HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 10, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

- IN FOCUS: PENNSYLVANIA RELEASES MLTSS DISCUSSION DOCUMENT
- ARIZONA MEDICAID ABANDONS FIVE PERCENT PROVIDER RATE CUT
- FLORIDA LEGISLATIVE UPDATES ON LIP, CON, AND FHIX
- EMORY, WELLSTAR BREAK OFF MERGER TALKS
- NEW YORK ALLOCATES VAPAP FUNDS
- PARTNERS HEALTH PLAN SELECTED FOR NEW YORK FIDA-IDD
- TEXAS HHSC COMMISSIONER JANEK TO STEP DOWN
- WEST VIRGINIA JUDGE GRANTS INJUNCTION IN MEDICAID MANAGED CARE EXPANSION CASE
- WHITE HOUSE REPORT SHOWS LARGE SAVINGS FOR EXPANDING MEDICAID
- ASSURANT HEALTH TO WIND DOWN AFTER UNABLE TO FIND BUYER
- HMA WEBINAR REPLAYS AVAILABLE ON MCO REGS, NEW YORK DSRIP

IN FOCUS

PENNSYLVANIA RELEASES MLTSS DISCUSSION DOCUMENT

This week, our *In Focus* section reviews the Commonwealth of Pennsylvania's Managed Long-Term Supports and Services (MLTSS) Discussion Document, jointly published this month by the Department of Human Services (DHS) and the Pennsylvania Department on Aging (PDA). The discussion document builds on work concluded last year by the Pennsylvania Long-Term Care Commission and Governor Wolf's proposed FY 2015-2016 budget, serving as an introduction to the state's current thinking on a model for MLTSS and soliciting stakeholder input. The state's proposed plan calls for a request for proposals (RFP) in the fourth quarter of 2015, with a phased-in managed care model for around 130,000 users of LTSS services and another 320,000 dual eligible individuals without

LTSS needs beginning in January 2017. Below, we highlight the design elements of the MLTSS and dual eligibles managed care program as outlined in the discussion document. However, these elements are subject to change through the stakeholder engagement and feedback process.

Target Population

The MLTSS program would extend mandatory managed care coverage for physical health, behavioral health, and LTSS to the following populations:

- All dual eligible adults over the age of 21.
- All non-dual eligible adults over the age of 18 who are nursing facility clinically eligible (NFCE).
- Non-Medicaid recipients of the Act 150 Program, a state-only funded program for adults with physical disabilities.

Excluded from the MLTSS program are those individuals with intellectual and developmental disabilities (I/DD) eligible for the Medicaid-funded and Base-funded programs available through the Office of Developmental Programs.

Mandatory Covered Populations	Est. Current Enrollment
Dual Eligible Adults (No LTSS)	318,000
Dual Eligible Adults (LTSS)	104,000
NFCE Non-Dual Adults	23,000
Act 150 Program	2,200
Total Mandatory Populations	**447,200**

Source: Pennsylvania MLTSS Discussion Document

The discussion document claims that annual Medicaid spending for LTSS for the 130,000 users of LTSS in the table above (excluding the non-LTSS dual eligible adults) is approximately $5 billion, or about $3,205 per enrollee per month.

MLTSS Program Components

The discussion document outlines the key program components that will likely feature prominently in the RFP process.

Components	Details Provided in Discussion Document
Person-Centered Program Design and Service Plan Development	Standard assessment for service planning; person-centered service planning; provider choice; maximization of self-directed services; focus on transition between settings and services based on needs and preferences; distinct, expeditious timelines for assessing and reassessing needs.
Services and Care Coordination	Coordination of all physical, behavioral, and LTSS; to include all Medicaid state plan services, all Medicaid HCBS waiver services, Medicare parts A, B, and D, and additional supportive services to the target population.
Access to Qualified Providers	Network adequacy to ensure adequate providers, credentialed/ qualified providers; participant protections including continuity of care, out-of-network rules; provider incentives to support existing provider transition to managed care.
Emphasis on HCBS	Consistent with federal HCBS waiver requirements; least restrictive setting; address institutional bias.

Performance-Based Payment Incentives	Payment structure to encourage quality outcomes, other program goals; leaves potential for three-way contracting with CMS, as in duals demonstrations.
Participant Education and Enrollment Supports	Conflict-free counseling, enrollment choice, advocacy/ ombudsman services seen as critical for mandatory MLTSS program.
Preventative Services	Existing Medicare preventive services will be integrated or expanded into MLTSS program.
Participant Protections	Grievance and appeals; coordination with Adult Protective Services and Older Adult Protective Services programs.
Quality and Outcomes-Based Focus	Integration of existing quality measures; evaluation of person-level encounter data; external measures such as HEDIS; MCO/vendor reporting on access, service plan development, enrollment, participant health, etc.

Timing of Public Comments, RFP, and Implementation

Pennsylvania will be accepting public comments on the discussion document through July 15, 2015, with six public hearings across the state scheduled to begin June 10, 2015. A full list of public hearing dates and locations, as well as contact information for public comments, are available here. The state currently intends to release a RFP in October, 2015, with a three-phased approach to implementation over three years, beginning January 1, 2017, and concluding in 2019.

Milestone	Date
Discussion Document Release	June 1, 2015
Public Comment and Engagement Period	June 1 - July 15, 2015
Deadline for Submission of Comments	July 15, 2015
RFP Release	October, 2015
Phase 1 Ramp-up Period	July-December, 2016
Phase 1 Enrollment Date	January 1, 2017
Phase 2 Ramp-up Period	July-December, 2017
Phase 2 Enrollment Date	January 1, 2018
Phase 3 Ramp-up Period	July-December, 2018
Phase 3 Enrollment Date	January 1, 2019

Current Medicaid Managed Care Market Overview

Pennsylvania's physical health managed care program (HealthChoices) is served by seven MCOs, which cover around 1.6 million beneficiaries as of March 2015. AmeriHealth Caritas is the largest of these MCO providers, with just over 30 percent market share (see the table below). Pennsylvania intends to reprocure the HealthChoices contracts in the second half of 2015 and is currently soliciting comments on a RFI for the rebid.

HealthChoices MCOs	Regions Served	March 2015 Enrollment	Market Share
AmeriHealth Caritas	Southeast; Lehigh/Capital; New West; New East	492,539	30.9%
UPMC	Southwest; Lehigh/Capital; New West;	257,706	16.2%
Gateway	Southwest; Lehigh/Capital; New West;	250,435	15.7%

Health Partners	Southeast	168,716	10.6%
United Healthcare	Southeast; Southwest; Lehigh/Capital;	158,506	9.9%
Aetna Better Health	Statewide	142,351	8.9%
Geisinger	New East	125,294	7.9%
Total Enrollment - All MCOs		**1,595,547**	

Link to MLTSS Documents

The MLTSS discussion document, fact sheet, and information on public hearings and comment submission are available at: http://www.dhs.state.pa.us/foradults/managedlongtermsupports/index.htm

HMA Medicaid Roundup

Arizona

Arizona Medicaid Abandons Five Percent Provider Rate Cut. On June 10, 2015, the *Associated Press/ABC15* reported that Governor Doug Ducey's administration announced it will not implement a five percent reimbursement rate reduction to hospitals, doctors, and other medical professionals as prescribed in the state's Medicaid budget for the upcoming fiscal year. The cuts amounted to a projected $37 million in savings. A statement from the state Medicaid agency said that provider comments played a role in the decision, as did lower utilization. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Inland Empire Health Plan Providing Grants to Providers to Offset Startup Costs. On June 3, 2015, KQED News reported on the Inland Empire Health Plan's grant program, aimed at reducing physician and other provider shortages in their Medi-Cal managed care service area. IEHP set aside $8 million from its cash reserves ($5 million for primary care, $3 million for specialists) to award as grants to providers. As of last month, grants have been approved for 123 physicians. Read More

Governor Appoints State's First Dental Director. Governor Jerry Brown has appointed Dr. Jayanth Kumar as the state's first dental director under the Department of Public Health. The position has long been advocated for by the California Dental Association. Dr. Kumar previously served as the dental director at the New York State Department of Public Health. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Lawmakers Agree on $1 Billion in LIP Funding, No Agreement on Allocation Policy. On June 8, 2015, *Health News Florida* reported that House and Senate lawmakers reached a tentative agreement to set aside $1 billion in state and federal funding for the Low Income Pool (LIP). In addition, $400 million in state funding will be put towards an increase in hospital reimbursements. Read More However, on June 9, 2015, Political Fix Florida reported that the policy determination of how LIP funds will be allocated could not be resolved in time by the House and Senate subcommittee negotiators and will be taken up now by the House and Senate appropriation committee chairs. Read More

House Committee Passes Six Health Bills. On June 10, 2015, *SaintPetersBlog* reported that the House Health and Human Services Committee passed six bills including bills to establish a new health care provider type called recovery care centers, to eliminate certificate of need (CON) requirements for hospitals, and to allow nurses and physician assistance to prescribe controlled substances. Read More

Governor, HCA Back House Bill to Eliminate State Approval Process for Hospital Construction. On June 9, 2015, the *Miami Herald* reported that Governor Rick Scott and the Hospital Corporation of America (HCA) have both backed a House proposal to eliminate the law eliminating the requirement of state approval for new hospital construction. Opponents, including the Florida Hospitals Association, claim that eliminating the requirement would discourage hospital construction in low-income areas. Read More

House Kills Senate's FHIX Expansion Plan. On June 5, 2015, *PalmBeachPost.com* reported that after a seven hour debate, the House voted against the Senate's proposed health care expansion called Florida Health Insurance Exchange (FHIX), calling it financially unreliable. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Emory, WellStar Break Off Merger Talks. On June 9, 2015, Atlanta's *WABE* reported that months-long discussion of a potential merger between Emory Healthcare and WellStar Health System have ended. According to statements from the two organizations, Emory Healthcare continues to believe a merger would serve the community, while the chair of the WellStar Board of Trustees stated that WellStar has declined to enter the next stages of discussions with Emory University. Read More

Indiana

With HIP 2.0 Nearing 300,000 Enrollees, State Plans Ad Campaign to Promote Program. On June 5, 2015, the *Indiana Business Journal* reported that the state will launch a $2 million ad campaign to promote the Healthy Indiana Plan (HIP) 2.0, which launched February 1, 2015. HIP 2.0 was devised as an alternative coverage expansion, with cost-sharing and other requirements dependent on income level. Nearly 60,000 of almost 290,000 enrollees in the program came from programs that were folded into HIP 2.0, but at least 170,000 are new to state-funded health insurance. According to Indiana Medicaid Director Joe Moser, 71 percent of HIP 2.0 participants are in the HIP Plus program, which requires POWER account (similar to a HSA) contributions. Read More

New Hampshire

Exchange Insurers Request Double Digit Rate Hike. On June 2, 2015, *New Hampshire Union Leader* reported that two insurers on the New Hampshire Exchange have proposed double digit rate hikes for next year. Minuteman Health requested rate increases ranging from 42 percent to 51 percent. Minuteman entered the Marketplace this year with the lowest premiums. Maine Community Health Options requested rate increases ranging from 19 percent to

22 percent. Both insurers have cited a new Medicaid expansion program called the Premium Assistance Program, which goes into effect January 1, as the reason for the increases. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New legislation would Create a New Behavioral Health Advisory Board. On June 8, 2015, *NJ Spotlight* reported that the state legislature has introduced a bill to establish a Behavioral Mental Health Advisory Board to review all aspects of behavioral mental health services in New Jersey and make recommendations for legislation or other actions with regard to improving, expanding, and facilitating the provision of behavioral mental health services. The bill, A-4416, comes at a time when the state is implementing behavioral health reforms including a contract with Rutgers University Behavioral Health Care (UBHC) to manage state, block grant and NJ FamilyCare interim managing entity services beginning July 1, 2015, under a fee-for service arrangement; continued plans for program-wide managed behavioral health care; and the integration of behavioral health care for individuals receiving managed long term services and supports from a managed care organization. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Vital Access Provider Assurance Program (VAPAP). As part of the 2015-16 state budget the governor established the Vital Access Provider Assurance Program. Funds in the amount of up to $245 million are available to individual hospitals in severe financial distress to enable these facilities to maintain operations and vital services through March 31, 2016, while they work toward longer-term solutions to sustainable health care services. A hospital receiving funding must collaborate with other providers to build more efficient and effective service delivery through reduced reliance on inpatient care and the strengthening of primary, ambulatory and community-based care appropriate to identified community needs consistent with the goals of the Delivery System Reform Incentive Payment (DSRIP) program. It is expected that successful applicants under this solicitation will develop a transformation strategy during the funding period that will ensure future fiscal sustainability while providing essential services to their communities.

The VAPAP eligibility criteria are nearly identical to the criteria for the Interim Access Assurance Fund (IAAF) program, which ended on March 31, 2015. The IAAF was intended to serve as a bridge for hospitals in financial distress to sustain them in the nine-month long DSRIP planning period. Hospitals in need of immediate cash assistance for the months of April 2015 and/or May 2015 were eligible for an expedited application process. Hospitals seeking to receive award payments in months following May submitted an application on April 30.

VAPAP funds will be authorized only for payroll and payroll-related purposes, direct patient care expenses associated with existing services, and indirect expenses to preserve existing services, awards cannot be used for capital, consultant fees, retirement of long-term debt, or bankruptcy-related costs. As part of the VAPAP process, applicants must submit a multi-year transformation

plan that is aligned with DSRIP program goals and objectives and demonstrates a path to long-term sustainability and improved patient care.

A total of $95 million has been distributed as of June 2015: $52 million during the April-May period, and $43 million in June. Sixty-five percent of the awards were made to five New York City hospitals; the remaining awards were distributed to 21 other hospitals across the state.

VAPAP Participating Facility	April-May 2015	Jun-15	April - June Totals
Brookdale Hospital	$13,893,229	$7,098,574	$20,991,803
Interfaith Medical Center	$6,835,509	$9,545,431	$16,380,940
Kingsbrook Jewish Medical Center	$5,106,218	$4,318,766	$9,424,984
St John's Episcopal	$1,258,754	$515,240	$1,773,994
Wyckoff Heights Medical Center	$2,763,883	$10,300,000	$13,063,883
Subtotal - NYC			**$61,635,604**
A.O.Fox Memorial Hospital	$ -	$1,252,223	$1,252,223
Benedictine Hospital- Health Alliance	$740,038		$740,038
Bon Secours Charity Health	$822,610	$ -	$822,610
Brookhaven Medical Center	$3,000,000	$487,942	$3,487,942
Cuba Memorial	$968,794	$ -	$968,794
Eastern Niagara Hospital	$640,119	$412,187	$1,052,306
Good Samaritan Hospital- Suffern	$ -	$1,820,621	$1,820,621
Lewis County General Hospital	$1,172,119	$623,358	$1,795,477
Margaretville Hospital- Health Alliance	$ -	$124,577	$124,577
Montefiore Mount Vernon Hospital	$2,550,496	$1,487,805	$4,038,301
Montefiore New Rochelle Hospital	$3,410,533	$ -	$3,410,533
Moses Ludington (Inter-Lakes)	$148,355	$60,133	$208,488
Nyack Hospital	$1,054,882	$191,863	$1,246,745
Orleans Community Hospital	$464,858	$1,400,000	$1,864,858
River Hospital	$195,073	$ -	$195,073
Rome Memorial Hospital	$27,406	$ -	$27,406
St James Mercy Hospital	$4,285,247	$2,152,426	$6,437,673
St. Joseph's Hospital	$432,233	$ -	$432,233
TLC Health Network	$1,135,076	$ -	$1,135,076
Women’s Christian Association (WCA)	$624,179	$651,412	$1,275,591
Wyoming County Community Health	$385,662	$410,542	$796,204
Subtotal - non-NYC			**$33,132,769**
Grand Total	**$51,915,273**	**$42,853,100**	**$94,768,373**

More information about the VAPAP program can be found on the DSRIP web site.

Duals Demonstration for IDD Population. The New York State Department of Health (DOH) and the Office for People with Developmental Disabilities (OPWDD) have announced their partnership with the Centers for Medicare and Medicaid Services (CMS) and Partner's Health Plan (PHP). This partnership implements an additional component of the Duals Financial Alignment Demonstration to provide better, more coordinated care to individuals with intellectual and developmental disabilities (IDD) who are dually eligible for both Medicare and Medicaid. The program will be known as Fully Integrated Duals Advantage (FIDA-IDD). The program focuses on individuals who receive long-term care and IDD service needs. The original FIDA demonstration, for duals requiring more than 120 days of community-based long term care services, began implementation in January 2015.

The FIDA-IDD program will offer more opportunities for individuals to direct their own services, be involved in care planning, and live independently in the community. Individuals´ existing Medicare and Medicaid benefits will be provided through an integrated benefit design that also includes a dedicated interdisciplinary team to address each individual´s medical, behavioral, long-term supports and services, and social needs. New York and CMS expect to contract with Partners Health Plan to coordinate the delivery of covered services for individuals who are eligible and who elect to enroll voluntarily. While the FIDA demonstration plan approved by CMS in 2013 allows for up to 10,000 duals with IDD to enroll in a FIDA-IDD plan, PHP, a plan established by the Nassau County AHRC Foundation, expects its enrollment will be no more than 5,000. PHP intends to serve the New York downstate region (New York City, Long Island, Rockland, and Westchester Counties). PHP is the only plan that completed the Medicare approval process necessary to operate as a FIDA-IDD plan. The targeted start date for enrollment in the program is no sooner than January 1, 2016. In the next several months, New York State and PHP will work through finalization of key protections and design elements. The program will include a rigorous independent evaluation of both the quality of care that individuals receive, as well as any impact the program has on Medicare and Medicaid costs. The MOU and three-way contract for the New York-CMS original FIDA partnership will serve as the basis for the MOU and three-way contract, currently being developed for the FIDA-IDD program.

More information about FIDA-IDD can be found on the OPWDD website.

Health and Recovery Plans. New York State continues to refine its planning for Health and Recovery Plans, a Medicaid managed care product designed for individuals with serious mental illness and/or substance use disorder. HARPs are scheduled to launch in New York City in October of this year, with a new set of home and community based services added to the benefit package as of January 2016. All HARP beneficiaries will undergo an assessment based on an InterRAI tool, conducted by a health home. The health home will be responsible for developing a person-centered care plan that integrates physical and behavioral health, including HCBS services. The new benefits have been stratified into two tiers. Tier 1 includes employment, education, and peer support services. Tier II includes the full array of 1915i-like services (Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, Habilitation/Residential Support Services, Family Support and Training, Short-term Crisis Respite, Intensive Crisis Respite, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Education Support Services, Empowerment Services -

Peer Supports, Non-Medical Transportation). The state is proposing a patient-specific limit of $8,000 for Tier 1 services and an overall HCBS limit of $16,000, with a 20 percent risk corridor (i.e., plans will not be penalized unless they exceed $10,000 for Tier 1 services or $20,000 for all HCBS services). Further, the state proposes limiting short-term crisis respite and intensive crisis respite to 7 days per episode and 21 days per year. All HCBS service limits may be exceeded with prior approval from the Office of Alcohol and Substance Abuse Services or the Office of Mental Health. A draft of the fee schedule has been posted on the web site of the Office of Mental Health. These fees and payment proposals must be approved by CMS prior to the planned January 2016 start date.

Westchester Medical Center Continues Expansion. Westchester Medical Center (WMC) recently entered into a joint venture with the Bon Secours Charity Health System, which operates Good Samaritan Hospital in Suffern, Bon Secours Community Hospital in Port Jervis, St. Anthony Community Hospital in Warwick, as well as a certified home health agency; two long-term care facilities; and an assisted living/adult home. Bon Secours employs more than 3,400 people. A year ago WMC acquired St. Francis Hospital in Poughkeepsie, which was renamed the MidHudson Regional Hospital of Westchester Medical Center. Over the last 10 years Westchester Medical Center has grown from a single campus to a $1.62 billion network with partners across the healthcare continuum, including a children's hospital and a behavioral health center. In recognition of that growth, they have launched a rebranding campaign. The system will now be known as WMCHealth, the Westchester Medical Center Health Network. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Senate Publishes its Biennial Budget. While there had been some discussion of pulling Medicaid expansion out of the budget and into a separate bill, that did not happen. In 2017, when federal funding for the expansion group will no longer be 100 percent federal, the Senate proposes to move the state's share of funding to a separate line item. Disbursement of those funds would then require Controlling Board approval. Controlling Board is the bipartisan panel that initially approved funding for the expansion in 2013. Hundreds of other changes were made to the bill. Next step is a reconciliation of versions proposed to date with a final budget in place by July 1. Read more. Some changes with the potential to impact Ohio's Medicaid Program are included below.

- Changes to the definition of imprisonment for purposes of Medicaid.
- Eliminates development of the Ohio Hospital Report Card.
- Removes the earmark and requirement that the Office of Health Transformation create the Ohio All-Payer Health Claims Database.
- Removes language and appropriations on the Healthier Buckeye Grant Program.
- Restores language to establish a Comprehensive Case Management and Employment Program.

- Eliminates provisions that exclude alcohol, drug addiction and mental health services from the Medicaid managed care system and requires those services to be included no later than January 1, 2018.
- Reduces a proposed rate increase for home health aides under an HCBS waiver program from 10 percent to 5 percent.
- Requires Medicaid managed care organizations to implement value-based payment strategies and that at least 50 percent of these payments are value-based by July 1, 2020.
- Restores Medicaid eligibility for pregnant women to 200 percent of FPL and coverage for the breast and cervical cancer eligibility group.
- Eliminates the proposed hospital franchise fee increases and reverts back to current law franchise rate of about 2.66 percent.
- Eliminates provisions in the bill having to do with "Healthy Ohio."
- Requires the Medicaid Director to establish an alternative purchasing model for nursing facility services.
- Requires the Department of Medicaid to establish a Medicaid waiver program under which certain Medicaid recipients, instead of participating in fee-for-service or managed care, must enroll in innovative and value-based health coverage that is modeled on health savings accounts and uses premiums, copayments, or both
- Requires the Medicaid program by July 1, 2016, to implement strategies to improve the integrity of the Medicaid managed care system.
- Authorizes the Medicaid Director contract with persons to receive and process requests for certain Medicaid-related data that will be used for commercial or academic purposes.
- Prohibits a Medicaid managed care plan from imposing prior authorization requirements for recipients of alcohol, drug addiction, or mental health services other than those prior authorization requirement of current law.
- Removes language that would have suspended a Medicaid provider agreement or Medicaid provider payments to entire entities on the basis of one individual's indictment on fraud.
- Creates a Graduate Medical Education Study Committee.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania First State to Announce Exchange Subsidies Backup Plan. Pennsylvania became the first state to announce a plan to save people's Exchange subsidies if the Supreme Court rules against the federal government sometime this month. Democratic Governor Tom Wolf said in a statement late Tuesday that he has submitted a blueprint to create a state-based Exchange to save subsidies for nearly 350,000 people with coverage through the Exchange, which he called "the responsible thing to do." In the case, *King v. Burwell*, the Supreme Court could strike down subsidies for 6.4 million people in the 37 states that currently use the federal Marketplace, HealthCare.gov, to sell

healthcare plans. Wolf had previously said that he was preparing a contingency plan. He is one of just a few governors who have been public about their plans for the ruling. Wolf's office underscored that the creation of a plan does not mean Pennsylvania will move to a state-run Exchange if the court upholds the subsidies. Read More

Pennsylvania's Attorney General Considers Options in Highmark, UPMC Dispute. Pennsylvania Attorney General Kathleen Kane is considering a number of interventions in the continuing Highmark-UPMC battle, including setting up two state-appointed commissions to ensure each of the health care entities complies with last summer's consent decrees. The development follows Commonwealth Court President Judge Dan Pellegrini's May 29 ruling prohibiting UPMC from locking out Highmark's estimated 182,000 Medicare Advantage members next year over a dispute about payments for cancer care. Insurer Highmark and UPMC health system officials last summer signed separate, but parallel, consent decrees about the pending expiration of their in-network contract. Despite the agreements, the two sides have continued to battle over reimbursement payments and eligibility criteria for in-network access to UPMC physicians and hospitals once the contract expired Dec. 31. Read More

Insurers Ask Pennsylvania Regulators for big rate increases. A national upswing of health insurance rates is coming to Pennsylvania, and that could mean bigger-than-expected cost increases next year for at least a couple hundred thousand Pennsylvanians who bought insurance in the Marketplace created by the 2010 federal health care law. Last week's deadline to file paperwork with the state Department of Insurance showed that some insurers selling plans on the Marketplace want rate increases of almost 10 percent – or well above that – in one or more of their plans. The Department of Insurance emphasized that it must approve any rate increase and that nothing is final. The Marketplace is a new experience for insurers, and they will be basing their 2016 premiums on a full year's worth of data, the first time that has happened during the 17-month history of Exchanges. Read More

Texas

HMA Roundup – Dianne Longley (Email Dianne)

Texas Health and Human Services Executive Commissioner Kyle Janek to Step Down. On June 5, 2015, the Texas Health and Human Services Commission announced that Kyle Janek will step down from his role as Executive Commissioner, effective July 1. The agency prepares for major reorganization after legislation calling for the consolidation of certain health and human services administrative functions and programs. Texas Governor Greg Abbott announced his intention to nominate HHSC Chief Deputy Commissioner Chris Traylor as the new HHSC Executive Commissioner and Charles Smith, Deputy for child support at the Texas Office of the Attorney General, as Deputy Executive Commissioner. Read More

Legislative Update. As previously reported, the Texas Legislature ended June 1st, passing a biennial budget that included more than $61 billion in Medicaid funding for fiscal years 2016 and 2017 and $77.17 billion for all Health and Human Services funding. (For more information on budget details, see previous Roundup, available here)

In addition to the funding details, the appropriations for the Health and Human Services Commission (HHSC) include dozens of riders that provide additional instructions for program implementation or clarification regarding how the Legislature intends HHSC spend certain funds. Following is a brief summary of some of the legislative riders:

- Contingency for Rate Increases in the Home and Community-based Services Waiver program: clarifies that $7.7 million in FY 2016 and $8.1 million in FY 2017 be used to fund rate increases for providers who meet certain cost accountability requirements.
- HHSC must publish a report requirement for non-state public hospitals, private hospitals, hospital districts, physicians and private administrators to provide expenditures made through the Disproportionate Share Hospital (DSH) program, the Uncompensated Care (UC) Pool, the Delivery System Reform Incentive Payment (DSRIP) Pool, and the Indigent Care program. The report must include expenditures by method of finance, and requires hospital providers to report payments to entities who provide consultative services regarding revenue maximization under the medical assistance program, UC, DSRIP and DSH, or any other governmentally funded program.
- HHSC must evaluate the impact of substance use disorder treatment services to Medicaid clients 21 years of age or older. HHSC must develop a methodology for evaluation of services and submit a progress report by December 1, 2015 and a final report by December 1, 2016.
- HHSC must issue a report by December 1, 2016 that summarizes their evaluation of the effectiveness of the medication therapy management pilot program in reducing adverse drug events and related medical costs for high-risk Medicaid clients, including those receiving treatment for asthma and COPD.
- Authorizes the implementation of certain quality-based reforms in Medicaid and CHIP, including quality-based payment systems for providers and/or facilities, as well as a Bundled payment Medicaid initiative, including a shared savings component for providers that meet quality-based outcomes
- HHSC must identify nearly $500 million in Medicaid savings and cost reduction using various initiatives, including the following options:
    - Fully implement dually eligible Medicare/Medicaid integrated care model and long term care services and supports quality payment initiative
    - Maximize co-payments
    - Explore changes to premium structure for managed care organizations and contracting tools to reduce costs and increase efficiency
    - Renegotiate more efficient contracts, including reducing the administrative contract profit margin and establish rebate provisions where possible
    - Develop a dynamic premium development process for managed care organizations that has an ongoing methodology for

reducing inappropriate utilization, improving outcomes, reducing unnecessary spending, and increasing efficiency
    - Review and determine the benefits of providing the MCOs with the ability to create pharmacy lock-in program

- Requires HHSC to implement changes to therapy-related services to achieve savings through rate reductions and medical policy initiatives that effectively reduce spending by $75 million per fiscal year.
- Conduct a thorough review of the agency's contract management and oversight functions for Medicaid and CHIP and make recommendations to improve the ability to identify anomalies in service utilization and their underlying cause.
- HHSC must monitor integration of Behavioral Health services into Medicaid managed care, prioritizing MCOs that provide services through a contract with a third party
- HHSC must evaluate data submitted by MCOs to determine the value of the information and whether it is needed to oversee contracts or evaluate the effectiveness of Medicaid. HHSC must develop a dashboard by October 1, 2016 that includes key data, performance measures, trends and problems and compares the performance of MCOs.

Senate Bill 200 - Health and Human Services Sunset Legislation. The Legislature also enacted Health and Human Services (HHS) Sunset legislation authorizing continuation of the HHS agencies for another 12 years. Affected agencies include the Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), and the Department of Family and Protective Services (DFPS). The legislation includes reorganizational changes as well as issues related to administrative oversight, regulatory activities, service integration and efficiency modifications. As a result of this bill, HHSC will be required to adopt substantive rules on dozens of various issues, many of which have relatively short time frames. The legislation affects virtually every activity of the five agencies at some level.

House Bill 3523: Medicaid Reform. HB 3523 makes additional changes to the Medicaid reform legislation enacted as SB 7 in 2013, including extends the statutory timeline for implementation dates of the Nursing Home Carve-In, STAR Kids and the Community First Choice (CFC) program to concur with the extensions already announced by HHSC. Additionally, HB 3523 delays transition of the Texas Home Living (TxHmL) Waiver Program carve-in to managed care from 2017 to September 1, 2018 and delays the Intermediate Care Facility/Intellectual and Developmental Disabilities (ICF/IDD), HCS, CLASS, and DMBD Waiver Program carve-ins from 2020 to 2021.

West Virginia

Judge Grants Injunction in Medicaid Managed Care Expansion Case. On June 10, 2015, the Charleston Daily Mail reported that a Kanawha County judge has granted an injunction preventing the Department of Health and Human Resources (DHHR) from expanding Medicaid managed care under any

contracts that have not satisfied the competitive bidding requirements. Additionally, the injunction prevents any new contracts that have not been competitively bid. The judge's decision comes in response to a lawsuit filed against DHHR, alleging that the Department had awarded new Medicaid managed care contracts and was expanding coverage under existing contracts without conducting a competitive bid process. DHHR was planning to expand Medicaid managed care on July 1, 2015, to cover a total of 350,000 lives and to carve-in the behavioral health benefit for all managed care enrollees. Read More

CareSource Joins Marketplace in 15 Counties; Highmark Proposes 20 Percent Rate Increase. On June 4, 2015, *The Charleston Gazette* reported that CareSource filed to enter West Virginia's Affordable Care Act Marketplace in 2016. CareSource will serve 15 counties, and Higmark will remain to serve the majority of the state. CareSource operates a per-payer, per-month model, as opposed to Highmark's fee-for-service model. According to CMS's released proposed rates, Highmark is looking for an increase of approximately 20 percent for all individual plans. The Kentucky Health Cooperative may enter the Marketplace in 2017 after stalling its entrance in 2015. Read More

National

States Prepare for Supreme Court Ruling. On June 5, 2015, *NewsWorks* reported that states are working on back-up plans in the event that King v. Burwell rules federally run Exchanges are not eligible for subsidies. In Pennsylvania, Governor Tom Wolf submitted blueprints for a "state-supported" Marketplace contingency plan. However, other states, like Arkansas and Arizona, have enacted legislation prohibiting a state-based Marketplace. New Jersey stated that it is still too premature to publicly discuss a contingency plan. Delaware, which currently has a partnership Marketplace, is exploring all options. The state has submitted a contingency plan for a state-supported Marketplace. Both the Delaware plan and the Pennsylvania plan would use the federal IT system and website, but the state would oversee Marketplace funding, consumer assistance, and insurance plan regulations. Read More

White House Report Shows Large Savings for Expanding Medicaid. On June 4, 2015, *USA Today* reported that according to a report from the White House Council of Economic Advisers, Medicaid expansion can save billions in uncompensated care costs. In states that have not expanded, expansion would lower uncompensated care costs by $4.5 billion. States that have already expanded Medicaid are on track to reduce costs by $4.4 billion in 2016. However, many Republican leaders oppose expansion, stating it is harmful to tax payers. Read More

State-Based Exchanges Struggle to Plan Transition When Federal Dollars Run Out. On June 4, 2015, *Kaiser Health News* reported that state-based Exchanges are struggling to come up with a plan to become financially self-sufficient when federal funding for the Exchanges runs out. In Minnesota, MNsure, has faced much opposition from Republican lawmakers, who hoped to do away with the Exchange. Although MNsure was left intact, a bipartisan task force was created to consider its future. Lawmakers also voted to ask the federal government for subsidies for health insurance bought from on the Exchange, as well as in the open market. The Colorado Exchange is still dealing with technical glitches and financial challenges. Connecticut has been successful with its Exchange, bringing in $26 million a year by charging insurers. To fund continued smooth

operations, however, the Exchange had to raise the assessment that insurers pay. Read More

More Patients Turn to Free Health Clinics in Non-Expansion States. On June 3, 2015, *Kaiser Health News* reported that there is a large growth of patients in free health clinics. Advertisements and information about the Marketplaces began bringing in people to free clinics who did not initially know about them and did not qualify for programs in the Marketplace. In Louisiana, the CEO of Teche Action Clinic, Gary Wiltz, stated that the number of patients has doubled in the last six or seven years. Additional funding for community health centers has also fueled the growth. The federal government estimates that new funding will provide 650,000 people nationwide better access to health care. Read More

Industry News

Assurant Health to Wind Down After Unable to Find Buyer. On June 10, 2015, *Modern Healthcare* reported that Assurant has announced it will wind down operations of Assurant Health, its health insurance subsidiary, over the next 18 months after it was unable to find a willing buyer. Assurant announced in April that it was looking to sell in the wake of announced financial losses of $148 million in a little over a year. The company expects the costs associated with winding down at up to $250 million, with up to $110 million of that total coming from expectations that premiums will not cover future medical claims. Assurant Health will not sell qualified health plan products on the Marketplace in 2016. The company offered plans in 16 state Exchanges this year and had proposed premium rate increased for the 2016 plan year of as much as 70 percent. Assurant will sell its limited self-funded small-group business and supplemental health plans to National General Holdings Corp. Read More

Update on Centene Acquisition of Trillium (Agate). On June 4, 2015, *The Oregonian* reported that Centene is prepared to pay between $80 million to $130 million for Trillium, a healthcare company serving approximately 100,000 Oregon Health Plan members. Centene announced in January that it had negotiated for the acquisition of Agate, the parent company of Trillium. However, critics are asking the state to block the sale for fear that care will suffer. Lawmakers stated that they have limited powers to stop the sale. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August 3, 2015	Michigan	Proposals Due	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
TBD 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
TBD 2015	Louisiana MLTSS - DD	RFP Release	15,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (Phase I)	450,000

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
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	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; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
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
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	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
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	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500				*Cancelled Capitated Financial Alignment Model*			
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

HMA NEWS

New this week on the HMA Information Services website:

- Ohio Medicaid managed care membership slips in 2014.
- Updated New Mexico Medicaid managed care market share data.
- Plus public documents for the 2015 Pennsylvania HealthChoices Physical Health RFI and the TX MMIS Takeover Draft RFP.

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Upcoming Appearance: Karen Brodsky to Present at 2015 State Health Research and Policy Interest Group Meeting

June 13, 2015
Minneapolis, Minnesota

HMA Principal Karen Brodsky, along with Angie Fertig (Medica Research Institute), Erin Taylor, and Sarah Gollust will be presenting State Health Access Reform Evaluation (SHARE findings) at the State Health Research and Policy Interest Group Meeting preceding the 2015 AcademyHealth Annual Research Meeting (ARM) on June 13, 2015. Read More

HMA Webinar Replays Available:

"HMA's 'First Take' on New Medicaid Managed Care Regulations."

Link to Webinar Replay

CMS just released a new set of proposed Medicaid managed care and CHIP regulations – the first major update of federal rules for health plans in state-sponsored programs in more than a decade. The changes seek to align Medicaid managed care regulations with those of other government-sponsored programs, while at the same time fostering innovation, transparency, quality and financial viability. Like all such rules, details matter. And at more than 650 pages, these proposed rules have a lot of details to digest. It will take weeks – if not months – to fully understand the ins and outs of the new regulations. However, an initial read reveals several important themes likely to dramatically impact Medicaid managed care going forward.

During this webinar, HMA experts offered a "first take," with initial thoughts and reactions to key components of the new regulations.

"New York State's Ambitious DSRIP Program: A Case Study."

Link to Webinar Replay

New York has by far the most ambitious Delivery System Reform Incentive Payment (DSRIP) Program in the nation. The program has a clear focus on full health system transformation and payment reform. The state will invest $6.4 billion to incentivize collaboration among health care providers, social service providers, and community-based organizations to dramatically alter the way health care is delivered to Medicaid recipients. The primary goal: a 25% reduction in avoidable hospital use over five years. Getting there will require

huge investments in community-based care, improvements in key quality metrics like hospital readmissions, and the continued shift from traditional fee-for-service payment models to value-based care.

Health Management Associates Principal Denise Soffel, PhD, has been on the front lines in helping New York plan, develop, and implement its DSRIP initiative. She provided an in-depth look at the initiative, including how the New York program will inform the thinking of other states considering applying for waivers, and why New York's clear focus on health system transformation and payment reform signals the future direction of DSRIP nationwide.

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

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.