HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: UPDATE ON NEW YORK DUALS DEMO AND MLTC EXPANSION

HMA ROUNDUP: NEW YORK SUBMITS $10 BILLION WAIVER APPLICATIONS; CALIFORNIA DUALS DEMO SUBMITTED; MASSACHUSETTS DUALS DEMO DELAYED; ILLINOIS BUDGET CUTS FINALIZED; GEORGIA REDESIGN DECISIONS EXPECTED THIS SUMMER

OTHER HEADLINES: NEW MEXICO TO REEVALUATE MEDICAID REDESIGN PROPOSAL TO CMS; FEDS QUESTIONING NEW HAMPSHIRE MEDICAID CUTS TO HOSPITALS; HAWAII CANCELS PLANNED MEDICAID SERVICE CUTS

DUALS CALENDAR: WAVE OF DUAL INTEGRATION PROPOSALS TO CMS BEFORE END-OF-MAY DEADLINE BRINGS TOTAL TO 26 STATES, NEARLY 3 MILLION LIVES

JUNE 6, 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: Update on New York Duals Demo and Managed Long Term Care

Growth in Integrated Long Term Care Programs

Over the last 15 years, New York has developed three approaches to managing and integrating acute and long-term care services. They all focus on improved management of long-term care services for a nursing-home eligible population. Enrollment in these programs has grown significantly over the last year, when the Medicaid Redesign Team (MRT) stated its intent to enroll all the State's Medicaid beneficiaries into some form of coordinated care management. As part of the MRT process, the state announced its plan to require that all dual-eligibles in need of community-based long-term care enroll in a managed long-term care program (MLTCP). The State's Duals Integration proposal, submitted to CMS on May 25, 2012, further builds on that approach.

Enrollment in these programs is still voluntary, as the State has not yet received CMS approval to begin mandatory enrollment of duals into MLTCPs. New York has over 750,000 dually-eligible Medicare/Medicaid recipients. Currently 51,000 duals are enrolled in one of two forms of managed long-term care (i.e., PACE or partially capitated MLTC), with an additional 1,900 enrolled in Medicaid Advantage Plus plans.

The table below presents enrollment growth by type of plan over the last 12 months.

Plan Type	May 2011	May 2012	Change	
			#	%
PACE	3,645	4,377	732	20.1%
MLTC – Partial Cap	30,510	46,845	16,335	53.5%
Medicaid Advantage Plus	1,374	1,918	544	39.6%
TOTAL	**35,529**	**53,140**	**17,611**	**49.6%**

The Program of All-Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly is a federal program providing an integrated delivery model. The program is capitated for all Medicare and Medicaid services. PACE is open to dual eligibles and to Medicare or Medicaid beneficiaries. 4,377 individuals were enrolled in 8 plans across New York State as of May 2012, an increase of 20 percent over the last year.

The Department of Health has recently received applications for a Certificate of Authority to operate a new PACE program from three entities, Care for Life (in Albany and Rensselaer), PACE CNY (Onondaga), and Independent Living for Seniors (Monroe), as well as three applications from already-operating PACE programs to expand their geographic service area.

MLTC PACE Plans	Enrollees
ARCHCARE SENIOR LIFE	217
CHS BUFFALO LIFE	98
COMPLETE SENIOR CARE	36
COMPREHENSIVE CARE MGMT	3,125
EDDY SENIOR CARE	114

INDEPENDENT LIVING FOR SENIORS	294
PACE CNY	414
TOTAL SENIOR CARE	79
Total MLTC PACE Enrollment	**4,377**

Source: State Enrollment Report, May 2012

Partially-Capitated Managed Long-Term Care

MLTCs are capitated for some Medicaid services only. The capitated benefit includes Medicaid community-based long-term care benefits in coordination with select ancillary services and social and environmental supports. Primary and acute care services are covered by fee-for-service Medicare or Medicaid. Any Medicaid beneficiary over the age of 18 residing within a plan's service area is eligible for the program. 33,303 individuals were enrolled in 14 plans across New York State as of May 2012, an increase of over 50 percent in the last year. 82 percent of total MLTC enrollment is in New York City.

In late 2011, the Department of Health lifted the moratorium on the development or expansion of new partially-capitated plans, which had been in place since 2006. As a result the State has received a large number of applications for new MLTCs as well as applications by existing MLTCs to expand their line of business, their geographic service area, or both. A total of 16 applications for new certificates of authority, 6 applications from plans wanting to expand their lines of business, and 19 applications for expansions in geographic service area were received.

MLTC Partial Capitation Plans	Enrollees
AMERIGROUP	1,485
CCM SELECT	4,191
ELANT	180
ELDERPLAN	5,523
ELDERSERVE	5,987
FIDELIS CARE AT HOME	457
GUILDNET	8,139
HHH CHOICES	1,340
INDEPENDENCE CARE SYSTEMS	2,159
SENIOR HEALTH PARTNERS INC	3,823
SENIOR NETWORK HEALTH	388
TOTAL AGING IN PLACE PROGRAM	123
VNS CHOICE	10,750
WELLCARE	2,300
Total MLTC Partial Capitation Enrollment	**46,845**

Source: State Enrollment Report, May 2012

Medicaid Advantage Plus

Medicaid Advantage Plus (MAP) is capitated for Medicare and Medicaid under two separate contracts, one federal and one state. Between Medicare and Medicaid all medically necessary services are provided. Individuals must be dually eligible with full Medicaid coverage, must be enrolled in the plan's Medicare Advantage product, and must reside

in the plan's service area. While some plans are available to all adults over the age of 18, most plans restrict enrollment to the over-65 population. 1,918 individuals were enrolled in 9 plans across New York State as of May 2012 and 81 percent of enrollees were in New York City. That represents an increase of almost 40 percent since May of 2011. While no new plans have applied for a Certificate of Authority to operate a Medicaid Advantage Plan, the State has received 8 applications for expansion from current MAP plans.

Medicaid Advantage Plus Plans	Enrollees
AmeriGroup	9
Elderplan	650
Guildnet	374
HIP of Greater New York	343
NYS Catholic Health Plan	104
Senior Whole Health	291
VNS Choice Plus	103
WellCare	44
Total Medicaid Advantage Plus Enrollment	**1,918**

Source: State Enrollment Report, May 2012

New Integrated Long Term Care Applicants

The table below provides information on applications the State has received, by plan and by type of application.

New Applicants for Capitated MLTC	New Applicants for PACE
Aetna Better Health Inc.	Care For Life
AgeWell New York, LLC	PACE CNY
Ahava Group III, LLC dba Revival Choice	Independent Living for Seniors
AlphaCare of New York, Inc.	
Aviva Care of New York, Inc	
Balm of Gilead	
Care Resources Corporation	
Centers Plan for Healthy Living, LLC	
Central Health Choice, LLC	
Empire Choice, LLC	
Hamaspik Choice	
Integra MLTC, Inc	
Montefiore HMO, LLC	
Opticare, LLC	
Village Senior Services dba VillageCare Max	
VNA Homecare Option, LLC	

Source: http://www.health.ny.gov/health_care/medicaid/redesign/docs/application_tracking.xls

These applications, which require approval by the Commissioner of Health, are being reviewed by the Public Health and Health Planning Council, who will forward their recommendations to the Commissioner.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

Late last week, the California Department of Health Care Services released its final proposal to CMS for its 30-day public comment period. In addition to submitting its plan to the federal government, the Department is also in the final stages of negotiating its budget proposals with the Legislature. A key provision is the proposal to expand the dual integration pilot from four counties (Los Angeles, Orange, San Mateo and San Diego) to also include Alameda, Santa Clara, Riverside and San Bernardino. With a fiscal deadline to pass a budget to the Governor by June 15, this expansion and related statutory provisions will be final within a week.

Known as the "Coordinated Care Initiative," the final proposal contains the following major elements or changes from the draft proposal:

- The implementation date has been moved from January 2013 to "no earlier than March 2013 and no later than June 2013." The state's budget for the next fiscal year is assuming significant savings (almost $670 million) and the continued delay will only place increasing pressure for alternative budget savings elsewhere in the Medi-Cal program.
- Initially seeking to implement in up to 10 counties, the Department has settled on eight counties (totaling 685,000 beneficiaries), but indicates that additional counties will be included in 2014 with a full statewide program by 2015.
- California continues to seek a six-month "stable enrollment period" despite CMS indications that such a proposal won't be acceptable.
- Excluded populations now include partial-benefit dual eligibles, dual beneficiaries with other health coverage, children under the age of 21, beneficiaries with end-stage renal disease (ESRD), beneficiaries with developmental disabilities, individuals currently enrolled in one of the state's 1915 (c) waiver programs, and beneficiaries that live in certain rural zip codes not currently covered by managed care.
- In spite of excluding waiver recipients from participation in the dual pilots, the state is essentially closing the waivers to any new enrollees that would otherwise be eligible and instead enrolling them in the pilot.
- Populations exempt from the passive enrollment process include PACE recipients, individuals enrolled with the AIDS Healthcare Foundation and beneficiaries enrolled in non-demonstration Medicare Advantage plans.
- Dual beneficiaries that are currently enrolled in non-demonstration D-SNPs will be exempt from passive enrollment until January 2014.
- Native American beneficiaries are exempt from the stable enrollment period.

- Beneficiaries that opt-out of the demonstration will still be mandatorily enrolled in managed care to receive Medi-Cal benefits (wrap-around services and HCBS/LTC services), pending approval by the Legislature.
- Specialty mental health services, currently administered by county mental health plans, will continue to be carved out of the capitation rate for the participating plans.
- Participating plans will be prohibited from limiting availability of Medi-Cal and Medicare services using more restrictive medical necessity criteria than what exists in the two programs today.
- Plans will be at risk for the provision and payment of all LTSS, most notably the In-Home Supportive Services program, a program that will continue to be operated through county social service departments.
- The Department is proposing to transition its existing Multipurpose Senior Services Program (MSSP) waiver into a benefit administered by the demonstration plans and counties by 2014.
- Health plans will be required, through the state/federal contract, to establish a "continuity of care" team to ensure beneficiaries are appropriately transitioned, especially those with life-threatening illness or currently undergoing treatment for a serious condition or scheduled for a transplant procedure.
- Rates continue to be negotiated between the Department and CMS. The state indicates that it is considering the use of risk corridors and risk-sharing, based on plan concerns over institutional costs and adverse selection.

All information related to the state's Care Coordination Initiative can be accessed at the Department's website: http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx

In the news

- **Fate of Exchange Not Tied to Court Ruling, Official Says**

  Peter Lee -- executive director of the California Health Benefit Exchange -- said the exchange will significantly expand health insurance coverage in the state, even if the U.S. Supreme Court strikes down the federal health reform law's individual mandate. Lee said the exchange "is going to have, we project, over two million people in it after a few years," which has "very little to do with the mandate." He said the exchange will aid residents because it is "a place where people can get subsidies for care, and can make informed choices." (California Healthline)

- **Duals Project Goes to CMS for Approval**

  The project is the Coordinated Care Initiative, also known as the duals demonstration project, and the document is the project's final plan, which was submitted late last week to CMS. Some details still need to be worked out including the department's insistence on a one-year lock-out enrollment provision while federal officials have voiced support for an opt-out provision to the passive enrollment process. (California Healthline)

- **Challenges, opportunities lie ahead for Medi-Cal as it readies for major expansion**

  As California's Medi-Cal program readies for an influx of 2 million to 3 million people when national health reforms kick in, major challenges lie ahead, including finding enough specialists who will see participants. The state's existing 7.5 million Medi-Cal recipients already have difficulty accessing specialists, according to a study by the California HealthCare Foundation. And adults on Medi-Cal are twice as likely to visit the emergency room as people with other coverage, the study reveals. This may be an indication of greater difficulty in seeing primary care doctors. (McClatchy)

- **California awards contract for Accenture to run web system**

  The California Health Benefit Exchange on Thursday said it would award the contract – worth $359 million – to Accenture LLC. The contract is for the California Healthcare Eligibility, Enrollment and Retention System, or CalHEERS for short. Exchange officials would not comment on the decision, citing a weeklong window for losing bidders to protest. Accenture will be charged with creating a consumer friendly website and enrollment system for individuals, families and small businesses seeking affordable health coverage. The system will manage insurance information for millions of Californians expected to become newly insured under the federal health care reform program. The contract includes about $183 million for developing the system. That money will come mostly from the federal government. Once the system is in place, another $176 million will pay for continued development and operating costs over about 3 1/2 years. (Sacramento Bee)

Georgia

HMA Roundup – Mark Trail

The Georgia Department of Community Health (DCH) is reporting that it expects to have a decision on the Medicaid redesign proposals reached by this summer. DCH is reviewing proposals from a package of redesign options that recommends transitioning the aged, blind, and disabled (ABD) Medicaid populations into the existing Medicaid managed care program.

In the news

- **Unlicensed homes to face more state scrutiny**

  Personal care homes are required to be licensed and regularly inspected by DCH. But advocates say they see a growing number of unlicensed homes — perhaps hundreds around the state — operating outside the law, unregulated by any agency. Georgia officials say a new law that takes effect July 1 will finally empower them to crack down on rogue operators. The law for the first time criminalizes the operation of an unlicensed personal care home, making the first instance a misdemeanor and the second a felony. It also allows the state to immediately impose fines. Beforehand, when an unlicensed home came to light, the state simply gave the owner a month or two to get a license. The new law also gives the Georgia Bureau of Investigation authority to investigate unlicensed personal care homes. (Atlanta Journal Constitution)

- **Reshaping Medicaid care to affect many**

  The state is widely expected to announce a plan this summer that would dramatically expand the use of for-profit insurance companies in a new approach to managing Medicaid. Doctors, hospitals, nursing homes and families who rely on Medicaid have expressed worries about the possible fallout if Georgia moves forward as expected. Georgia already ranks 49th nationally in per-person spending on Medicaid. They wonder if it's possible for the companies to improve care, spend less and earn a profit on a program that doctors and hospitals say doesn't pay enough to cover the cost of caring for Medicaid patients. Among the specific concerns: Would the redesign drive even more doctors to leave Medicaid? Would managed care companies interfere with plans for disabled people that families have spent years arranging? Will patients be turned down for treatments that doctors say they need? Will hospitals make even less money from Medicaid, leading them to charge privately insured Georgians even more? (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Last Thursday evening, the Illinois legislature finalized a package of Medicaid savings, cuts, and related policy actions to help shore up a $2.7 billion deficit in the Healthcare and Family Services (HFS) Medicaid budget. SB 2840, known as the SMART Act, includes $1.6 billion in Medicaid savings. Several of the key impacts of the SMART Act are:

- A 3.5 percent Medicaid rate cut to hospitals, except safety-net and critical access hospitals, which will see no rate reductions.
- A 2.7 percent rate cut to other providers, excluding physicians, dentists, and community health centers.
- Various service reductions, including elimination of adult drug benefit, and utilization controls.
- Elimination of eligibility for roughly 35,000 adults on Medicaid.

For a full summary of savings and other cuts, see: (HFS SMART Act Budget Actions)

The package of bills passed also includes a cigarette and tobacco tax, the revenue from which will be directed into the state Medicaid program along with associated Federal matching funds. As noted in last week's Roundup, the legislature also passed a bill allowing an early Medicaid expansion for the Cook County Health and Hospitals System.

In the news

- **Medicaid fix a complex deal of winners and losers**

  In the most far-reaching achievement of the spring legislative session, lawmakers approved Medicaid reforms to prevent what some warned was the possible collapse of the costly system of delivering health care to the poor and disabled. But building support for it in Springfield involved sacrifice, haggling and trade-offs resulting in a multi-layered $2.7 billion package of cuts and taxes. Gov. Pat Quinn now is poised to sign it. Among the winners are doctors, who dodged a Medicaid payment cut; investor-owned

hospitals, which got a new tax break; and Cook County's health system, which gained a clear path to federal matching money in an early Medicaid expansion tied to President Barack Obama's federal health care overhaul. Losers include Medicaid recipients who lost services, cigarette smokers whose tax-per-pack doubled and nursing homes with comparatively healthy residents that now face steep payment cuts. Local taxpayers both won and lost — they now are on the hook for a smaller state Medicaid liability, but lose the prospect of getting help from hospitals on local property taxes. (Northwest Herald)

Massachusetts

HMA Roundup – Tom Dehner

The state confirmed in the past week that it is no longer contemplating a January 1, 2013 implementation of the proposed dual eligible demonstration. The State appears to be contemplating an early to mid-2013 implementation, but that decision has not been finalized and the timing of passive enrollment is an issue under discussion. Plan readiness in coordination with the state and CMS was a factor driving the delay.

In the news

- **In Mass., the only state with an individual mandate, few are forced to pay insurance penalty**

  In Massachusetts, the only state with a so-called individual mandate, the threat of a tax penalty has sparked little public outcry since the state's landmark health care law was signed in 2006 by the governor, Mitt Romney. Even with the mandate, the Massachusetts law remains popular. Two polls taken in the past year show more than 60 percent of Massachusetts residents approve of the law. One reason the mandate has failed to undermine that support is that so few people have had to pay. In 2009, the most recent year for which the state has figures, less than 1 percent of residents drew the penalty. Not everyone has escaped the mandate. Massachusetts collected about $77 million in penalties from residents as a result the requirement from 2007-2009. While that may seem like a lot of money, the penalties have touched just a tiny fraction of the state's population of more than 6.5 million. (Washington Post)

- **Health reform gets messy in Massachusetts**

  Gov. Deval Patrick wants Massachusetts to "crack the code" on health care costs, a punchy slogan he uses when he's promoting nationally the Bay State's cost-containment efforts. But transforming his ambition into policy has produced some messy sausage-making in his state Legislature. Key stakeholders aren't sure whether the springtime rush to craft a state approach to health care costs will create a national model — much the way Massachusetts's 2006 coverage expansion signed by Gov. Mitt Romney helped create a framework for President Barack Obama's 2010 national health law. In fact, some are wondering whether the cost-savings effort will even work in Massachusetts. (Politico)

New York

HMA Roundup – Denise Soffel

Governor Cuomo announced his plan to request a federal waiver that would generate $10 billion to invest in New York's health care infrastructure. The State projects that MRT initiatives will generate a total of $34 billion in savings over the next 5 years, of which $17 billion will be federal savings. They are requesting $10 billion of the federal savings to implement the MRT Action Plan.

Reductions in New York Medicaid spending growth are largely attributable to the global spending cap imposed in 2011. The global spending cap limits growth in state Spending on Medicaid to the medical component of the consumer price index, currently around four percent. For SFY 2012, Medicaid spending came in $14 million below the $15.3 billion cap. During the 2012 fiscal year the state adopted 78 recommendations that had been proposed by the MRT, many of which had to do with improving care management and moving toward fully integrated managed care. The State has moved aggressively to implement health homes and other provider-level strategies.

The waiver request would support a multi-year action plan that translates additional MRT recommendations into health care reforms and reinvestments. The initial plan identifies 13 areas where the state envisions reinvestment of funds.

1. **Primary Care Expansion** – capital funding to modernize and expand primary care capacity, available to patient-centered medical homes and Health Homes.
2. **Health Home Development** – bridge funding to allow health homes sufficient time to become self-sustainable after the federal enhanced match end.
3. **New Care Models** – investment in ACOs, provider partnerships, telehealth initiatives, and integrated physical/behavioral health models.
4. **Expanding Vital Access Provider and Safety Net Provider Programs** – two already operating programs designed to assist essential community providers that are financially stressed.
5. **Public Hospital Innovation** – funding for primary care services to the remaining uninsured post-Affordable Care Act (ACA).
6. **Medicaid Supportive Housing Expansion** – funding for housing for Medicaid beneficiaries with complex health needs who meet the health home criterion.
7. **Managed Long-Term Care Preparation Program** – funds for nursing home modernization in preparation for fully-integrated care management.
8. **Capital Stabilization for Safety Net Hospitals** – providing funding to cushion the transition from in-patient to out-patient settings, reduce debt, and finance modernization efforts in safety net hospitals.
9. **Hospital Transition** – funding for capital investment in primary care linked to bed closures, workforce retraining, and developing outpatient networks.
10. **Workforce Retraining** – funding to increase the health care workforce in areas likely to see increased demand as a result of the ACA (long-term care, care coor-

dination, primary care) as well as additional funding for Doctors Across New York and the Primary Care Services Corps, which provide loan repayment and recruitment incentives for physicians and non-physicians in medical underserved areas. Establishing a Health Workforce Incentives and Opportunities Clearinghouse and a Health Workforce Data Repository to improve data collection and analysis on workforce issues.

11. **Public Health Innovation** – integrating public health prevention programs (e.g., the Nurse-Family Partnership and home visits for environmental assessments for asthma prevention) into Medicaid to promote population health.
12. **Regional Health Planning** – establishing multi-stakeholder collaboratives to align health care resources and community health needs.
13. **MRT and Waiver Evaluation Program** – to allow for a systematic, data-driven evaluation of the state's activities.

Prior to submitting its waiver request to CMS, the State will conduct a stakeholder engagement process that includes four public hearings during the month of June, on-line webinars and surveys, focus groups with Medicaid beneficiaries, and tribal consultation. Information about the waiver, including the dates of the public hearings, can be found at: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

According to an article in the Scranton Times, state tax revenue collections during May are $43.8 million below projections, adding a new twist to the debate over restoring proposed state spending cuts in next year's budget. The state collected less in sales and corporate income taxes than anticipated last month. As a result, the total state revenue shortfall for the current fiscal year is $333 million, or 1.3 percent below estimate, the Revenue Department reported Friday.

OTHER HEADLINES

Arizona

- **KidsCare II open to Arizona's uninsured children**

  More than 100,000 Arizona children are on a waiting list for KidsCare, the state health-insurance program for children whose parents earn too much to qualify for Medicaid but not enough to afford traditional insurance. A new, temporary version of the program opened May 1, and so far the state has enrolled about 2,500 kids. There's room for 21,700 children, and they will be covered through January 2014. (The Arizona Republic)

Florida

- **State accommodates counties on Medicaid billing, but sticking points remain**

  Representatives of Florida's counties say that although they are still suing the state to block a Medicaid bill-collection scheme that became law this year, they have been able mitigate some of the new law's contentious effects. Next week the Agency for Health Care Administration will wrap up its meetings with the final three of the state's 67 counties, which will also a face a deadline to pay the state for the first round of monthly bills. In a few months they will also have to start paying down the backlog of unpaid bills from previous years. The state has allowed counties to pay their bills ahead of time and inform the state of charges they dispute, allowing them to avoid the reductions in state revenue-sharing as proposed in HB 5301, as long as they make their payments up to two days before the June 7 deadline. On that date, AHCA is required to certify the unpaid bills for the previous month, which can then be docked from the amount of revenue the state shares with counties. On Friday, county representatives traveled from across the state for a rulemaking workshop in Tallahassee where they asked the state for other changes. (The Florida Current)

Hawaii

- **Hawaii cancels proposed cuts to Medicaid services; State will still tighten QUEST eligibility**

  Hawaii has canceled proposed cuts to outpatient Medicaid services. The state Department of Human Services said Thursday it will restore Medicaid coverage for outpatient rehabilitation, prosthetics and optometry services to non-disabled adults younger than 65. DHS Director Pat McManaman says restoring critical services is key to addressing health care needs of beneficiaries of QUEST, Hawaii's health plan for the poor. Administrators proposed eliminating those services as part of its plan to save $75 million. Hawaii will continue with its plan to tighten QUEST income eligibility levels in July. The changes include restricting eligibility to 133 percent of the federal poverty level. That income level would mean an estimated 3,000 adults would lose coverage. (The Republic)

Michigan

- **Mich. Medicaid Director: "A Struggle" To Meet Deadlines If Law Upheld**

  KHN's Mary Agnes Carey talks to Michigan Medicaid Director Steve Fitton about how it will be a "struggle" for his state to be ready to implement the health law on schedule if the Supreme Court upholds the measure. But he's confident that Michigan can handle the expected new enrollees in Medicaid. Fitton says Michigan officials want to move beneficiaries with both Medicare and Medicaid into managed care if the law is upheld. (Kaiser Health News)

New Hampshire

- **Medicaid calls state to task**

  Federal Medicaid officials are threatening action against the state if it cannot show within 30 days that Medicaid patients still have access to health care given that lawmakers drastically reduced Medicaid payments to the state's hospitals last year. The $230 million cut in state and federal money forced several hospitals to lay off staff and some to say they could no longer afford to treat Medicaid patients. Ten of the state's 13 largest hospitals are suing the state in federal court over the cuts. The judge overseeing that case concluded in a ruling issued in March that the state was "highly likely" to have violated federal Medicaid rules in the way it cut reimbursement rates to hospitals. The case is still pending. The May 23 letter from the Centers for Medicare and Medicaid Services to Health and Human Services Commissioner Nick Toumpas echoes concerns raised in the lawsuit. It follows months of seemingly unsuccessful negotiations between the two. (Concord Monitor)

New Jersey

- **Feds ask N.J. to refund $30M over faulty Medicaid claims for mental health services**

  Federal officials are asking for a $30 million refund from New Jersey after an audit found that adult mental health services providers in the state did not make Medicaid claims in accordance with state and federal standards. The report from the U.S. Health and Human Services Department's inspector general was released Thursday. (NJ.com)

New Mexico

- **State to alter federal application to redesign Medicaid**

  New Mexico has voluntarily withdrawn its application to the federal government to redesign Medicaid, the low-income government health insurance program that covers one of every four New Mexicans. The administration, however, will send a new proposal to the federal Centers of Medicare and Medicaid Services sometime later this year, after the state conducts at least two more public forums to collect comments on the proposal and consults further with New Mexico's 22 tribal nations, according to the May 29 letter. (Santa Fe New Mexican)

North Carolina

- **Republicans Hit Dental Bill That Private Equity Hates**

  A North Carolina bill would place new strictures on dental companies, which have become a favored investment of the private equity industry. Private equity firms have bought or put money into at least 25 dental-management companies in the last decade. At least six such firms are under scrutiny by two U.S. senators and authorities in five states over allegations that they soak taxpayers through excessive Medicaid billings, abuse patients via needless treatments and run afoul of laws that say only licensed dentists can practice dentistry. The fight in North Carolina comes as at least five states are conducting audits or reviews of how dental-management companies do business. (Bloomberg)

Texas

- **Medicaid recruiters scramble for Texas dental patients**

  A WFAA article investigates recruiters whose job is to find Medicaid-eligible children for dentists to work on. In 2010, Medicaid paid $1.6 billion for dental work on children, more than $500 per child. The recruiter's job is to entice parents to take their children to the office of a certain dentist. They often give free gifts to parents to seal the bargain. Some dentists, in turn, compensate the recruiters by giving them a bonus for each child they bring in to the office. One-to-one solicitation of patients is illegal, according to the Texas Department of Health and Human Services. (WFAA News)

National

- **Study: Caution needed in handling care for dual eligibles**

  Policymakers must be cautious in formulating plans to streamline care for some low-income elderly and disabled patients, according to an analysis published in the journal Health Affairs. Estimates about savings from new plans and demonstration projects must also be approached with skepticism, the authors wrote. The report emphasized that "one size will not fit all" and that specific subgroups of dual eligibles — people enrolled in both Medicare and Medicaid — will need programs specifically designed for them. (The Hill)

- **ACO-Type Models Growing in Medicaid**

  For the past couple of years, health policy makers have been developing new ways of delivering care in Medicare, most notably accountable-care organizations. But less attention has been given to similar models that are a growing trend in Medicaid. Within the next week or so, the Center for Medicare and Medicaid Innovation is expected to announce a round of "innovation awards" that could support Medicaid demonstration projects that test out methods of coordinating care in a manner similar to accountable-care organizations (ACOs). Medicare ACOs require medical providers to coordinate care for patients. They then share in any savings from this new model of care and, depending on the amount of risk a group is willing to assume, they could face penalties for not meeting savings goals. (CQ Healthbeat)

- **Medicaid DSH Payment Cuts Could Add to Financial Woes of Safety Net Hospitals**

  Cuts to Medicaid disproportionate share hospital payments required by the health care law could leave safety net facilities unable to pay for necessary modernizations in health care delivery, experts said Monday. In addition to losing DSH funds, hospitals will be more limited in their ability to use commercial insurers to cross subsidize care since the health overhaul provides for a review of premium increases for private insurance. Policymakers can mitigate the squeeze by focusing Medicaid and disproportionate share dollars better, providing organizational flexibility to the facilities and clearing up antitrust issues at the state level to allow better integration of health facilities. (CQ Healthbeat)

- **On Exchanges: What if the Mandate Does Survive the Supreme Court?**

  Many policy analysts are focused on the impact of a possible U.S. Supreme Court ruling in June that finds the individual coverage mandate in the health care law unconstitutional. But what will happen if the high court leaves the mandate unscathed and states are then under the gun to open exchanges by 2014 as the overhaul requires? Two things: more states may be ready to open their own exchanges than doomsayers say. And the coverage that these new marketplaces offer may be very pricey. Those were a couple of the takeaways from a Washington, D.C., forum on Friday about the exchanges created by the health overhaul law. Another: exchanges opened by Democratically controlled state governments won't necessarily be markedly different from those in Republican-dominated states. (CQ Healthbeat)

- **2014 Medicaid Expansion a Challenge, Say State Directors**

  With a year and a half to go before Medicaid is supposed to be expanded to cover an additional 16 million people under the health care law, on Thursday Medicaid directors said they are worried that they will not be ready to handle the surge in enrollment. Most states face budget constraints that make it hard for them to expand enrollment in a phased-in way in preparation of the huge surge in the program in 2014 under the law. They have outdated technology that they must decide whether to replace or try to build on. And they face huge uncertainty about whether the expansion will actually take place or be derailed by a Supreme Court decision expected next month or a change in administrations after the November elections. (CQ Healthbeat)

COMPANY NEWS

- **ILS Strengthens Management Team With Appointments Across Corporate Development, Informatics & Sales**

  Independent Living Systems LLC, a national leader in providing innovative long-term care, care management, post discharge and nutrition services to the elderly, dual eligible and special needs populations, today announced the expansion of its organization with four executive appointments in the areas of company informatics, corporate strategy and sales. The new appointments include VP of Corporate Development, Chief Information Officer, VP of Sales & Marketing, and VP of Long Term Care Northeast/Mid Atlantic Market Operations. (WSJ MarketWatch)

- **Universal Health Services, Inc. to Acquire Ascend Health Corporation**

  Universal Health Services, Inc. announced today that they have reached a definitive agreement whereby UHS will acquire Ascend Health Corporation for $500 million in cash. Including the assumption of $17 million in Ascend net debt, the total transaction consideration is approximately $517 million. (Universal Health Services)

- **McKesson and ValueOptions Strategic Partnership to Focus on Integrated Care for Dual Eligibles and High-Risk Comorbid Populations**

  ValueOptions and McKesson announced a strategic partnership to deliver holistic, coordinated care to dual eligible individuals across the nation. McKesson Corporation is a Fortune 500 healthcare services and information technology company and ValueOptions is a health improvement company that specializes in serving individuals suffering from mental illness and substance abuse disorders. The partnership delivers an integrated, comprehensive suite of services that support better health for individuals with complex conditions through robust physical and behavioral healthcare coordination. This improved care coordination helps reduce long-term care spending, unnecessary emergency room visits and lower hospitalization rates. (WSJ MarketWatch)

RFP Calendar

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

Date	State	Event	Beneficiaries
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 20, 2012	Florida CHIP	Contract awards	225,000
End of June	Kansas	Contract awards	313,000
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 is a summary table of the progression of states 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	X	7/1/2012			N/A[+]	Spring 2013	N/A	1/1/2014
California*	Capitated	685,000	X	4/4/2012	X	6/30/2012			5/24/2012	9/20/2012	12/7/2012	3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012			N/A	N/A	N/A	1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012			N/A	N/A	N/A	12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012			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
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012			N/A	N/A	N/A	1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012			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
Missouri	Capitated[‡]	6,380	X		X	7/1/2012			N/A	N/A	N/A	10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012			TBD	TBD	TBD	1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012			TBD	TBD	TBD	1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012			N/A	N/A	N/A	1/1/2013
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	7/1/2012			N/A	N/A	N/A	7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012			N/A	N/A	N/A	1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012			TBD	TBD	TBD	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012			TBD	9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012			TBD	TBD	TBD	1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012			TBD	TBD	TBD	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012			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			TBD	TBD	TBD	1/1/2014
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	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***2***					

**Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

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

[‡] Capitated duals integration model for health homes population

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 ACA and beginning in 2014, Medicaid eligibility will expand to 133% of the FPL for nearly all individuals. Arizona is one of the few states that already covers 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)**

Upcoming HMA Appearances

AHIP - Preparing for Exchanges: Medicaid and Exchange Linkages

Joan Henneberry, Panelist

June 20, 2012
Salt Lake City, Utah

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

The National Council for Community Behavioral Healthcare - Medicaid Health Homes for Individuals with Behavioral Health Conditions

Alicia Smith, Panelist

June 25, 2012
Washington, D.C.

Healthcare Financial Management Association: HFMA National Institute 2012

Jennifer Kent, Panel Participant

June 27, 2012
Las Vegas, Nevada

Leadership Institute's Leadership and Learn Symposium: The Road I Have Traveled...

Izanne Leonard-Haak, Presenter

June 28, 2012
Harrisburg, Pennsylvania