services and Supports (MLTSS) Training Available Online. As DMAHS prepares to implement MLTSS on July 1, 2014, it has prepared a series of training videos and presentations that are available on its website. The trainings are designed to inform stakeholders about MLTSS services and how to interact with the new system of care under managed care. The trainings cover the basics about MLTSS in New Jersey and the many components of MLTSS including: 1) Participant Direction – Personal Preference Program services, 2) Assisted Living services, 3) Program of All-Inclusive Care for the Elderly (PACE) information, 4) Area Agencies on Aging information 5) Aging Disability Resource Connection (ADRC) information, and more. The trainings can be accessed here.

New York

HMA Roundup – Denise Soffel

Xerox Wins Contract to Revamp NYS Medicaid Management System. On May 27, 2014, *Politics on the Hudson* reported that the New York State Department of Health has awarded Xerox Corporation a five-year, $500 million Medicaid Administrative Services contract to revamp the state's Medicaid management system. Xerox beat out Hewlett-Packard for the contract. The deal is pending,

awaiting a signed agreement and approval from the state Attorney General's Office, Comptroller's Office, and CMS. Read more

Brooklyn's Long Island College Hospital Closed. On May 22, 2014, the *New York Times* reported that Long Island College Hospital has closed and almost all employees have been laid off as the facility transitions to an urgent care center. Justice Johnny Lee Baynes of State Supreme Court approved a settlement that allowed the hospital to close last week, except for the emergency department, while the State University of New York (SUNY), which owns the hospital, negotiates a sale to a real estate developer. Realtor Peebles and investment firm the Witkoff Group have proposed paying SUNY $260 million for the facility. The settlement states that if the proposal goes through, Peebles will work with the community surrounding the hospital to assess community health care needs in order to design the most "reasonable" plan for the site. Read more

DOH Releases Names of Performing Provider Systems Interested in Participating in DSRIP. This week, the New York State Department of Health (DOH) released a list of emerging Performing Provider Systems (PPS) that have expressed interest in partnering with providers to participate in the Delivery System Reform Incentive Payment (DSRIP) Program. A total of 51 letters of interest were identified by the DOH as "emerging" PPSs; while many of these still do not meet all network expectations, the DOH has written to all emerging PPSs with guidance on what they can do to address network weaknesses. The DOH is encouraging providers to reach out to these emerging PPSs to see how they might be able to collaborate. The Department also released a list of 27 non-emerging PPS, along with reasoning for why these PPSs are considered "non-emerging." Read more

Ohio

Veterans on Medicaid May Have Option of VA Care. On May 27, 2014, the *Columbus Dispatch* reported that some of Ohio's 880,000 veterans on Medicaid may be eligible for services at VA facilities. Veterans with at least a 70 percent service-connected disability can likely receive services for free through the Veterans Administration, which would save state Medicaid programs money. Using VA services rather than Medicaid can also be useful for veterans enrolled in long-term care, as the government has the right to place a lien on these patients' homes to cover the cost of care provided by Medicaid. The Ohio Department of Veterans Services favors the approach of letting veterans choose whether they want to rely on Medicaid or federal health benefits for long-term health care. State officials cannot yet say how many Ohio veterans are enrolled in Medicaid and how much money could potentially be saved by shifting care to VA medical centers. Read more

Oklahoma

Medicaid Reimbursement Rate Cut Could Limit SoonerCare Enrollees' Access to Care. On May 28, 2014, the *Tulsa World* reported that looming cuts to the Oklahoma's Medicaid (SoonerCare) program have raised concerns that SoonerCare enrollees will have limited access to care. The state is proposing to cut Medicaid reimbursements rates by 7.75 percent to make up for a projected $90 million budget deficit in the next fiscal year. Lower reimbursements will likely dissuade many doctors from accepting SoonerCare recipients, thus

restricting the SoonerCare provider network. Overall, the rate cut translates to a $150 million loss to the state's Medicaid system. Read more

Oregon

Oregon Basic Health Plan Study RFP Award Made to Wakely Consulting. On May 22, 2014, the Oregon Health Authority announced its intent to award the Oregon Basic Health Plan Study RFP (RFP 3766) to Wakely Consulting Group, Inc. Wakely Consulting Group will be tasked with assessing the costs and impacts of operating of a Basic Health Program in the state. From this assessment, state policymakers will determine the feasibility of implementing a statewide Basic Health Program to provide coverage for low-income individuals.

Pennsylvania

HMA Roundup – Matt Roan

Health Care Cost Containment Council Issues Report on Acute Care Hospital Finances. The Pennsylvania Health Care Cost Containment Council issued a report this month on the financial strength of general acute care hospitals across the Commonwealth. The report was compiled from hospital financial statements for state fiscal year 2013 (July 1, 2012-June 30, 2013). Key findings in the report include:

- The statewide average operating margin for hospitals decreased from 5.73 percent in FY 2012 to 4.69 percent in FY 2013, while total margin (including non-operating income) increased from 5.93 percent in FY 2012 to 6.1 percent in FY 2013.
- The cost of uncompensated care increased by 5.41 percent from $989M in FY 2012 to $1.042B in FY 2013. 49 percent of uncompensated care was reported as bad debt, while 51 percent was reported as charity care.
- 59 of the 169 hospitals analyzed reported negative operating margins in FY 2013. This number is up from the 37 hospitals that reported negative operating margins in FY 2012.
- Hospital inpatient utilization decreased slightly from FY 2012 to FY 2013 with approximately 40,000 fewer discharges in FY 2013.
- In FY 2013, Commercial Insurance accounted for 47.1 percent of statewide hospital revenues, Medicare made up 35.1 percent, and Medicaid was 12.8 percent. Five percent of revenue came from other sources. Read more

Highmark CEO Ousted by Board of Directors. The Board of Directors of Highmark, the largest health insurer in Pennsylvania, announced last week that it was replacing CEO Dr. William Winkenwerder with David Holmberg, a Highmark Executive who had responsibility for the company's diversified businesses division, which includes a number of subsidiaries including Davis Vision and United Concordia Dental. Winkenwerder was selected as the CEO two years ago after then CEO Kenneth Melani was forced out by the Board after an arrest for assaulting his girlfriend's husband. At the time, Winkenwerder's impressive resume and credentials were attractive to Highmark as it sought to

move beyond an embarrassing scandal. In the two years since becoming CEO, Winkenwerder has been the subject of criticism over his leadership style, with insiders complaining that he was not visible and accessible to the public and did not project a strong vision for the company. In naming Holmberg as CEO, Highmark hopes to capitalize on his proven record with Highmark subsidiaries of attracting and retaining customers. Read more

Rhode Island

EOHHS Releases Updated Medicare/Medicaid Financial Alignment Timeline. This month, the State Executive Office of Health and Human Services released an updated timeline for Phase II of its Integrated Care Initiative. The Integrated Care Initiative is a patient-centered care model aimed at improving coordination of various types of care increasing access to appropriate care. Phase II is the full integration and financial alignment of Medicare and Medicaid, which is accomplished through a three-way contract with CMS, RI Office of Health and Human Services, and the selected Health Plan(s). Demonstration proposals are due on July 7, 2014; the effective contract date and opt-in enrollment effective date will be April 1, 2015. Read more

Texas

Texas Weighing Sovaldi Coverage for Medicaid, Prison Populations. On May 26, 2014, the *Texas Tribune* reported that the high cost of Sovaldi, a new hepatitis C treatment, has raised debates in the state regarding the criteria for approving the $84,000 drug. Texas HHSC is currently working on a revised proposal for drug coverage criteria, which it hopes to get approved by the Medicaid drug review board by August. The University of Texas Medical Branch's correctional managed care department has been tasked for determining eligibility criteria for prisoners. Read more

Utah

Medicaid Expansion Discussions Likely Delayed Till 2015. On May 21, 2014, the *Salt Lake Tribune* reported that continued disagreement among lawmakers over the prospect of Medicaid expansion has likely delayed the decision to next year. Governor Gary Herbert hoped to get the program approved by the Legislature this summer, but lawmakers remain in a stalemate. House Speaker Becky Lockhart said that it is unlikely House leaders would support approving a Medicaid expansion plan during a special session; several lawmakers have expressed the desire to instead resume discussions during next year's general session so that they can dedicate the time needed to hammering out the issue. Read more

National

CMS Conducting Study on State Payment Rates to MCOs. On May 27, 2014, *Modern Healthcare* reported that CMS is conducting an actuarial study on how states set Medicaid managed care capitation rates to MCOs in an attempt to understand whether payment rates, and subsequently provider

reimbursements, are actuarially sound. CMS intends to release the findings of this study this summer. Read more

Safety-Net Hospitals Reporting More Paying Patients and Revenue as Uninsured Americans Sign Up For Health Insurance. On May 27, 2014, *Kaiser Health News* reported on the financial benefits gained by safety net hospitals as a result of the ACA's expansion of health insurance coverage. Safety-net hospitals, which are usually government-owned or non-profit and primarily treat the very poor and uninsured, have historically provided billions of dollars in uncompensated care. But as more uninsured sign up for health insurance, hospitals around the country are reporting a significant drop in uninsured patients seeking treatment and substantial increases in revenue as a result. Read more

Congressmen Ask CMS If States Will Be Penalized for Medicaid Application Backlogs. On May 22, 2014, the *Hill* reported that state lawmakers are asking CMS if it plans to reduce federal payments to states that have a backlog in processing Medicaid applications. Representative Fred Upton (R-Michigan) and Senators Orrin Hatch (R-Utah) and Lamar Alexander (R-Tennessee) wrote to CMS Administrator Marilyn Tavenner last week saying it would be unfair for CMS to penalize states because the backlogs are in part the result of problems states have had with the federal website, HealthCare.gov. The lawmakers went on to say that if CMS plans on decreasing payments, they must explain which states will be affected, the scope of payment reductions, and when the federal government will give states all the data they need to process outstanding Medicaid applications. Read more

More Insurers, Health Systems Interested in Joining Health Exchanges in 2015. On May 25, 2014, the *New York Times* reported that several insurers who have had limited participation in health Exchanges are planning to enter more markets in 2015. As Exchange enrollment is projected to increase by 13 million people next year, many insurers have identified new enrollment as a good business opportunity. More health systems also seem interested in offering plans next year. The companies must decide in the coming weeks whether they want to participate in the federally run Exchanges, and states may have their own deadlines. Read more

NAMD Questions Clinical Evidence Supporting Effectiveness of Sovaldi; Advises Medicaid to Use the New Drug Only After "Careful Consideration." On May 20, 2014, Matt Salo of the National Association of Medicaid Directors released a statement in response to a report released by the Medicaid Evidence Based Decisions Project (MED). According to Salo, the Center has reviewed ten published studies on the new and extremely costly hepatitis C treatment, Sofosbuvir (branded Sovaldi) and found that each study uses questionable methodology. The Center found that none of the studies showed whether Sovaldi works better than current treatments and for the people most likely to have it prescribed. Because there are no longitudinal studies of Sovaldi's efficacy, Salo advises that "Medicaid programs must be deliberate in their decisions and may need to adapt their strategies over time as more detailed clinical research becomes available." Read more

Industry News

Beacon Health Strategies and ValueOptions to Merge: On Tuesday May 27, Beacon Health Strategies and ValueOptions announced the successful negotiation of a merger agreement, the financial terms of which were not disclosed. HMA served as an advisor to Beacon Health Strategies on the transaction.

According to a statement released by Beacon Health Strategies:

Beacon Health Strategies has entered into a definitive agreement to merge with ValueOptions, in a transaction designed to create the premier managed behavioral healthcare company in the United States. Financial terms of the private transaction were not disclosed.

The transaction brings together two best-in-class mission driven companies that share similar visions. "Our combined company will continue our unwavering efforts to improve access to high quality, appropriate behavioral healthcare services to individuals living with mental health or substance use conditions. We will strive to improve the health and social wellbeing of individuals through recovery-focused programs and effective provider partnerships," said Tim Murphy, Beacon's CEO, who will now serve as the CEO for the combined companies.

"ValueOptions firmly believes combining with Beacon offers our clients, providers and members the industry's best behavioral healthcare management partner. Both entities know each other well. Both are financially strong. Both are recognized leaders. This move just makes sense from the perspective of providing a broader range of services to all of the different populations we now serve individually," said Heyward Donigan, President and Chief Executive Officer of ValueOptions. Upon completion of the transaction, Ms. Donigan will serve as an advisor to Mr. Murphy.

The transaction will combine two industry leaders in the behavioral health management services sector. "We are well positioned to address emerging needs of clients and members during the era of the Affordable Care Act and Federal mental health parity law," said Tim Murphy. "Our new combined operation will immediately distinguish itself by offering our clients superior clinical management, a strong Employee Assistance Program (EAP) and insightful analytics to improve the delivery of care. As a company exclusively focused on behavioral health management, we have the resources to invest and tailor our programs to each client's needs," Murphy added.

The combined business will serve 43 million people across all 50 states and the United Kingdom. It will have approximately 4,000 employees and be headquartered in Boston, MA. The merger is subject to regulatory review, which is expected to be completed in the fall of 2014. In the meantime, the two companies will continue to operate as independent organizations. Read more

Walter D. Hosp Named CFO at AMC Health. On May 22, 2014, leading telehealth solutions provider AMC Health announced the appointment of Walter D. Hosp to the newly created position of Chief Financial Officer, starting on July 7, 2014. Hosp currently serves as a Director and Chair of the Audit Committee for the Trustwave Holdings, Inc., Board and has served as Executive Vice President, CFO, and Chief Administrative Officer of HMS Holdings Corporation. Hosp also formerly served as the Vice President and Treasurer of Medco Health Solutions, Inc. (now Express Scripts) and CFO and President of the Business Support Center at CIBA Specialty Chemicals Corporation (now BASF Corporation). Read more

HCA Healthcare Acquires Citrus Memorial Hospital. On May 22, 2014, *Health News Florida* reported that Florida's largest for-profit chain, HCA Healthcare, will purchase Citrus Memorial Hospital in Inverness in a $127.5 million deal. The announcement comes nearly a year after the financially troubled hospital took bids from potential buyers or hospitals wanting to merge. Read more

Kindred Healthcare Appoints Phyllis R. Yale as Chair of the Board of Directors. On May 22, 2014, FORTUNE 500 healthcare services company Kindred Healthcare announced that Phyllis R. Yale has been named Chair of the Board of Directors, effective immediately. Ms. Yale has been a member of Kindred's Board since January 2010 and succeeds Edward L. Kuntz, who recently announced his retirement. Yale was a partner with global management consulting firm Bain & Company, Inc., from 1987 to 2010 and has significant experience working with healthcare payers, providers, private equity firms, and medical device companies. She is currently Chair of Blue Cross Blue Shield of Massachusetts. Read more

Ascension Health Considers Acquiring Large Insurance Company. On May 22, 2014, *Modern Healthcare* reported that hospital operator Ascension Health is in talks to acquire an unnamed insurance company that operates in 18 states. CEO Robert Henkel said that the potential deal is one strategy to improve Ascension's capacity to accept the financial risk of value-based contracts with employers and insurers. This represents a trend among hospital operators nationwide towards entering the health plan business in order to control costs and improve quality of care. Read more

WellCare Health Plans Interim CEO Gallitano Discusses His Plans for Growing the Company. On May 23, 2014, the *Tampa Bay Times* reported on the significant changes to WellCare Health Plans instituted by interim CEO Dave Gallitano. Since filling the position six months ago, Gallitano has focused on tailoring the managed health care company to the needs of its health plan members rather than the financial goals of its investors. While WellCare has been a major competitor in Medicare, Medicaid, and prescription drug plan markets nationwide, recent allegations of fraud have brought the company's priorities into question. In this first media conference since becoming interim CEO, Gallitano discussed a number of company reforms he is planning, including expanding the company by 1000 positions and nurturing recent acquisitions in Arkansas, Mississippi, Tennessee and New Jersey. Read more

RFP Calendar

Date	State	Event	Beneficiaries
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	Indiana ABD	RFP Release	50,000
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	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
March 1, 2015	Texas Duals	Passive enrollment begins	168,000
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		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	168,000				5/23/2014	1/1/2015	3/1/2015	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***			***11***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

[1] Capitated duals integration model for health homes population.

HMA News

HMA's Accountable Care Institute Paper:
"The Critical Role of Public Health Departments in Health Care Delivery System Reform"

This paper presents a variety of models for greater involvement of health departments in system-wide reforms at the community level. Its goal is to connect local and state public health officials with the leadership of hospitals, physicians, and other providers, and public and private payers in an effort to improve the health of individuals and to reduce avoidable health care spending. To access this paper, please click here. To access the full ACI Toolkit, please click here.