HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: THE PACE MODEL AND LESSONS FOR DUAL ELIGIBLE INTEGRATION

HMA ROUNDUP: CALIFORNIA GOV. RELEASES "MAY REVISE" BUDGET; ILLINOIS ISSUES DUAL INTEGRATION RFP; PENNSYLVANIA ISSUES EXCHANGE PLANNING AND DESIGN RFQ; PENNSYLVANIA MOVES AHEAD WITH MEDICAID PHARMACY DISPENSING FEES

OTHER HEADLINES: SIX STATES AWARDED COMBINED $181M IN FEDERAL EXCHANGE GRANTS; ALABAMA ISSUES HEALTH INSURANCE EXCHANGE RFP; LOUISIANA, NEW JERSEY EXCHANGE PROGRESS HALTED; NEW HAMPSHIRE PANEL APPROVES MEDICAID MCO CONTRACTS; WEST VIRGINIA DISCUSSES MEDICAID MCO EXPANSION, ISSUES MEDICAID MMIS RFP

DUALS RFP CALENDAR: ILLINOIS DUALS RFP ADDED; 11 OF 22 STATES SUBMIT PROPOSALS TO CMS

MAY 16, 2012

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: THE PACE MODEL AND LESSONS FOR DUAL ELIGIBLE INTEGRATION

This week, our *In Focus* section looks at the Program of All-Inclusive Care for the Elderly (PACE) and identifies potential lessons from this model for dual eligible integration. With more than twenty states pursuing dual eligible integration demonstrations, either through a managed fee-for-service or capitated managed care structure, PACE can serve as an important point of reference as interested parties consider integrating care for dual eligibles. PACE combines Medicaid and Medicare funding to provide all medical and support services to individuals with complex health needs. In some states with PACE programs, PACE enrollees will be given the choice to remain in their PACE program or the choice to enroll in a dual eligible managed care plan.

In the discussion below, we describe the characteristics of the PACE program and provide some perspective on its strengths and challenges through an interview with HMA Principal, Amy Shin. Prior to joining HMA earlier this year, Amy served as the Chief Administrative Officer for On Lok Senior Health Services, the founding PACE organization. Amy's experience with the PACE program offers unique insight into the challenges that organizations will face in developing care coordination programs for dual eligibles. We posed several questions to Amy related to PACE and the dual eligible integration demonstrations.

About Amy Shin

Amy came to HMA from On Lok Senior Health Services, the founding Program of All Inclusive Care (PACE) organization, where she has served as the Chief Administrative Officer for over eight years. In her role as Chief Administrative Officer, Amy was responsible for critical functions of the organization, including business development, marketing and enrollment, regulatory affairs, information systems, Medicare Part D operations, quality assurance, provider network contracting and relations, facilities management, purchasing, fund development, and oversight of delegated provider groups. Prior to her position at On Lok, Amy was Senior Vice President, Professional Services for Pharmaceutical Care Network, a pharmacy benefits management company. Earlier in her career, Amy served as a Senior Director of the Alameda Alliance for Health, the public Medicaid HMO of Alameda County.

About PACE

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long term services and supports to Medicaid and Medicare enrollees. PACE enrollees are served by an interdisciplinary team of health care providers. Most PACE enrollees are able to receive care at home rather than receive care in a nursing home as a result of the care coordination received through the program. PACE organizations must be a not-for-profit entity or organized under a public entity, such as a state, county, or tribal organization. PACE organizations could be for-profit if approved under a CMS demonstration waiver. The only state with for-profit PACE plans is Pennsylvania.

Figure 1 – How does PACE work?

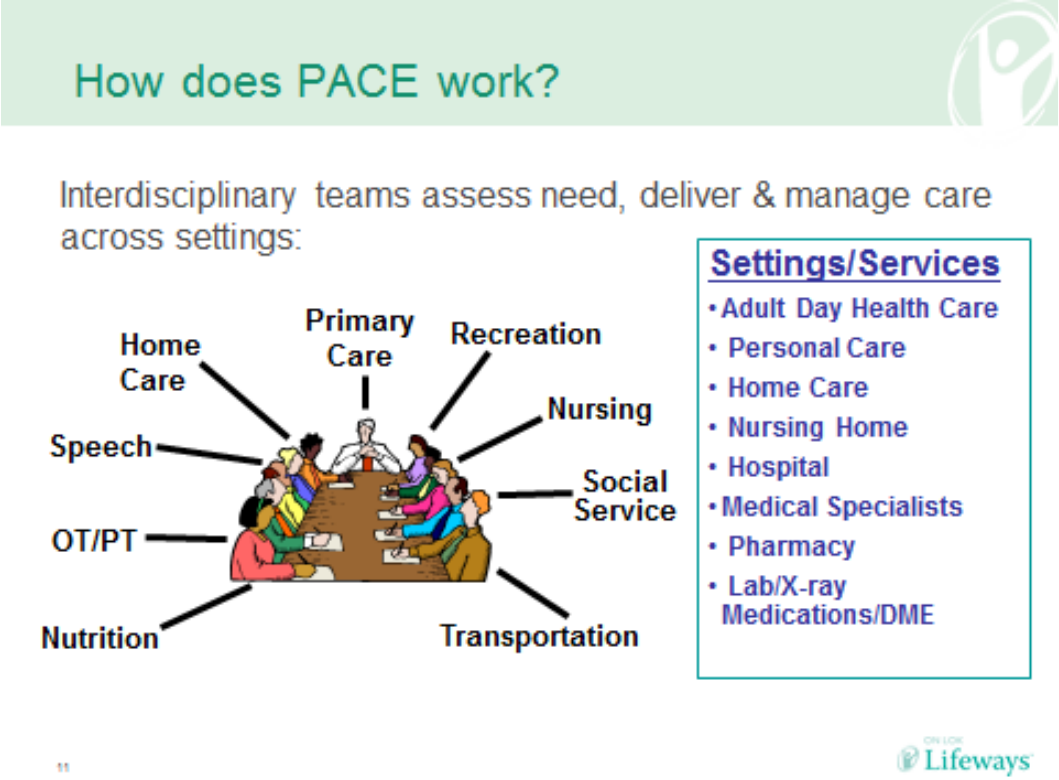
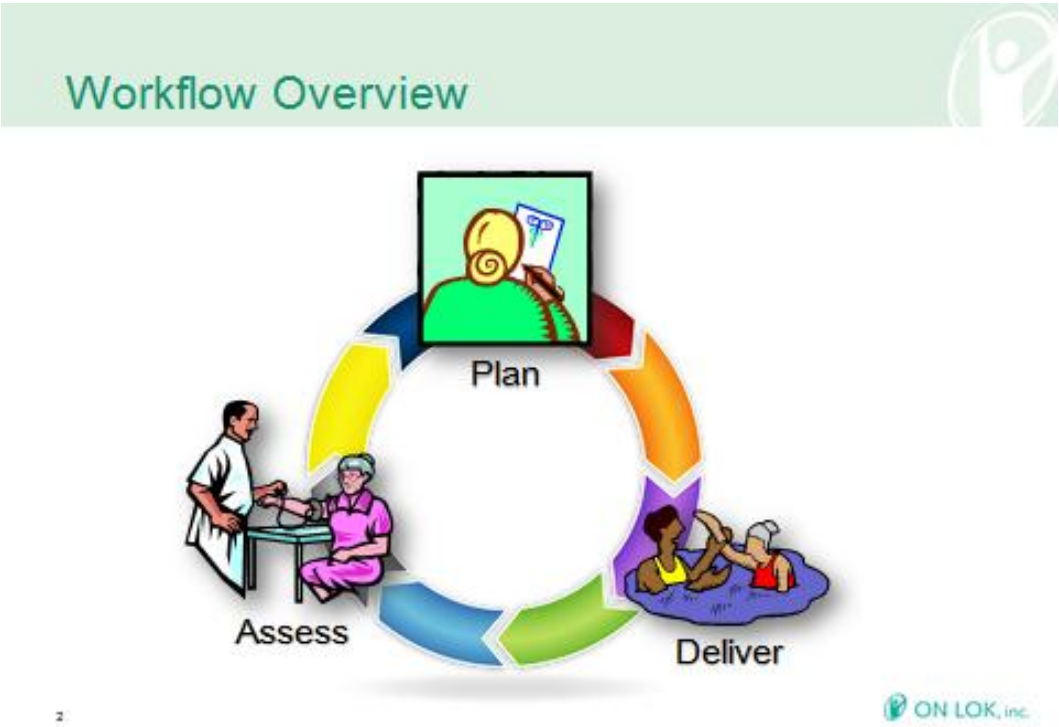


Figure 2 – Workflow Overview



Under a capped financing structure, providers are able to deliver all necessary health care services, rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. PACE enrollees must meet the following enrollment criteria:

- Age 55 or older
- Live in the service area of a PACE organization
- Eligible for nursing home care
- Be able to live safely in the community

The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. Individuals can leave the program at any time.

Interview with Amy Shin

What do you consider to be the strengths of the PACE model?

PACE is the original truly fully integrated health care system that is also a medical home or health home. PACE fully integrates Medicare, Medicaid, Long Term Care, and Social Services. All PACE services are predominantly provided in the PACE center that allows for efficiency for the provider and convenience for the ber. And finally, the interdisciplinary team (as opposed to multi-disciplinary) model is key to the comprehensive care plan developed, executed, and modified frequently based on patient needs. See Figure 1 above.

What are the limitations of the PACE model as a basis for a broader dual eligible integration approach?

While the PACE model of care is ideal for all dual eligibles, there are limitations that are difficult to overcome. The three key limitations are:

1. Eligibility criteria – currently PACE is only limited to nursing home eligible frail seniors over 55. However, the PACE model would work for anyone with functional limitation with chronic diseases or cognitive impairment.
2. Staff model nature of PACE – PACE is center based with each PACE center having both a licensed community clinic and an adult day health center (ADHC) in most cases. Therefore, startup costs are high, licensure approval process lengthy and therefore, is not easily scalable.
3. Limited active mental health component - PACE is a good model for seniors with behavioral issues arising from dementia but not psych issues.

Based on your PACE experience, what do you consider to be the most significant challenges in coordinating care for dual eligibles?

Care for the dual eligibles require as much focus on improving functional issues of the patient as well as their medical/health issues. Improving the dual eligible's deficiencies with Activities of Daily Living (ADL) or preventing deficiencies in ADLs should be just as important as treating chronic diseases and acute illnesses. In order for this to be accomplished, managed long term care services (specifically home and community based services – HCBS) must be integrated into dual eligible's care planning. In PACE, all Medicare, Medicaid and LTC benefits are integrated. Organiza-

tions serving dual eligibles will find it challenging to coordinate all benefits seamlessly for the dual eligibles and develop one comprehensive care plan (for example, a care plan that incorporates medical care, social work, physical therapy, home care, home health, nutrition, and transportation needs into one plan) . Towards those goals, technology needs cannot be understated. While currently available EMRs are useful for medical care, most do not have modules to plan, treat, and document functional issues of the patients. In order to create a comprehensive care plan, assessments from various providers will have to be aggregated. That comprehensive care plan will be hard to develop without the help of good technology tool.

What lessons can managed care organizations and provider sponsored organizations that are considering participation in dual eligible integration demonstration programs learn from the PACE experience?

In addition to integrating HCBS long term care and social services, a frequent and full comprehensive assessment of the patient is important to ensure that the right care plan is being deployed. In PACE, the model dictates – assess, plan, deliver (care), then assess, plan, deliver, and so on and so forth (see Figure 2 above). This is done by the interdisciplinary team that meets daily to develop one comprehensive care plan for all members. As an example, if a patient is identified as high risk for falls, each member of the interdisciplinary team will assess and develop a plan around that risk. Examples include the PCP assessing for orthostatic hypotension, physical therapist increasing functional maintenance plan, home care ensuring no obstacles around the house to trip over, etc. This would be done for all risks/problems/conditions identified for the patient. This type of integrated delivery of care (not just integrated benefits) through a comprehensive care plan will be the key to success.

PACE Enrollment by State

PACE Enrollment as of January 2011		PACE Plans
National PACE Enrollment	**21,947**	
Alabama*	15	Mercy LIFE of Alabama
Arkansas	32	Total Life Health Care
California	2,554	AltaMed Senior Buena Care Center for Elders Independence On Lok Lifeways St. Paul's PACE Sutter SeniorCare
Colorado	1,579	Rocky Mountain PACE Senior CommUnity Care Total Longterm Care
Florida	495	Chapters Health PACE Florida PACE Centers, Inc. Hope PACE Suncoast Neighborly Care

PACE Enrollment as of January 2011		PACE Plans
Illinois	284	Chicago REACH
Iowa	95	Immanuel Pathways Siouxland PACE
Kansas	262	Midland Care Connection Via Christi HOPE
Louisiana	242	PACE Baton Rouge PACE Greater New Orleans
Maryland	146	Hopkins ElderPlus
Massachusetts	2,267	Elder Service Plan of Harbor Health Services Elder Service Plan of the Cambridge Health Alliance Elder Service Plan of the East Boston Neighborhood Health Center Elder Service Plan of the North Shore Summit ElderCare Upham's Elder Service Plan
Michigan	674	Care Resources Center for Senior Independence CentraCare Life Circles
Missouri	175	Alexian Brothers Community Services
New Jersey	292	LIFE at Lourdes LIFE St. Francis Lutheran Senior Life at Jersey City South Jersey Healthcare, LIFE
New Mexico	374	Total Community Care
New York	3,953	ArchCare Senior Life Catholic Health - LIFE CenterLight Healthcare Complete Senior Care Eddy SeniorCare Independent Living for Seniors PACE CNY Total Aging in Place Total Senior Care
North Carolina	137	Elderhaus, Inc. LIFE St. Joseph of the Bines PACE @ Home, Inc. PACE of the Triad Piedmont Health SeniorCare
North Dakota	58	Northland PACE

PACE Enrollment as of January 2011		PACE Plans
Ohio	722	McGregor PACE TriHealth SeniorLink
Oklahoma	77	Cherokee Elder Care
Oregon	910	Providence ElderPlace
Pennsylvania	2,670	Albright LIFE Community LIFE everyday LIFE LIFE - NWPA LIFE - Pittsburgh LIFE - University of PA School of Nursing LIFE Geisinger LIFE Lutheran Services LIFE St. Mary Mercy LIFE LIFE AT HOME NewCourtland LIFE SeniorLIFE Ebensburg SeniorLIFE Johnstown SeniorLIFE Washington/Union/Green SeniorLIFE York VieCare, Inc.
Rhode Island	210	PACE Organization of Rhode Island
South Carolina	409	Palmetto SeniorCare The Methodist Oaks
Tennessee	319	Alexian Brothers Community Services
Texas	1,016	Bienvivir Senior Health Services La Paloma The Basics at Jan Werner
Vermont	98	PACE Vermont
Virginia	654	AllCARE for Seniors Centra PACE InovaCares for Seniors Mountain Empire PACE Riverside PACE Sentara Senior Community Care
Washington	406	Providence ElderPlace
Wisconsin	837	Community Care

*Alabama enrollment was 0 as of Jan. 2011, enrollment shown from April 2012
Source: National PACE Association

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein / Jennifer Kent

Governor Jerry Brown released the "May Revise" budget on Monday, May 14. The Governor projects that the budget deficit has increased from $9.2 to $15.7 billion. Of particular note in the budget is that the state is proposing to reduce the number of counties for the dual eligible integration pilot from ten to eight counties and delaying implementation to March 2013. The eight counties are San Mateo, Orange, LA, and San Diego, the current selected counties, plus San Bernardino, Riverside, Alameda and Santa Clara. Currently the Administration has authority to proceed with four counties and is proposing to expand that authority. Sacramento and Contra Costa counties are two counties that will not be part of the pilot in 2013 although the state may add them to the pilot in 2014. The state stressed that implementation is contingent on securing a six month stable enrollment period and 50 percent of total savings from the federal government. The Administration is unclear on whether the pilots can be cost effective and proceed if these conditions are not met. The budget includes over $660 million in state savings in 2012-13 and over $880 million in state savings on an ongoing basis from these pilot programs.

Other changes in the Governor's "May Revise" budget:

- The budget includes various changes to hospital financing - $150 million state general fund in 2012-13 and $75 million in 2013-14.
- Splits the unused unspent 1115 waiver savings with the public hospitals allowing the public hospitals to claim additional cost against the waiver and sharing the resultant federal funds on a 50-50 basis with the public hospitals.
- $75 million in general fund cuts to the district hospitals (mostly small and rural) by no longer using state general funds for the non-federal share of their Medicaid payments and requiring the district hospitals use their funds for the non-federal share of Medi-Cal inpatient hospital payments. This is the current structure for the county and University of California hospitals. Some of the fiscal impact to these hospitals may be reduced by providing them with safety net funding from the state's Medicaid 1115 waiver.
- Delay DRG implementation for fee for service hospital payments to July 1, 2013.
- Eliminate the cost of living increase (COLA) for nursing facilities for 2012-13 for a general fund savings of $46.7 million. This COLA was agreed to in 2011 as part of an agreement to renew and increase the nursing home fee. The Governor proposes to continue the fee at the current level.
- Restores funds for the court challenge losses on provider rate reductions.
- Continue the proposal to move all of Healthy Families to Medi-Cal. The proposed Medi-Cal managed care rate for these children has been increased based upon more current information on the cost of providing services to children under Medi-Cal.

- Due to denial by the federal government of copays for all Medi-Cal enrollees and most services, reduce the copay proposal to only increasing the copay on pharmacy and non-emergency services in the emergency room with a savings of $20.2 million general fund in 2012-13. It is unclear if these copays will be required or allowed in Medi-Cal managed care. Currently there are no copays in Medi-Cal managed care.
- Recognize that the federal government will not approve the application of the state's sales tax on IHSS services at a general fund cost of $57.3 million in 2011-12 and $95.5 in 2012-13.

In the news

- **May Budget Revise Hits Health Care Hard**

  Health care reductions made up more than one-third of the additional $6.5 billion Governor Jerry Brown (D) needed to trim since the last budget proposal in January. Five months ago, the governor was only staring down a $9.2 billion deficit. Now it's estimated at $15.7 billion. Brown's new proposal released yesterday included about $2.5 billion in cost reductions to health care programs. The plan calls for new cuts for hospitals and nursing homes, more cutbacks in Medi-Cal services and another reduction to In-Home Supportive Services. (California Healthline)

- **Q&A: Insurance Commissioner Dave Jones on health care reform**

  Since he took office early last year, state Insurance Commissioner Dave Jones has made health care reform his top priority. Now he's backing a ballot measure – the Insurance Rate Public Justification and Accountability Act – that would give him the power to block health insurance rate increases he deems excessive. He spoke to the Sacramento Bee about the initiative and health care reform. (Sacramento Bee)

- **Coalition Supports Alternative to Brown's Plan on Kids' Health Care**

  A coalition of 40 groups opposing Gov. Jerry Brown's (D) proposal to shift nearly one million children from subsidized private insurance into California's Medi-Cal program have given their support to an alternate plan. The coalition supports a plan to preserve Healthy Families and move about 200,000 children between the ages of six and 18 into Medi-Cal in 2013. Those children already are expected to move into Medi-Cal in 2014 under a provision in the federal health reform law that expands Medicaid to families with incomes below 133% of the federal poverty level. (California Healthline)

Colorado

HMA Roundup – Joan Henneberry

The Colorado Health Benefit Exchange Board has reportedly selected an IT vendor for the Exchange, however, they did not announce a winner at the meeting on Monday.

The Colorado Division of Insurance released its annual report on the small group market that shows the number of employers offering coverage continues to decline, but at a slower pace than previous years. The *2011 Colorado Small Group Market Activity Report* is available here. The report shows that employers who offer health coverage are giving

their employees more choice. The number of group plans for employers with 26 to 50 employees grew by 342, or about 53 percent; and covered 18,628 more lives in 2011, a 59 percent increase. Small employers shifted to more multi- option plans that provide employees more choice, and decreased the use of Health Savings Account (HSA) qualified plans in proportion to other plans.

Illinois

HMA Roundup – Jane Longo / Matt Powers

The Illinois Department of Health and Family Services (HFS) released the dual eligible integration RFP on Monday, May 14, 2012. The state issued separate procurements for the Greater Chicago region and the Central Illinois region. In each region, the state will award two to five plans contracts to serve the dual eligible population. The Greater Chicago region covers an estimated 118,000 dual eligible lives in Cook, DuPage, Kane, Kankakee, Lake, and Will counties. The Central Illinois region covers just under 18,000 dual eligible lives in Champaign, Christian, De Witt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, and Vermillion counties. RFP responses are due on June 18, 2012. The RFPs and information on data release are available at the HFS Care Coordination Innovations Project website: HFS CCIP Website.

Illinois Care Coordination and Budget Timeline – Key Dates and Milestones

Date	Care Coordination	Budget/Medicaid Cuts
January 2012	***Phase I RFP Released*** Complex Adults, no MCOs	
February 2012	75 LOIs received	***Gov. Address, Feb. 22.*** Call for $2.7B in Medicaid cuts.
March 2012		HFS released menu of possible cuts and associated savings.
April 2012	***Phase I Proposal Due Date Delayed***	***Gov. Budget Proposal*** April 19, 2012
May 2012	***Dual Integration RFP Released*** May 14, 2012	Legislative Scheduled Session ends May 31, 2012
June 2012 through August 2012	***Phase I Proposals Due*** June 15, 2012 ***Dual Integration Proposals Due*** June 18, 2012 ***Dual Integration RFP Winners*** To be announced July 1, 2012 ***Phase II RFP Release*** Complex Children ***Medicaid MCO RFP*** Summer 2012, may be delayed	If nothing passes, Legislature moves to extended session with two-thirds majority required to pass a law.
January 2013	***Phase I, Phase II, Duals*** Go live January 1, 2013 ***Medicaid MCOs*** Depends on possible delay	

NOTE – all elements in the table are estimates and subject to change

In the news

- **Quinn may order start of health insurance exchange**

  Illinois Gov. Pat Quinn may use an executive order to establish a health insurance exchange, a website where consumers could comparison shop for insurance that's a key piece of President Barack Obama's health care law, according to Quinn's chief health care adviser. Michael Gelder, the governor's adviser, said the Legislature's workload on Medicaid and pension reform makes it unlikely lawmakers will be able to pass legislation authorizing an insurance exchange during the current session, which is scheduled to end later this month. Looming federal deadlines leave the governor with two choices: calling the Legislature back into special session or issuing an executive order, Gelder said. (Evansville Courier & Press)

- **Clock ticking on Medicaid reforms**

  In order for any funding reductions to take effect when the new fiscal year begins July 1, the Quinn administration must give the public a chance to have input into any changes. The deadline to submit a public notice about the comment period ends May 21. The possible flurry of last-minute negotiations over the state's Medicaid problems comes as the General Assembly is juggling a number of controversial and complicated issues. Along with the possible Medicaid changes, Quinn is pushing for an overhaul of the state's underfunded employee pension systems. Because of their impact on state spending, both issues must be dealt with before the House and Senate can put the finishing touches on next year's spending plan. Quinn wants to cut the rate it pays to hospitals for providing services to low-income patients by an estimated 8 percent. He also wants to eliminate scores of specialized Medicaid programs, tighten eligibility for some programs and more than double the state's cigarette tax in order to come up with $2.7 billion. (Pantagraph)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The state is moving forward with the Medicaid pharmacy dispensing fee changes as proposed earlier this year. Beginning June 1, 2012, the Medicaid program will implement a $2.00 dispensing fee for prescriptions for compensable non-compounded legend and nonlegend drugs and $3.00 for compensable compounded prescriptions. Additionally, there will be a $0.50 dispensing fee certain drugs filled Medicaid recipients with a pharmacy benefit resource that is a primary third party payer, to cover the pharmacy's cost to transmit the claim to the Medicaid program for secondary payment.

The Pennsylvania Department of Insurance issued an RFQ to procure contracts for research and planning related to the potential development of a health insurance exchange. The proposed projects to support the further research and planning for a potential exchange include the following general items: Background Research; Procedural, Regulatory and Contractual Action; Governance; Program Integration; Financial Management; Oversight and Program Integrity; Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints; Business Operations of the Exchange; Project Management; and Grant Management.

In the news

- **$27.6B state budget bill poised for Senate vote**

  A $27.6 billion state budget bill that restores some $500 million of proposed state spending cuts awaits a Senate floor vote today after having cleared a key committee by a unanimous bipartisan vote. But action on the final budget won't be completed until next month after the House offers its own version and the governor weighs in on the negotiated legislation. By restoring $84 million for county human services programs, a proposed $168 million, or 20 percent cut, in state aid would be halved to 10 percent. The Senate bill doesn't address Governor Corbett's plan to combine seven of these programs in a single block grant. (Citizens Voice)

OTHER HEADLINES

Alabama

- **RFP: Alabama Health Insurance Exchange System**

  The Office of the Alabama Health Insurance Exchange (HIX) is issuing an RFP to obtain competitive responses from qualified organizations to provide and implement the Alabama Health Insurance Exchange System (System), a state-of-the-art automated system that supports HIX in providing all of the functionality described in this RFP. It is the intent of HIX to provide prospective Vendors with sufficient information to enable them to prepare and submit proposals to Alabama HIX, especially information that is specific to Alabama versus general information available from the Federal Government. Key Dates: Questions for Pre-Proposal Conference – May 16, 2012; Mandatory Pre-Proposal Conference – May 25, 2012; Questions after conference – May 31, 2012; Proposals Due – June 11, 2012.

Georgia

- **Grady still in the red, but sees financial improvements**

  Grady Memorial Hospital is still in the red. However, the hospital is seeing significant financial improvements in comparison to a year ago. In the first quarter of the year the hospital had a shortfall of $1.3 million dollars. That's $10 million dollars less than what the hospital lost during the same time last year. (Public Broadcasting Atlanta)

- **New group gains role in State's Medicaid planning**

  A task force working with state officials on restructuring Medicaid has given rise to a new group — one that's specifically concerned with mental health and substance abuse issues. The state is contemplating a whole new structure for Medicaid and PeachCare. The Department of Community Health is working on a ''redesign'' of how the two government insurance programs are run. The process has drawn intense interest from stakeholders, policymakers and health insurance companies expected to bid on contracts. State officials will soon put together a request for proposals (RFP) that it will give to potential bidders on the Medicaid contract. The new group will provide input on how that RFP is worded, which is potentially very important. (Georgia Health News)

Kentucky

- **Outside Medicaid Managed Care Company Attempting to Gain Foothold in Louisville**

  State officials have not yet given private Medicaid operators permission to do business in the Louisville area, but that hasn't stopped one company from trying to make inroads. Currently, Passport Health Plan runs Medicaid in and around Louisville. The federal government has ordered the state to open the region to competition, but the area remains closed. In anticipation of a change, United Healthcare recently sent letters to dental centers in the area, encouraging them to sign up with United once the state allows outside companies to begin operations. (WFPL News)

- **Medicaid contractor reverses position**

  Medicaid contractor Coventry Cares halted its plans Monday to cut off payments for a high-priced medication that treats addiction, responding to legal threats over its drug coverage. Coventry announced that it will continue authorizing payments for buprenorphin, a narcotic that helps reduce cravings in drug addicts and is commonly prescribed under the brand name Suboxone. SelfRefind, a Harrodsburg-based network of addiction clinics, was poised to file a lawsuit Monday alleging that Coventry violated its state contract and federal law when it sent out a notice last week refusing to pay for the medication. (Courier-Journal)

- **Denton Says Lawmakers Will Remove CoventryCares From Medicaid System if Tough Bargaining Continues**

  Kentucky Senator Julie Denton says the state's largest private Medicaid company is underpaying and threatening healthcare providers, and she says lawmakers may kick the company out of the state Medicaid system if the behavior persists. CoventryCares is one of three new private Medicaid Managed Care Organizations (MCOs) that began business in the commonwealth last year. But problems with the privatized system popped up quickly. They began in Eastern Kentucky. Hospital chain Appalachian Regional Healthcare sued Coventry for making inadequate and late payments to hospitals for care that should be covered by Medicaid. Coventry officials say they're operating within the new state rules for private Medicaid operators. (WFPL News)

Louisiana

- **Louisiana Senate panel sinks plan to set up health insurance exchange**

  Sen. Karen Carter Peterson said pushing for a state-run health insurance exchange is not a partisan exercise, but the newly elected Louisiana Democratic Party chairwoman had little shot of winning such an argument with a panel dominated by Republicans. So, with a decisive 8-1 vote late Tuesday evening, the Louisiana Senate Finance Committee buried a bill that would have set up a body of elected and appointed officials to craft the exchange. (NOLA.com)

Maine

- **Maine budget cuts target Medicaid**

  Nearly 7,000 young adults will lose Medicaid coverage if the Legislature approves a proposal to eliminate 19- and 20-year-olds from the state's Medicaid program, which goes by the name MaineCare in Maine. Gov. Paul LePage proposed revamping the state's Medicaid program and eliminating other services and programs administered by the Department of Health and Human Services. Supporters of the cuts say that welfare spending is unsustainable and that Maine provides Medicaid coverage to 35 percent more of the population that the national average. The latest proposed cuts, which must be approved by the full Legislature, will help close an $83 million budget shortfall at the health department. (Bangor Daily News)

Massachusetts

- **Deval Patrick addresses state and national audiences as he talks health care**

  Speaking to both state and national audiences, Governor Deval Patrick today defended the idea of government promoting near universal health care, even as he called on lawmakers, health care providers, and the business community to work jointly on controlling its cost. Patrick said he will only support final legislation that controls spending, provides flexibility in how to achieve it, "accountability" for failing to do so, and makes changes to the state's tort laws. In particular, the governor said he would not favor any plan that allows cost increases at a percentage rate exceeding the growth of the Gross State Product. He said that limit would ensure health care costs don't crowd out other public or private-sector spending. (Boston Globe)

Missouri

- **Lawsuit on Medicaid managed care contract in Missouri is dismissed**

  A lawsuit challenging the state's Medicaid managed care contract was "unsupported by facts and the law," a St. Louis judge said Friday in a ruling dismissing the case. California-based Molina Healthcare sued the state in March after it did not receive a contract to participate in Missouri's $1.1 billion managed care program, which mostly covers children and pregnant women in 54 counties. The company alleged state officials violated competitive bidding laws and changed its rules to favor certain bidders. (Kansas City Star)

Nebraska

- **Solicitation: Managed Care Program For Mental Health And Substance Abuse Services**

  The Nebraska Department of Health and Human Services (NDHHS), Division of Medicaid and Long-Term Care (MLTC) desires the submission of written information from interested parties, including behavioral health organizations, health maintenance organizations, prepaid health service organizations, providers and provider organizations, recipients, family members and other advocacy organizations, on how to address, under a managed care structure, the delivery of all mental health and substance abuse services offered through Nebraska Medicaid benefits. Proposals are due June 1, 2012.

New Hampshire

- **Council okays managed care**

The Executive Council approved contracts worth a combined $2.2 billion to have three private companies implement managed care for New Hampshire's Medicaid program. The all-Republican council voted 3-2 to approve the trio of three-year contracts, which had been tabled twice previously, in March and April. The companies are Granite State Health Plan, run by Centene Corp. of St. Louis; Granite Care-Meridian Health Plan of New Hampshire, run by Detroit-based Meridian Health Plan; and Boston Medical Center HealthNet Plan. (Concord Monitor)

New Jersey

- **N.J. Gov. Christie vetoes health-exchange measure**

New Jersey Gov. Chris Christie on Thursday put the kibosh on his state's effort to create a health-insurance exchange as required under the Affordable Care Act, saying it should wait until the Supreme Court decides whether to uphold the landmark federal law. Christie went on to say that some of the troublesome provisions of the act include limiting the pool of participants in the exchange, thus increasing costs and cutting options, and by offering each member of a proposed board that would oversee the exchange a salary of $50,000. (Market Watch)

New Mexico

- **Molina Opens 1st Medicaid Clinic**

Molina Healthcare Inc., a publicly traded health insurance company that has a state contract to provide Medicaid managed care, on Friday opened the first of what it projects will be four medical clinics around New Mexico. They will serve its Medicaid health plan members, Medicare and Medicaid fee-for service beneficiaries, and the uninsured. (InsuranceNewsNet)

Oregon

- **Oregon's Idea For Fixing Medicaid Hits The National Stage**

The federal government has taken the unprecedented step of giving Oregon almost $2 billion, for what amounts to a health care experiment. Oregon's governor has convinced the Center for Medicare and Medicaid Services that he has a way to make Medicaid treatment better and cheaper. But the feds have said that if the state doesn't cut Medicaid spending by 2 percent next year, all the new federal funds could dry up. (Oregon Public Broadcasting)

Texas

- **Officials investigate kids' illegal Medicaid rides to therapy**

Millions of public dollars have been spent for the transportation of poor and unaccompanied children, some as young as 3, to rehabilitation clinics in the Rio Grande Valley even though the rides have been illegal for years. Data obtained by the Houston Chronicle shows the Medicaid-paid van service - set up decades ago to ferry low-income children to physical, occupational and speech therapy - as well as Medicaid

payments to rehabilitation clinics that directly benefit from the transport service are higher in the Rio Grande Valley than any region in the state. (Houston Chronicle)

West Virginia

- **W.Va. officials to discuss Medicaid changes**

  West Virginia officials outlined plans Monday to shift around 57,000 people who rely on Medicaid into managed care, telling lawmakers the move would improve the health of some of the sickest people who rely on this government program while also cutting an estimated $15 million annually in prescription and medical costs. Several members of the House-Senate Legislative Oversight Commission on Health and Human Resources Accountability greeted the details with cautious optimism. But several also echoed concerns from advocates for these low-income residents about the state's ability to provide the needed care. (Bloomberg Businessweek)

- **RFP: Replacement Medicaid Management Information System**

  The Bureau for Medical Services is soliciting proposals to obtain the services of a qualified vendor to provide the fiscal agent services and the Design, Development, and Implementation (DDI); Centers for Medicare and Medicaid Services (CMS) certification; and operation for a replacement Medicaid Management Information System (MMIS) solution. Questions are due May 23, 2012. Proposals are due June 21, 2012.

National

- **More states work to implement health care law**

  Health and Human Services (HHS) Secretary Kathleen Sebelius announced today that Illinois, Nevada, Oregon, South Dakota, Tennessee and Washington will receive more than $181 million in grants to help implement the new health care law. The grants will help states establish Affordable Insurance Exchanges. Starting in 2014, Affordable Insurance Exchanges will help consumers and small businesses in every state to choose a private health insurance plan. These comprehensive health plans will ensure consumers have the same kinds of insurance choices as members of Congress. Including today's awards, 34 states and the District of Columbia have received Establishment grants to fund their progress toward building Exchanges. HHS also issued two guidance documents today to help states build Affordable Insurance Exchanges. (HHS News Release)

- **NAMD sends letter to Sec. Sebelius on Medicare-Medicaid "duals."**

  On May 9, 2012, NAMD sent a letter to U.S. Department of Health and Human Services Secretary Sebelius in support of HHS' duals demonstration activities and ongoing work with all states to improve care coordination for this population. On May 10th, NAMD convened a "Duals Fly-In," bringing Medicaid directors and project leads from states working on duals demonstration proposals to D.C. to meet with senior CMS Medicare staff and other federal policymakers. Throughout the daylong series of meetings, states shared information about the Medicaid practices they hope to build on to better serve the dually eligible population. (NAMD)

- **NCSL releases state budget update**

  The National Conference of State Legislatures (NCSL) released "State Budget Update: Spring 2012" report. The 50-state data report shows that revenue performance remains positive, expenditures in most states are stable and few states have faced mid-year budget shortfalls in fiscal year (FY) 2012. Twenty-one states predict by 2013 to bring in the amount of tax revenue that they did before the recession started. However, some states reported it will take at least three years to return to their peak revenue collections. According to NCSL's analysis nine states had to close gaps for their current 2012 budgets as they began work on their 2013 budgets. For 2013, 34 states had no budget gaps at all, while 16 states and Washington, D.C. have projected shortfalls totaling more than $16 billion. (NCSL.org)

- **Medicare's Quality Incentive System Does Not Adequately Account for Special Needs of Dual-Eligible Populations**

  A new report issued by the Association for Community Affiliated Plans (ACAP) finds that the Medicare Stars quality rating system for health plans participating in the Medicare Advantage program does not adequately account for the special needs of Medicare beneficiaries who are dually eligible for both the Medicare and Medicaid programs. These beneficiaries, commonly known as "dual eligibles," have fewer economic resources, are more likely to be in poor health and live with cognitive impairments or other disabilities. (ACAP)

- **Enrollment Assumptions for 2013 Financial Alignment Demonstration States**

  The Medicare-Medicaid Coordination Office (MMCO) has posted target enrollment data for several state dual eligible demonstration projects. (CMS)

- **Insurers Face $1 Trillion Revenue at Stake in Health Law**

  Health insurers will gain $1 trillion in new revenue over the next eight years under the 2010 health- care law, assuming it's upheld by the Supreme Court, according to a Bloomberg Government study. The amount is equal to about one-half percent of the nation's estimated gross domestic product from 2013 to 2020, and insurers led by UnitedHealth Group Inc. (UNH) would keep about $174 billion -- $22 billion a year -- for profit and administrative costs. The money comes from U.S. subsidies to people purchasing insurance beginning in 2014 and an expansion of Medicaid, the government's health program for the poor. (Bloomberg Businessweek)

- **Medicaid payments to primary care doctors will rise under new regulation**

  Primary care doctors could get a pay raise next year for treating Medicaid patients, under a rule announced by the Obama administration Wednesday. The proposed regulation implements a two-year pay increase included in the 2010 health-care law. The increase, effective in 2013 and 2014, brings primary care fees for Medicaid, which covers indigent patients, in line with those for Medicare, which insures the elderly and some disabled patients. (Washington Post)

COMPANY NEWS

- **CHI to outsource revenue-cycle operations, take stake in Conifer**

  Catholic Health Initiatives will acquire a minority stake in Tenet Healthcare's Conifer Health Solutions, while Conifer will provide revenue-cycle services to 56 CHI hospitals, the parties announced Wednesday. No financial terms were disclosed, but a Conifer spokesman described the deal as a "game changer," citing an increase in annual patient revenue from $11 billion to $18 billion. Before the deal, Conifer served more than 330 healthcare facilities, including about 100 hospitals. (Modern Healthcare)

- **Adreima Announces New Chief Executive Officer**

  Phoenix, AZ, May 16, 2012 – Adreima, a national provider of outsourced healthcare revenue cycle management (RCM) services, today announced that Bob Wilhelm has been named Chief Executive Officer, effective May 7. Wilhelm has more than 15 years of healthcare executive experience, including most recently as a division president for The TriZetto Group, a leading technology and service solutions provider to the healthcare market. Adreima, a portfolio company of Waud Capital Partners (WCP), is a leading healthcare RCM company, combining Medicaid expertise with a clinically integrated suite of patient access and reimbursement solutions, including eligibility, denials prevention/management and accounts receivable management services, to more than 100 hospital clients in 16 states.

- **Towers Watson & Co to buy largest private Medicare exchange**

  Towers Watson & Co, a New York-headquartered professional services company, said on Sunday it would buy Extend Health Inc, operator of the largest private Medicare exchange in the United States, to boost its health benefits offering for employers. (Chicago Tribune)

- **Centene Corporation Awarded Medicaid Contract in New Hampshire**

  Centene Corporation announced today the Governor and Executive Council of New Hampshire have given approval for the Department of Health and Human Services (DHHS) to contract with Granite State Health Plan, a wholly-owned subsidiary of Centene, to serve Medicaid beneficiaries in New Hampshire. Granite State is one of three plans selected. The initial term of the contract will be three years with an optional contract extension for one additional two-year period for a total contract term of five years. Operations are expected to commence in the fourth quarter of 2012. This contract award marks Centene's entry into its 17th state. (Centene Press Release)

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
May 14, 2012	Illinois Duals	RFP Released	136,000
May 18, 2012	Kansas	Contract awards	313,000
May 25, 2012	Ohio Duals	Proposals due	115,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	New York LTC	Implementation	200,000
June 4, 2012	Massachusetts Duals	Proposals due	115,000
June 18, 2012	Illinois Duals	Proposals Due	136,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida LTC	RFP released	90,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	136,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
September 20, 2012	Ohio Duals	Contracts finalized	115,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
Late 2012	New Hampshire	Implementation (delayed)	130,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida TANF/CHIP	RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	136,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida LTC	Enrollment complete	90,000
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
February 1, 2014	Georgia	Implementation	1,500,000
October 1, 2014	Florida TANF/CHIP	Enrollment complete	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

Below we provide an ongoing look at states as they progress toward implementing dual eligible integration demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012					N/A[+]	Spring 2013	N/A	1/1/2014
California*	Capitated	800,000	X	4/4/2012					5/24/2012	9/20/2012	12/7/2012	1/1/2013
Colorado	MFFS	59,982	X	4/13/2012					N/A	N/A	N/A	1/1/2013
Connecticut	MFFS	57,568	X	4/9/2012					N/A	N/A	N/A	12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012					TBD	7/1/2013	TBD	1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Idaho	Capitated	17,219	X	4/13/2012					N/A	9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012			TBD	TBD	TBD	7/1/2013
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012			N/A	N/A	N/A	1/1/2013
New York	Capitated	460,109	X	3/22/2012					TBD	TBD	TBD	1/1/2014
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	5/20/2012			N/A	N/A	N/A	7/1/2013
Oregon	MFFS	68,000	X	3/5/2012	X	6/13/2012			N/A	N/A	N/A	1/1/2013
South Carolina	Capitated	68,000	X	4/16/2012					TBD	9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012					TBD	TBD	TBD	1/1/2014
Texas	Capitated	214,500	X	4/12/2012					TBD	TBD	TBD	1/1/2014
Virginia	Capitated	56,884	X	4/13/2012					TBD	TBD	TBD	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012			TBD	TBD	TBD	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Totals	**17 Capitated, 5 Managed FFS**	***3,194,012***	***22***		***11***		***2***					

**Duals eligible for demo based on approval of 10 county expansion, Gov. Brown's May Revise Budget limits to 8 counties, delays implementation date to March 1, 2013..*

[+] Acure Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

HMA Recently Published Research

Health Care Use and Chronic Conditions Among Childless Adult Medicaid Enrollees in Arizona

Jack Meyer, Managing Principal
Esther Reagan, Senior Consultant
Dennis Roberts, Senior Consultant

Under the Affordable Care Act (ACA), beginning in 2014, Medicaid eligibility will expand to 133% of the federal poverty level for nearly all individuals. Arizona is one of the few states that already cover adults without dependent children in Medicaid through a longstanding Section 1115 waiver. This report, based on 2007 Medicaid claims data for adult Medicaid enrollees in Arizona, provides an analysis of health care utilization and health conditions for childless adults and compares them with parents and adults with disabilities. Understanding the health care use and needs of low-income childless adults can help inform other states' efforts to care for these adults under the Medicaid expansion in 2014. **(The Kaiser Commission on Medicaid and the Uninsured)**

Webcast: Proven Steps to Clinical Efficiency

Sharon Silow-Carroll, Managing Principal

April 9, 2012: When hospitals seek to enhance value in care delivery, their goal is twofold: improve quality and use resources as effectively as possible. Bill Santamour of Hospitals & Health Networks (H&HN) talks with Sharon Silow-Carroll of Health Management Associates about four hospitals that have successfully done just that by better managing service lines, harnessing data and technology and rethinking clinical staffing. **(H&HN Magazine - Link to Webcast)**

UPCOMING HMA APPEARANCES

19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – Medicaid: Current and Future Challenges

Kathy Gifford, Presenter

May 23, 2012

Princeton, New Jersey

19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – How Are States Progressing in Setting up State-Based Exchanges?

Jennifer Kent, Presenter

May 24, 2012

Princeton, New Jersey

AcademyHealth Annual Research Meeting – The Impact of the ACA on State Policy: Early Findings

Jennifer Edwards, Panel Facilitator

June 25, 2012

Orlando, Florida

AcademyHealth Annual Research Meeting – Health Insurance Exchanges: Progress to Date

Joan Henneberry, Panel Facilitator

June 25, 2012

Orlando, Florida