HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

HMA'S ACCOUNTABLE CARE INSTITUTE LOOKS AT VALUE-BASED REIMBURSEMENT FOR PROVIDERS

This week, our *In Focus* section reviews *"Health Care Providers and Value-Based Reimbursement,"* a paper released by HMA's Accountable Care Institute (ACI) this month. Movement of patients into managed care is a significant part of health care transformation currently underway in the United States. Managed Care Organizations are increasingly offering value-based payment models as a way to help the provider community achieve high-quality care, cost containment, and patient satisfaction. This paper serves as a starting point for health care providers who are exploring value-based payment models. It is designed to help providers understand the reimbursement continuum, potential risks and rewards, and the flow of money.

HMA's Deborah Gracey is the primary author on the paper, with contributions from HMA's Art Jones, MD, Margaret Kirkegaard, MD, and Meghan Kirkpatrick.

A Move to Value-Based Payment Models

Many providers recognize that U.S. health care in its current form is inefficient, overly expensive, and not sustainable. Under a fee-for-service model, they have little financial incentive to transform the way medicine is practiced. Not only are they not rewarded for economizing; they are penalized if they provide fewer services or lower-cost services. And although MCOs work hard to manage care and costs, their impact is limited since they do not make the day-to-day diagnostic and treatment decisions that determine costs. To correct these deficiencies, MCOs and other direct payers are moving to value-based payment models designed to reward providers for implementing health care transformation that results in better clinical outcomes, improved member satisfaction, and cost containment. The key elements of value-based payment models are:

- Financial incentives are not based on the volume of services, and payment is not limited to billable encounters traditionally reimbursed on the fee-for-service schedule.
- Financial rewards are tied to the achievement of quality standards, overall management of care, and the elimination of unproductive costs from the system of care.

Value-based payment structures are gaining popularity for many reasons.

1. Financial incentives can be designed to reward behavior and promote practice changes needed to successfully implement more efficient and effective models of care.
2. Financial incentives can help providers pay for investments in technology, process improvements, staff training, and culture changes needed for practice transformation.
3. Value-based payment promotes the delivery of the right care in the most timely and cost-effective setting. Patient portals, secure email, and nurse triage can be deployed without a negative impact on the provider's revenue. Routine care issues that may not require an exam can be handled more quickly and conveniently for the patients, and early intervention may prevent a costlier visit later or an adverse event.
4. The use of alternative members of the care team becomes practical. In many instances, nurses, medical assistants, pharmacists, dieticians, patient navigators, and others can deliver certain types of care more efficiently and effectively.
5. Providers are remunerated based on the value they produce, even if the volume of services is reduced.

Value-Based Payment Methodologies

There are several value-based payment methodologies that can be used alone or in combination. They form a continuum of payment formulas that tends to increase in value to the provider as it increases accountability for outcomes, including cost of care. It is important to match the model with a provider's ability to manage any financial risk. With the exception of capitation (partial and

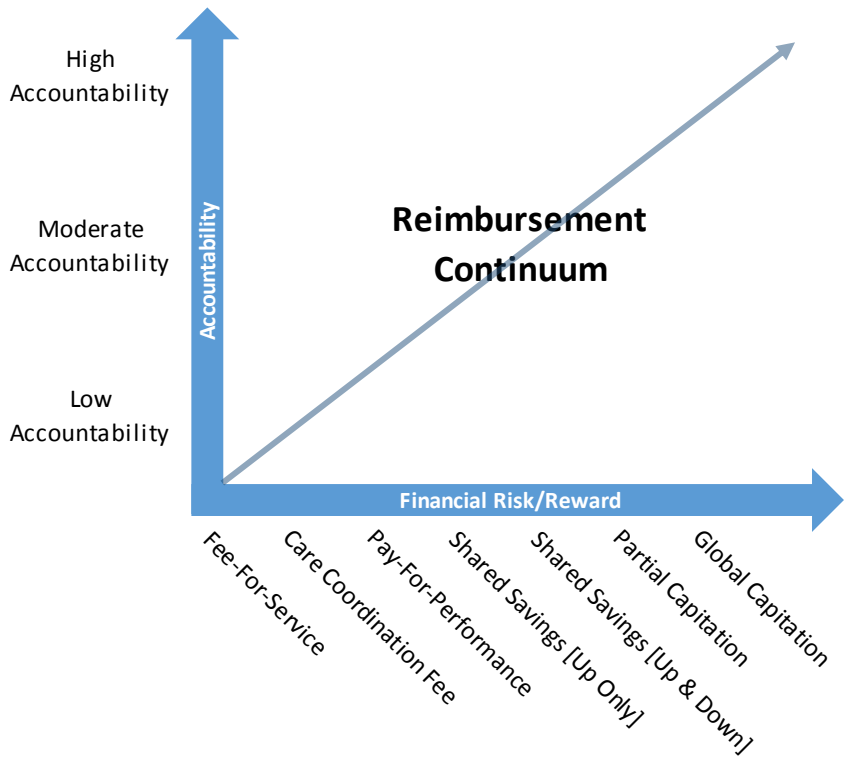
full), payment structures build on fee-for-service payments with a goal of eliminating the incentives to provide low-value services.

Certain types of value-based payments such as pay-for-performance or payment for specific quality improvement activities can be applied to an individual primary care physician, specialist, or other practitioner, regardless of how many or how few patients they have on their panel. On the other hand, reimbursement such as shared savings and partial or full capitation are contingent on providers' having a minimum patient panel size to ensure that the risk pool is large enough to spread risk – that is, to offset the effect of high-cost patients whose care will be costly no matter how well-managed (insurance risk) and to avoid rewarding savings that occur by chance alone. An individual practitioner or a small group of physicians who has a large panel of the same type of patients may be eligible for this type of payment. Independent Physician Associations (IPAs), Physician Hospital Organizations (PHOs), and health systems can negotiate value-based payment on behalf of a large patient population that is on the panel of many member practitioners.

The Reimbursement Continuum

Approaches that are designed to give providers more responsibility for controlling costs and improving quality in exchange for the prospect of greater financial rewards can be thought of as a continuum, where greater responsibility is matched with greater potential financial payment, as shown in **Figure 1** below.

Figure 1 – Reimbursement Continuum



The reimbursement continuum (**Figure 1**) is the mechanism by which the transition can be made over time:

- At the low end of the continuum is fee-for-service, where providers are paid for each visit, service, or procedure.

- Care coordination fees, pay-for-performance, and shared savings earnings are all in addition to fee-for-service payments. The revenue that is earned through the additional payments can be used to offset or replace any fee-for-service revenue that is sacrificed or additional expenses that result from practice redesigns. These mechanisms have no financial risk associated with them, so providers have a safe environment and time in which to figure out how to transform their care, master financial management, respond to MCO's data that gives a new perspective on their performance, and achieve culture shifts in their own organizations.
- When the provider is ready for some level of financial risk, which can be taken through partial risk, partial capitation, or full capitation, the positive revenue potential becomes greater, based on the premise that operates in all parts of the free market system – with greater risk comes greater reward. Providers can choose to never take financial risk, or they can accept it along with the added responsibility and control.

The table below (Figure 2) describes how each of the payment methodologies works and the implications for the provider.

Figure 2 – Value-Based Reimbursement Methodologies

	Fee-For-Service	Care Coordination Fee	Pay-for-Performance	Shared Savings [Upside Only]
How it works	• Starting point is Medicaid or Medicare FFS rates • May be negotiated up or down by a few percentage points	• PMPM payment for specific populations • May have no contingencies attached to payment • May be contingent on PCMH accreditation, certain facility enhancements for persons with disabilities, or other parameters	• Usually tied to performance metrics required of MCOs by CMS or states, such as: HEDIS measures; State-specific quality measures; CAHPS; Cost/quality drivers such as readmission rates	• Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved • Allows more flexibility in practice redesign, innovative care and financial incentives for overall appropriate cost management and premium management
Implications to Provider	• Encourages volume-based vs. value-based medicine	• Helps to fund people, processes, and technology for upgraded care • Sometimes can be used only for care and cannot be used for reserves	• Helps to fund upgraded care • Helps to focus on specific areas of improvement • May be used to build reserves	• Perfect way to gain understanding and control of holistic financial performance without taking any financial risk • Allows provider to get ready to take financial risk, if desired • Shared savings money can be distributed in ways that incent desired behavior changes • May be used to build reserves

	Shared Savings [Upside & Downside]	Partial Capitation	Global Capitation
How it works	• Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved or pays a percentage of the deficit • Step one of financial risk • With risk comes enhanced reward opportunities (higher percentages on upside along with responsibility for downside) • Even more flexibility for providers to influence their own practice redesign, innovative care	• A percentage of premium is paid for one area of care; PCP, Part B, Parts A/B, Part D • Total financial responsibility within limited area of care • Provides maximum flexibility for that area of care	• Percentage of premium for total care • Can be accompanied by delegation of care management, claims and other functions • Total financial risk and reward for high quality care and cost management • Maximum Flexibility
Implications to Provider	• A good method to take on limited financial risk with opportunity for more financial gain • Shared savings money can be distributed in ways that incent desired behavior changes • May be used to build reserves	• Allows provider significant flexibility and financial responsibility in an area of strength without having financial responsibility for total care • Excess money beyond the cost of care can be used for anything the provider deems important: reserves, incentives, people, processes, technology	• Provider gains significant leverage with payers, total control of practice design, incentives & investments in people, processes, technology • Provider can take financial risk directly from government programs and share nothing with MCOs

For more information on the different stages of the reimbursement continuum, their implications for providers and MCOs, and the required capabilities providers must have to effectively achieve advanced value-based reimbursement arrangements, see the full report at the ACI Toolkit link below.

About the ACI

HMA's Accountable Care Institute (ACI) is a multi-disciplinary practice within HMA, centered around four primary areas that have emerged as critical health care redesign components:

1) Models of Care (building new approaches to clinical practice and the payments that support them);

2) System Redesign (transforming health systems both within single entities and in multiple-provider organizations);

3) Policy (linking state and federal legislative and regulatory initiatives to on-the-ground experience in delivery system reform); and

4) Information and Technology Innovations (assessing and developing new technologies that will support these new approaches to care).

The ACI expands HMA's capacity and focuses on the development of innovative approaches (policies, tools, organizational structures, financing mechanisms, and clinical practices) that will facilitate health system restructuring initiatives. HMA considers the ACI a critical venue for developing these innovative approaches to health care reform, disseminating best practices, and training new leaders in health system change.

For more information on the ACI, visit our website and download the ACI Toolkit, which includes "Health Care Providers and Value-Based Reimbursement," available here.

HMA Medicaid Roundup

Arizona

Newly Insured Patients Ask Judge To Defend Medicaid Expansion in Lawsuit. On April 22, 2015, *The Kansas City Star* reported that newly insured patients are asking to testify in favor of Medicaid expansion in a lawsuit challenging the expansion. Former governor, Jan Brewer, approved expansion back in 2013. However, Republican House leaders claimed that the cost of expansion is a tax that required a two-thirds vote, whereas the law passed with barely a majority. They sued shortly after. Arizona Governor Doug Ducey has also repeatedly opposed the health care overhaul law. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Gold Coast Health Plan Hires CEO. On April 27, 2015, *Ventura County Star* reported that the Ventura County Medi-Cal Managed Care Commission named Dale Villani as CEO of Gold Coast Health Plan, effective June. Former CEO and HMA Principal Michael Engelhard left Gold Coast in September, and Ruth Watson took over as interim. Villani was previously chief operating officer of Arizona Priority Care before accepting this position. Read More

Health and Welfare Programs May Receive Some of State's Surplus. On April 27, 2015, *California Healthline* reported that California is expected to exceed FY 2015-2016 revenue estimates by $4 billion, according to a Legislative Analyst's Office report. Under a state school funding law, the surplus would go to schools and community colleges. However, if revenues exceed by $4.4 billion, California's health and welfare programs could receive some of that money. Read More

California Assembly Budget Subcommittee on Health and Human Services Meet April 20; Topics Include Medi-Cal Rates. The Assembly Budget Subcommittee met on April 20, 2015. One of the larger issues was regarding "consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations." Additionally, the subcommittee noted that the Legislative Analyst's Office reviewed the Department of Health Care Services' baseline access analyses and quarterly monitoring reports and found numerous concerns with the quality of the data and methodologies. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Connect for Health Colorado Approves $5.1 Million for Technology Fixes. On April 13, 2015, *The Denver Post* reported that the board of Colorado's health exchange, Connect for Health Colorado, approved $5.1 million to be spent to resolve online enrollment technology problems. The board expects the fixes to result in savings as high as $9 million. Operational issues this year increased the cost of call centers to $21 million from $13.6 million. The original $26 million annual budget was found to be insufficient. As a result, budgets for the next three years will fluctuate from $34.5 million to $44.1 million. The fee on health insurance plans may rise from 1.4 percent to 3.5 percent. Read More

Governor Hickenlooper Signs $25 Billion Budget. On April 24, 2015, *The Pueblo Chieftain* reported that Governor John Hickenlooper signed Colorado's $25 billion budget, which increases money spent on schools, transportation infrastructure, and refunds to taxpayers. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Scott Poised to Call Special Session on Budget as Lack of Agreement on Medicaid, LIP Continues. On April 29, 2015, *Health News Florida* reported on the status of the legislative budget negotiations, which hinge significantly on the issues of Medicaid expansion and the renewal of the Low Income Pool (LIP) funding. On April 28, the House abruptly ended its session three days before its scheduled end, prompting Senate President Andy Gardiner to challenge the Florida House to come back into session Friday in a letter directed to the Speaker of the House. House Speaker Steve Crisafulli shot back fast after President Andy Gardiner alleged the House was violating the state constitution by leaving town early, saying in a letter of his own that the House stands willing to work in a Special Session. The Senate backs a Medicaid expansion model in concert with a redesigned LIP funding model, pending federal approval. Governor Rick Scott, meanwhile, filed a lawsuit against the federal government, claiming they have improperly linked the Medicaid expansion and LIP funding issues. Hours after Governor Scott filed the lawsuit, CMS officials issued a clarifying statement that LIP funding is not dependent on Medicaid expansion. As it stands today, the legislative session ends on Friday, May 1, with Governor Scott stating he will call legislators back for a special session in the coming weeks to resolve the budget. Read More. As the 2015 legislative session melted down on Wednesday, Gov. Rick Scott moved forward with his proposed Commission on Healthcare and Hospital Funding, reports the Miami Herald. Scott suggested the idea earlier this month, when he said he would readily call a special session to resolve outstanding budget issues. Read More

Public Hearings on LIP Redesign Kick Off in Orlando. For the first time, on April 29, 2015, the public will get to weigh in on what to do with a federal program for the uninsured that's created gridlock in Tallahassee. The Wednesday meeting in Orlando kicks off a series of statewide hearings on the Low Income Pool, or LIP. The meetings are planned in Orlando, Miami and Tallahassee. The hearings will collect comments on a proposal to extend LIP for

two years. Those comments will be sent to the Centers for Medicare and Medicaid Services. Dudek said "Our goal would still be to try and get the LIP approval for the state and that's what we're working on." Read More

Senate Proposes Bill to Improve Enforcement and Oversight at ALFs. On April 27, 2015, the *Miami Herald* reported that following an investigation that revealed abuse, neglect, and deaths of residents at assisted living facilities, the Senate proposed a bill to improve enforcement and oversight at 3,027 facilities in Florida that serve over 86,000 senior residents. The bill imposes higher penalties and requires financial and regulatory disclosure on the AHCA website. It also requires nursing homes to get mental health licenses if they serve any state-supported mental health resident. However, critics are saying that because HB 1001/SB 382 reduces the number of monitoring visits required for nursing homes with good records, seniors can be left vulnerable if the homes falter. The state only has to inspect homes with good track records once every two years. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Defends Nursing Home Payments. On April 22, 2015, *Georgia Health News* reported that after a federal ruling saying the state needs to return $100 million in improper nursing home payments, Georgia responded by defending their payments. Department of Community Health Commissioner Clyde Reese wrote a letter to CMS stating that refunding the money would result in an "unjust enrichment to the federal government" and the closure of over 30 nursing homes. Read More

Indiana

Maximus Recommended for Enrollment Broker Services Contract. On April 16, 2015, Maximus Health Services, Inc. was invited to begin contract negotiations to provide enrollment broker services for the Indiana Family & Social Services Administration. The term of the contract will last four years from the date of contract execution. There may be two one-year renewals for a total of a six-year engagement at the State's option. The Award Letter can be found here.

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Chicago Mental Health Provider to Close this Spring. On April 24, 2015, *WBEZ News* reported that Community Counseling Centers of Chicago, known as C4, will be closing at the end of May. The organization provided mental health services and essential medication supplies for more than 10,000 individuals across Chicago each year. The City of Chicago and State of Illinois say they are working on a transition plan to ensure access to services. Read More

IHA Reports on Localized Impact of Governor's Proposed Hospital Cuts. On April 29, 2015, the Illinois Hospital Association (IHA) published an analysis on the House and Senate District-specific impacts of Governor Bruce Rauner's proposed FY 2016 budget cuts. The Governor's proposal would eliminate roughly $750 million in Medicaid reimbursements to hospitals and health

systems. The analysis found that 33 Senate districts would each lose at least $14 million in economic activity and 100 jobs (collectively more than $48 million in lost economic activity and nearly 350 jobs in those districts), while 61 House districts would lose at least $5 million in economic activity and 35 jobs (collectively more than $27 million in lost economic activity and nearly 200 jobs in those districts). Read More

Kansas

Kansas Medicaid Plans Report Combined Losses of $52 Million. On April 28, 2015, *insurancenewsnet.com* reported that health plans offering coverage for Kansas' Medicaid program, KanCare, lost a total of $52 million in 2014. Sunflower Health Plan lost $35 million, Amerigroup lost $16 million, and UnitedHealthcare lost $1.5 million. Overall, the plans fared better than in 2013, when their combined losses were $116 million. Read More

Massachusetts

Gaps Found in State Addiction Care. On April 28, 2015, *Common Health* reported that according to a report by the Center for Health Human Information and Analysis, there are not enough beds in two-week and four-week programs for patients coming out of detox. In fact, there are four times as many patients leaving detox beds as there are two- and four- week programs. This leaves patients to relapse or seek treatment in states with shorter wait times. The report will go to the Health Policy Commission for recommendations. Read More

BMC HealthNet to End Provider Relationship with BHS Facilities. On April 25, 2015, *The Berkshire Eagle* reported that BMC HealthNet will no longer cover Berkshire Health Systems facilities, effective May 15. Approximately 15,000 Berkshire residents will need to find a new insurance carrier. Read More

Minnesota

House Approves $1 Billion Cut to Health and Human Services, Proposes to End MinnesotaCare. On April 29, 2015, *StarTribune* reported that the Minnesota House voted 72-60 to cut $1 billion in spending on health and human services, bringing the budget to $11.8 billion. This falls short of the $12.8 billion needed to keep up with inflationary pressures, according to the Minnesota Management and Budget Office. The most controversial provision in the legislation was a proposal to eliminate MinnesotaCare. MinnesotaCare is a publicly subsidized health care program for residents who do not have access to affordable health care coverage. It is funded by a state tax on Minnesota hospitals and health care providers, federal Medicaid funds and enrollee premiums. If approved, MinnesotaCare enrollees would face disruptions in coverage and may not be able to afford another insurance plan. Read More

Missouri

House Passes Budget without Across the Board Cuts to Mental Health, Health and Senior Services, and Social Services. On April 23, 2015, *St. Louis Post-Dispatch* reported that the House passed a budget without $140 million general revenue cuts to social programs (approximately 4 to 6 percent), which came under fire from Governor Nixon and the Senate. However, as a compromise, the House cannot put as much money into higher education. The budget also includes expansion of Medicaid managed care. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Federal Trade Commission Weighs In on DSRIP and Certificate of Public Advantage. The Federal Trade Commission sent a letter to the NYS Department of Health providing comments on the state's use of Certificate of Public Advantage (COPA) to protect Performing Provider Systems being formed under DSRIP from federal antitrust restrictions. COPA would allow PPSs to receive antitrust immunity for activities among participating health care providers, including the sharing of competitively sensitive information and engaging in joint price negotiations. The FTC made several points: that collaborations among health care providers can, in fact, be pro-competitive, and therefore would not need COPA protections; that the main effect of the COPA regulations would be to immunize conduct that would not pass muster under antitrust laws; and that such conduct would likely lead to increased health care costs and decreased access to health care services for New York consumers. The letter concludes "FTC staff not only believes that New York's COPA regulations are unnecessary to promote the goals of health care reform, but also is concerned that the COPA scheme is likely to foster anticompetitive conduct to the detriment of New York health care consumers." The FTC letter can be found here.

DSRIP Quarterly Reports. The DSRIP program requirements outlined by the Centers for Medicare and Medicaid Services (CMS) requires the state to prepare and submit progress reports to CMS on a quarterly cycle to describe DSRIP status, deliverables, and transformation milestones. The first three quarterly reports, covering the period from April 2014 – December 2014, were recently posted on the DSRIP website.

The quarterly reports include updates on key accomplishments for the quarter, including stakeholder engagement activities. It describes funding made available during the quarter. It provides information on the status of Performing Provider System planning activities, as well as tasks accomplished by the Independent Assessor, the Public Consulting Group, contracted to establish a transparent and impartial process for project plan review and scoring as well as a mid-point assessment process. The quarterly report also includes an update on activities of the DSRIP Support Team, KPMG, contracted to work with individual Performing Provider Systems in developing their project applications.

DSRIP Timeline. The DSRIP Year 1 timeline has again been revised to reflect recent changes made to DSRIP key deliverables and is now available here. The state has shifted the DSRIP year to align with the state's fiscal year, beginning April 1, rather than the calendar year. That change effectively adds three months

to Year 1, allowing Performing Provider Systems additional time to achieve necessary milestones. The state expects to have finalized valuation of DSRIP PPSs by May 7, with the first payment being made by the end of May.

FIDA Duals Demonstration. The NYS duals demonstration, Fully Integrated Duals Advantage (FIDA), is off to a slow start. Program implementation began in January 2015, and the first wave of passive enrollment occurred on April 1. Of the 4,158 individuals enrolled in FIDA on April 1, 1,100 had disenrolled by the middle of the month. In addition, almost 42,000 potential enrollees had opted out prior to being passively enrolled. The state originally estimated that as many as 124,000 individuals were FIDA-eligible.

Behavioral Health Transition. New York has received a draft of the Standard Terms and Conditions governing the transition of behavioral health services into Medicaid managed care, and the establishment of Health and Recovery Plans for individuals with serious mental illness, proposed by CMS. Federal approval is pending as final details are resolved. The state has posted a revised timeline for implementation of both the Adult and Children's Behavioral Health Medicaid Managed Care transition. The adult behavioral health transition will begin in NYC on October 1, 2014, with individuals who are eligible for enrollment in a Health and Recovery Plan being passively enrolled over a three-month timeline. Home and Community-Based Services available as part of the HARP benefit will be available in January 2016. Plans have completed the desk audit phase of readiness review, and are now responding to corrective action items, as well as updating networks to include HCBS providers. An RFQ for qualifying Medicaid managed care plans outside of NYC will be released at the end of June, with enrollment beginning July 2016. Read More

Local Service Plan Guidelines for Mental Hygiene Services. The Office of Alcohol and Substance Abuse Services has posted guidelines for the preparation of the 2016 Local Service Plan for Mental Hygiene Services. Each county is responsible for developing a local services plan that articulates long-range goals and objectives. The plan is meant to be multi-disciplinary and responsive to the objectives of three state agencies: the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities. The 2016 guidelines can be found on the OASAS website.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio's Budget Bill Now in the Senate. HB 64 representing $71.6 billion in general revenue appropriations ($131.6 billion all funds) passed the House April 22. The House eliminated nearly all of the tax proposals in the governor's budget and sent many other initiatives to study committees. The House also chose to adopt more optimistic budget projections than those in the Governor's proposal. It also added language to implement cost transparency measures, require the Department of Medicaid to seek waivers for health savings accounts and work requirements, and return Medicaid eligibility determination to the legislature. Despite controversy, HB 64 maintained funding for Ohio's Medicaid expansion.

Health Care Reform Bill Introduced. There had been rumors that Medicaid-related health care provisions might be pulled out of the House's version of the budget bill into a separate bill. While this never materialized, a separate piece of legislation, HB 157 has been introduced with claims that its provisions would improve Ohio's system of health care by adding health care savings accounts for Medicaid beneficiaries, requiring provider price transparency, and providing hospitals and some insurance companies incentives as part of some legislators see as a solution to spending concerns.

Oregon

Transparency Legislation Killed by Top State Legislators. Oregon's Senate President killed Senate Bill 891, which would have given the public access to online tools that would disclose insurers' price information currently only available to enrolled health plan members. The original bill had been more expansive in scope and would have required hospitals to post the amounts paid by health insurers, Medicare, Medicaid, school districts and state employees for common procedures. The changes to the bill were made to gain the support of a key senator on the committee of jurisdictions, but were not enough to convince the hospitals and insurers not to lobby against the bill.

Another transparency bill is still under discussion in the Oregon legislature. Senate Bill 900, which is supported by the hospital association, would make public Oregon Health Authority data on median prices for hospital services. The data provided would be more general, making it both easier to present and less relevant for a consumer seeking individualized information. Read More

Hospital Revenue is on the Rise in the Post-ACA Environment. After slowing in 2013, net patient revenue for all hospitals is up the first half of 2014, according to data from the Oregon Health Authority's Office of Health Analytics. Hospitals of all types saw operating margins rise from 2013 to the first half of 2014. Total margins also rose across all types of hospitals, though larger DRG hospitals saw more significant gains than smaller (type A and B) hospitals. Most hospitals saw gains, with 47 of the 57 hospitals in Oregon experiencing larger total margins through Q2 2014 than they had for the same period in 2013. For more details on hospital finances and utilization, see The Oregon Health Authority Office of Health Analytics report.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

April Meeting of the Medical Assistance Advisory Committee. The PA MAAC met on April 23. The Department of Human Services announced that it was still on target for its April 27th implementation date for the Medicaid expansion transition to HealthChoices. It also announced a Request for Application to be released in August or September of 2015 (earlier than expected) for a re-procurement of managed care plans in all five HealthChoices zones. The Office of Long Term Living discussed a document that will be published at the end of May to initiate the stakeholder input process for a plan to implement a type of Managed Long Term Supports and Services in Pennsylvania.

Transition to Full Medicaid Expansion Hits a Milestone Today. Workers at the Pennsylvania Department of Human Services (DHS) will shift about 120,000 people from the short-lived Healthy PA program to the larger HealthChoices plan, starting April 27. The department expects to finish the transfers by September 30. DHS also reported it will stop admitting new enrollees into the Healthy PA program. The Healthy PA program was first created under former Governor Corbettbut is being phased-out under Governor Tom Wolf. DHS says as many as 350,000 more people may qualify for participation in the HealthChoices program as a result of Governor Wolf's Medicaid expansion. Read More

Confirmation Hearing for Acting Secretary of DHS. A confirmation hearing for Ted Dallas, Acting Secretary for Pennsylvania's Department of Human Services was held on Wednesday April 22. Discussion of Gov. Tom Wolf's executive order for home-care workers dominated the confirmation. Republican senators criticized the order, saying it would facilitate the unionization of the workers. Also discussed at the confirmation hearing was the elimination of an asset test to food stamp eligibility. It cost the state $3.5 million a year to administer and resulted in the erroneous denial of $1.5 million in Supplemental Nutrition Assistance Program benefits, otherwise known as food stamps, to senior citizens or people with disabilities who were eligible to receive them. Pennsylvania is one of only 12 states that apply an asset test. Notwithstanding the elimination of the asset test, Dallas assured that strict federal eligibility rules will apply, including documentation and electronic checks before anyone is approved for food stamps. The committee approved Mr. Dallas' nomination, passing it along to the full Senate for a confirmation vote. Read More

Wolf Administration, PA Attorney General Petition Court to Enforce Consent Decree. The Wolf Administration and the Office of the Attorney General today filed a motion in Commonwealth Court to protect seniors who rely on Medicare Advantage by enforcing the Consent Decrees entered into by UPMC and Highmark regarding provider network participation and to force the two sides into arbitration to settle outstanding disputes to end the confusion for consumers. Recently, UPMC decided to cancel its Medicare Advantage plan with Highmark, putting over 180,000 seniors at risk of losing access to their doctors. This is the latest dispute between the two sides that have put seniors and people with cancer in the middle. The Commonwealth has worked with UPMC and Highmark to mediate their serial disputes to ensure compliance with the Consent Decrees. Read More

Home Health Aides Vote To Unionize Amidst Lawsuits to Block Them. On April 24, 2015, *The Wall Street Journal* reported that home health aides voted to be represented by the United Home Care Workers of Pennsylvania, with 89 percent of votes in favor of unionization. However, there are currently two pending lawsuits that claim the vote violates the state's constitution and labor laws. Read More

Rhode Island

Reinventing Medicaid Working Group Finds $85.5 Million In Medicaid Savings. On April 22, 2015, the *Providence Journal* reported that the working group tasked with identifying half of the $90 million goal in FY 2016 savings in Governor Gina Raimondo's proposed budget, found $85.5 million in savings.

The chart below outlines the categories of savings, which can be found in the report, Reinventing Medicaid: FY2016 Initiatives.

	Payment and Delivery System Reforms	Targeting Fraud, Waste, and Abuse	Administrative and Operational Efficiencies	Total
Behavioral Health	$4.5	-	$0.4	$4.9
Delivery System Reform	$31.9	-	-	$31.9
High Utilizers	$5.1	-	-	$5.1
Long Term Care	$14.4	$1.6	$3.9	$19.9
Internal	-	$2.3	$21.3	$23.6
Total	$55.9	$3.8	$25.7	$85.5

$ millions (state funds)

The savings include large cuts to hospital and nursing home reimbursement rates. However, the proposal includes an incentive system that can allow providers to earn back the lost rates. The bonuses would not be seen by hospital until fiscal 2017 at the earliest. Read More

Tennessee

Governor Haslam Questions Federal Uncompensated Care Funding Review. On April 23, 2015, *The Tennessean* reported that Governor Haslam is questioning the federal government's approach toward states with regard to uncompensated care funding, calling the attempt to tie Medicaid expansion to uncompensated care pool funding "heavy handed." HHS stated that expansion is only one factor in deciding funding. Read More

West Virginia

Taxpayers File Injunction to Stop No-Bid Contracts in Medicaid Expansion Program. On April 26, 2015, it was reported that West Virginia taxpayers have filed for an injunction in Kanawha County Circuit Court to stop the state from allowing no-bid contracts in the Medicaid managed care expansion program. They will also sue state agencies over the failure to follow state law and purchasing regulations in obtaining managed care contracts. Not getting competitive bids for the Medicaid contracts goes against SB 194 and SB 356, according to the injunction. The current managed care contracts are with Health Plan of the Upper Ohio Valley, UniCare, CoventryCares, and West Virginia Family Health Plan. Read More

National

University Hospitals at Risk from ACA. On April 22, 2015, *The Wall Street Journal* reported that the Affordable Care Act may threaten the margins of academic health centers. These clinical operations have been a major source of revenue for universities. Historically, the hospitals had operating margins of 3 percent to 5 percent. However, because they tend to charge higher prices for services, they are less attractive to insurance plans operating in the price-sensitive exchanges. Additionally, many of them are located in urban areas and treat a higher percentage of uninsured or Medicaid patients. Margins are expected to drop by four to five percentage points by 2019, pushing some hospitals into negative margins. Read More

Industry News

Assurant Health To Be Sold or Shut Down. On April 28, 2015, *Milwaukee Wisconsin Journal Sentinel* reported that Assurant Inc. announced it will either sell or shut down Assurant Health. According to one analyst, Assurant Health has struggled from the Affordable Care Act and is expected to report an operating loss of $80 million to $90 million in the first quarter of 2014, after reporting losses of $64 million in 2014. Assurant Health had $2 billion in revenue last year and offered insurance plans to individuals in 41 states and on 16 Marketplaces. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
April 27, 2015	Florida Healthy Kids	Contract Awards	185,000
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 14, 2015	Georgia	Proposals Due	1,300,000
May 19, 2015	Iowa	Proposals Due	550,000
May 22, 2015	Kentucky	Proposals Due	1,100,000
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, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
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
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.*

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
California	48,976	51,527	58,945	122,908	123,079	124,239	122,520
Illinois	49,060	49,253	57,967	63,731	64,199	60,684	58,594
Massachusetts	17,465	18,104	17,918	17,867	17,763	17,797	17,474
New York				17	406	539	6,660
Ohio				68,262	66,892	65,657	63,625
South Carolina					83	1,205	1,398
Texas						20	15,141
Virginia	28,642	29,648	27,701	27,333	26,877	27,765	25,563
Total Duals Demo Enrollment	**144,143**	**148,532**	**162,531**	**300,118**	**299,299**	**297,906**	**310,975**

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA WELCOMES…

Allison Bayer, Principal – Boston, Massachusetts

Allison Bayer comes to HMA most recently from Cambridge Health Alliance where she most recently served as the Executive Vice President and Chief Operating Officer for the last five years of her 12 year tenure with them. In this role, Allison was responsible for providing system operation oversight for this $600M safety net health system that included three hospitals, an extensive ambulatory network servicing over 100,000 primary care patients, a physician MSO, a municipal health department, and (prior to 2011) a $500M Medicaid managed care organization. Allison was charged with executing the system transformation to meet the market demands of payment reform and care integration resulting in key system capacity growth to manage safety net population health requirements including complex care management, risk assignment, and contracting infrastructure. Before serving in the role of EVP/COO, Allison served in several roles with CHA including Senior Vice President and Chief Operating Officer; and Senior Director, Applications and Education – Information Technology.

Prior to her work with CHA, Allison served as the Director of the Health Services Technology Practice for John Snow, Inc. There, she provided consulting and business development services supporting governmental, health care, and community-based service organizations to include technology strategy development, system selection, and project management.

Additional roles that Allison has served in include Independent Consultant/Team Project Manager for Partners HealthCare System, Inc.; Vice President of Clinical Operations and Director of Clinical Operations for Boston Medical Center; Director of Ambulatory Operations with the Lahey Clinic Medical Center; and Administrative Director for the New England Medical Center.

Allison received both her Master of Science in Management Information Systems (with Honors) and her Master of Business Administration (with a concentration in Health Care Management) from Boston University. She received her Bachelor of Arts degree from Mount Holyoke College.

Ellen Breslin, Senior Consultant – Boston, Massachusetts

Ellen Breslin comes to us most recently from EBD Consulting Services, LLC where she has served as the President for the last nine years. In this consulting role, Ellen provided policy, financial, and analytical services to a variety of clients including state governments, foundations, non-profit organizations, consumer-based organizations, health plans, and providers. Some of her work included providing policy and financial analysis to state Medicaid programs in Kentucky, Massachusetts, New Mexico, North Carolina, and Pennsylvania; developing financial models to assess the budget impact of policy and payment structures and state health reforms; researching, writing, and creating policy and analytical presentations relative to the dual financial alignment demonstration programs; and providing policy analysis to MMPI on the Senior Care Options program in Massachusetts.

Prior to her work with EBD, Ellen served as the Director of Managed Care Reimbursement and Analysis for MassHealth for the Executive Office of Health and Human Services for seven years. Here she established a new unit to develop, negotiate, and manage all financial aspects of the managed care contracts; developed capitation rates and risk-sharing arrangements for managed care providers and contractors; developed and negotiated complex health care premium and case-mix methodologies for multiple populations; and secured approval of all financing arrangements for managed care contracts with CMS.

Additional roles that Ellen has served in include Principal Analyst for the Congressional Budget Office; Policy Analyst with the Division of Capital Planning and Operations; and Budget Analyst for the House Ways and Means Committee.

Ellen received her Masters of Public Policy from Duke University and her Bachelor of Arts in Political Science and French from the University of Massachusetts.

John Shen, Principal – Sacramento, California

John Shen comes to us most recently from the California Department of Health Care Services where he has served as the Chief of the Long-Term Care Division for the last four years. In this role, John oversaw the funding and implementation of California home and community based programs which included In-Home Support Services, Community Based Adult Services, 1915(c) waiver programs targeting various senior and disabled populations, Money Follows Persons, as well as Medicare/Medicaid integrated PACE and SCAN health plan. John also participated in the development of the Coordinated Care Initiative integrating medical and long-term services and support through selected MediCal health plans.

Prior to his work with HCS, John served as the Executive Director of Marin Community Clinics for four years. There, he repositioned the clinic as the lead provider of Marin County's safety net services for 28,000 low income and uninsured residents; doubled the organization's revenue and patient care volume; expanded pediatric and adult medicine; added women's health, obstetrics, dental, and mental health services; improved the clinic's MediCal rates for all facilities; implemented a new EMR system; improved the clinic's financial performance; and strengthened the operational infrastructure.

Additional roles that John has served in include Independent Consultant for Marin County Health and Human Services, The Houei Group (Japan); and Haven of Hope Hospital and Haven of Hope Christian Services (Hong Kong); Director of Planning and Business Development for On Lok Senior Health Services; Geriatric Planning Director for Mount Sinai Medical Center; Director of PACE for On Lok, Inc.; and Administrator, Research Projects Manager, and Senior Research Associate for On Lok Senior Health Services.

John received his Doctorate in Social Welfare as well as his Masters in Social Work from The University of California, Berkeley. He has a Master of Arts in Educational Psychology from Michigan State University and received his Bachelor of Science in Chemistry from the University of Oregon, Eugene.

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; Olympia, Washington; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

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