HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: NEW YORK'S MLTC EXPANSION

HMA ROUNDUP: FLORIDA POSTS PRELIMINARY HOSPITAL RATES; GEORGIA SELECTS MEDICAID DESIGN CONSULTANT; TEXAS GOVERNOR SIGNS MEDICAID REFORM BILL; EXCHANGE PLANNING IN INDIANA

OTHER HEADLINES: STATE TAX REVENUES CONTINUE TO IMPROVE IN 2Q11; OHIO OPTS TO CREATE EXCHANGE, MONTANA DOES NOT; DEBT CEILING DISCUSSIONS OFFER FEW DETAILS ON POTENTIAL MEDICAID IMPACT

PRIVATE COMPANY NEWS: CLEARVIEW CAPITAL ACQUIRES PYRAMID HEALTHCARE

HMA WELCOMES: DENNY LITOS JOINS OUR LANSING OFFICE

MEDICAID MANAGED CARE RFP CALENDAR UPDATED: WASHINGTON AND MASSACHUSETTS BEHAVIORAL RFP RELEASES DELAYED; CONTRACT AWARDS IN LOUISIANA SCHEDULED FOR MONDAY.

JULY 20, 2011

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

---

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA
LANSING, MICHIGAN • NEW YORK, NEW YORK • SACRAMENTO, CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

CLARIFICATION: CMS DUAL INTEGRATION ENROLLMENT POLICY

In last week's Roundup, we highlighted guidance articulated in a letter from CMS to the states on July 8 related to the enrollment of dual eligibles in care delivery models that integrate both the federal and state financing for all services. In our discussion, we noted that a limitation of the guidance was that enrollment would be required to be voluntary on the part of the member. We noted that states' experience with voluntary enrollment into integrated care delivery systems (such as PACE) has been mixed, with plans' ability to achieve requisite scale limited by scarce administrative resources.

In subsequent discussions with industry contacts, we have learned that CMS remains open to an "opt-out" model in which states could enroll dual eligibles into an integrated health plan (either on a voluntary or auto-assigned basis) without their prior approval, with the member retaining the right to "opt-out" of managed care and revert to traditional fee for service for his/her Medicare benefits. This is similar to the "passive" Part D enrollment model for dual eligibles, though a fee for service option would be available for Medicare Parts A and B (not the case for Part D). In such a scenario, the Medicaid benefit package would most likely remain in a mandatory managed care setting. It is our understanding that CMS' intent is to encourage demonstration models that result in significant participation among the target population, suggesting states will have flexibility to model their programs in such a way as to migrate beneficiaries into managed care plans on an expedited basis.

We view the opt-out model as an attractive option for health plans participating in integrated dual eligible programs. In our opinion, the rate of disenrollment from such a model is likely to be low, particularly if the Medicaid benefit package would remain in a mandatory managed care setting. As a result, mandatory enrollment for both Medicare and Medicaid services, even with an "opt-out" feature, would allow plans to achieve requisite scale while minimizing the deployment of scarce administrative resources.

IN FOCUS: NEW YORK'S MANAGED LONG TERM CARE EXPANSION

This week, our *In Focus* section looks at New York's plan to implement mandatory enrollment into its Medicaid managed long-term care (MLTC) program beginning next year. New York is one of a number of states with plans to carve long-term care (LTC) services and supports into its capitated managed care benefits package alongside Ohio, New Jersey, Florida and Washington. While an important trend to monitor across the country, the expansion of managed long-term care is particularly noteworthy in New York given the state's outsized long-term care expenditures, unsuccessful attempts to achieve similar goals in the past and the accelerated timeline for implementation. In the discussion below, we provide some background on the state's historic spending pattern, its existing delivery system options for LTC beneficiaries and details regarding the pending programmatic changes. The key takeaway is that in the context of managed long-

term care program expansions, New York's represents the largest new business opportunity for managed care organizations with Amerigroup, UnitedHealth and WellCare the only multi-state plans with existing operations in the state.

Background

New York spends more money on Medicaid than any other state in the country, and much of that disparity is attributable to long-term care services and supports. According to Kaiser State Health Facts, in 2009 New York spent $49.4 billion on Medicaid, $8 billion (or 18%) more than the second-highest spending state (California) and more than twice as much as the third-highest spending state (Texas). New York and California spent a roughly equivalent amount on acute care benefits in 2009 (~$25 billion), but New York spent $7.5 billion (~55%) more than California on long-term care services. In fact, more than 17% of all Medicaid long-term care expenditures in the United States in 2009 occurred in New York State, by far the largest percentage in the country. The table below lists the ten states that spent the most on long-term care services in 2009, illustrating the disparity between New York and its peer states.

2009 Medicaid Long-Term Care Expenditures, Top Ten States

$ in millions	Long Term Care	% of US Total	Total Medicaid	% of US Total
New York	**$21,299**	**17.4%**	**$49,369**	**13.5%**
California	$13,751	11.3%	$41,683	11.4%
Pennsylvania	$6,619	5.4%	$17,232	4.7%
Texas	$5,697	4.7%	$23,705	6.5%
Ohio	$5,627	4.6%	$14,057	3.8%
Florida	$4,320	3.5%	$15,089	4.1%
New Jersey	$3,964	3.2%	$9,667	2.6%
Massachusetts	$3,660	3.0%	$12,481	3.4%
Illinois	$3,478	2.8%	$13,140	3.6%
North Carolina	$3,419	2.8%	$11,506	3.1%
United States	$122,082		$366,471	

Source: statehealthfacts.org

New York's long-term care expenditures are the highest in the country on a per-capita basis as well. In 2007, New York spent 126% more than the national average per disabled member and 77% more than the national average per elderly member on long-term care services.

	Disabled	% vs. US
New York	**$28,223**	**125.8%**
Minnesota	$25,525	104.2%
Alaska	$23,194	85.6%
Connecticut	$21,650	73.2%
New Jersey	$20,584	64.7%
Rhode Island	$20,220	61.8%
North Dakota	$20,194	61.6%
Wyoming	$19,762	58.1%
Maryland	$19,606	56.9%
District of Columbia	$19,289	54.3%
United States	**$14,481**	

	Elderly	% vs. US
New York	**$22,159**	**77.3%**
Connecticut	$21,507	72.1%
Montana	$21,385	71.1%
Pennsylvania	$20,702	65.6%
North Dakota	$19,572	56.6%
District of Columbia	$19,188	53.5%
Alaska	$19,143	53.2%
Ohio	$18,087	44.7%
Massachusetts	$18,069	44.6%
New Hampshire	$17,905	43.3%
United States	**$12,499**	

Source: statehealthfacts.org

Looking at New York's long-term care expenditures by service category, the disparity between New York and other states with large long-term care programs is broadly based except with respect to services delivered in mental health facilities. In particular, New York's spending on intermediate care facilities for the mentally retarded (ICF-MR) comprises more than 25% of total spending on these services nationwide. The state also maintains very generous home health benefits relative to its peers.

$ in millions	ICF-MR	% of US Total	Mental Health Facilities	% of US Total	Nursing Facilities	% of US Total	Home Health & Personal Care	% of US Total	Total
New York	**$3,590**	**25.8%**	**$351**	**8.0%**	**$7,619**	**15.0%**	**$9,740**	**18.4%**	**$21,299**
California	$864	6.2%	$1,337	30.5%	$4,100	8.1%	$7,450	14.1%	$13,751
Texas	$969	7.0%	$21	0.5%	$2,152	4.2%	$2,555	4.8%	$5,697
Pennsylvania	$624	4.5%	$73	1.7%	$3,666	7.2%	$2,256	4.3%	$6,619
Minnesota	$176	1.3%	$54	1.2%	$851	1.7%	$1,980	3.7%	$3,062
Ohio	$716	5.2%	$532	12.1%	$2,582	5.1%	$1,797	3.4%	$5,627
Massachusetts	$265	1.9%	$162	3.7%	$1,611	3.2%	$1,623	3.1%	$3,660
Florida	$328	2.4%	$14	0.3%	$2,403	4.7%	$1,574	3.0%	$4,320
Connecticut	$524	3.8%	$53	1.2%	$1,240	2.4%	$1,516	2.9%	$3,333
North Carolina	$549	4.0%	$88	2.0%	$1,288	2.5%	$1,493	2.8%	$3,419
United States	**$13,896**		**$4,382**		**$50,920**		**$52,841**		**$122,039**

Source: statehealthfacts.org

Given the level of spending on long-term care services and supports in New York, it is no surprise that the state's Medicaid Redesign Team (MRT), commissioned by Governor Cuomo to identify savings opportunities in Medicaid as part of the FY 2012 budget, included a recommendation to convert the state's voluntary managed long-term care program into a mandatory one.

Current Delivery System

In addition to the traditional fee for service delivery system, New York currently operates four distinct Medicaid programs for elderly and disabled Medicaid beneficiaries. Below, we briefly summarize each model.

1. Partial Capitation Model

This is the name for the state's existing MLTC program. It only covers Medicaid benefits, and enrollment is entirely voluntary on the part of the beneficiary. Each beneficiary in the partial capitation program must be nursing home certifiable. As we discuss below, this is the principal vehicle through which new enrollment will gain access to services upon

implementation of the mandatory requirement in April 2012. As of March 2011, there were just under 30,000 Medicaid beneficiaries enrolled in this program.

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

The PACE program integrates Medicare and Medicaid payments from the CMS and the state to provide the full benefits package to dual eligible beneficiaries. Typically, PACE programs are aligned with adult day health centers or similar facilities. PACE plans are exclusively operated by non-profit entities and receive payment through a three- way contract between the plan, the state and CMS. As of March 2011, there were seven PACE organizations in New York with total enrollment of 3,591.

3. Medicaid Advantage

Plans participating in the Medicaid Advantage program cover acute care Medicare (including Part D) and Medicaid benefits for enrolled members, but long-term care services are carved out. For-profit and not-for-profit plans are allowed to participate in Medicaid Advantage, and each plan is required to be licensed to participate in the Medicare Advantage program. The plans receive two monthly payments, one from the state and one from CMS. Beneficiary participation in the Medicaid Advantage program is voluntary with 5,855 members enrolled as of March 2011.

4. Medicaid Advantage Plus

Medicaid Advantage Plus (MAP) is similar to the Medicaid Advantage program except that long-term care services and supports are included in the plans' benefit package. As a result, Medicaid Advantage Plus and PACE are the only programs that currently offer integrated coverage for all Medicare and Medicaid benefits for dual eligibles in New York. Importantly, beneficiaries in MAP must be eligible for a nursing home level of care (at enrollment) but be capable of remaining in their home without jeopardy to their health. As of March 2011 there were 1,289 members enrolled in Medicaid Advantage Plus.

Below we summarize enrollment in the MLTC program, Medicaid Advantage and Medicaid Advantage Plus programs as of March 2011.

Plan	MLTC	Medicaid Advantage	Medicaid Advantage (Plus)	Total
VNS (Visiting Nurse Service)	8,748	0	58	8,806
Guildnet	6,212	0	326	6,538
Comprehensive Care Mgmt.*	1,950	0	2,574	4,524
Elderplan	3,619	0	431	4,050
HealthFirst/Managed Health/Senior HP	2,605	91	0	2,696
HIP/GHI	0	2,470	106	2,576
Independence Care Systems	1,642	0	0	1,642
WellCare	**1,294**	**0**	**62**	**1,356**
Touchstone	0	1,230	0	1,230
Fidelis/NY Catholic Health Plan	391	792	44	1,227
Amerigroup	**973**	**0**	**13**	**986**
HHH Choices	960	0	0	960
Senior Whole Health	0	543	249	792
Liberty Health Advantage	0	426	0	426
Senior Network Plan	380	0	0	380
Elderserve	362	0	0	362
Affinity Health Plan	0	207	0	207
Elant	154	0	0	154
Total Aging in Place Program	141	0	0	141
Metro Plus	0	95	0	95
UnitedHealth	**0**	**1**	**0**	**1**
Total	29,431	5,855	3,863	39,149

**Includes 2,574 MLTC PACE members counted as MAP*

Source: New York State Department of Health

MLTC Expansion Plan

Senate Bill 2809 (S2809) is the legislation that describes New York's plan to require specific population groups to enroll in the state's Medicaid managed care program as well as other programmatic changes. The bill was signed by the governor and is now awaiting waiver approval from CMS, which is expected. In an April letter to CMS describing the planned changes, the state clearly articulates its commitment to a capitated Medicaid managed care program, noting:

> *"… We believe that the Medicaid managed care program is a better model of care for these populations since managed care plans provide an organized system of care, an accountable entity and the ability to coordinate and manage care."*

The letter goes on to indicate that favorable enrollee satisfaction measures and quality of care data both support expanding the managed care program. Moreover, the state notes that while Medicaid long-term care expenditures increased by 26.4% from 2003 to 2009, MLTC costs per recipient only increased 0.3% over the same time period.

New York State seeks to build on this success by extending mandatory MLTC enrollment to Medicaid beneficiaries that meet the following criteria:

- Age 21 or older;

- Eligible for Medicare and Medicaid; and
- In need of community-based long-term care services for more than 120 days.

There are 72,335 beneficiaries meeting these criteria across the state. In addition, non-dual disabled adults will have the option of selecting either a MLTC plan or a Medicaid managed care plan. The state intends to transition eligible beneficiaries in New York City beginning April 1, 2012, with the rest of the state rolling out once there is sufficient plan capacity in each area. Accordingly, the state is increasing the number of plans that can receive a Certificate of Authority (COA) to operate in the state from 50 to 75. The state is also eliminating the nursing home certifiable requirement to enroll in MLTC and the requirement that every application be reviewed by a Department of Health Services caseworker. In this way, the state hopes to expedite enrollment in the MLTC program.

In addition to having a large potential pool of applicants, MLTC capitation rates in New York are also well above average. According to a presentation prepared by the New York Department of Health, current spending is $4,268 PMPM, suggesting a market opportunity of approximately $3.6 billion statewide. We note that the state did reduce capitation rates by 2% in order to capture immediate savings from the program, though our sense is that this rate reduction will be more than offset by the benefits of scale and the reduction in administrative costs associated with moving to mandatory enrollment.

At this time, there are 21 managed care organizations participating in the MLTC, Medicaid Advantage and Medicaid Advantage Plus programs of which 14 are non-profit. Of the remainder, only three, WellCare, Amerigroup and UnitedHealth operate Medicaid plans in multiple states and are shareholder-owned. Given the capital requirements necessary to absorb this high-cost population, we believe these organizations are best positioned to capitalize on the near-term market opportunity. That said, New York is not a procurement state; with the 25 available slots for new plan entrants, we would not be surprised to see other entities pursue this opportunity.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

As noted last week, the Basic Health Plan bill passed out of the Assembly Health Committee but still faces a significant hurdle in the Assembly Appropriations Committee. The bill would create a plan with an essential benefits package for individuals with incomes above Medicaid eligibility, but still below 200% of the Federal Poverty Level. The plan would also cover low-income legal immigrants excluded from Medicaid coverage. We believe the Committee will take up the bill in August.

In the news

- **Adult Day Health Care centers fight for life**

  The fate of about 300 centers that serve tens of thousands of frail, elderly and disabled Californians remains uncertain more than six months after Gov. Jerry Brown proposed

eliminating the $169 million-a-year program to help solve the budget crisis. Brown's administration is moving forward with plans to transition 37,000 low-income, disabled and elderly adults off Adult Day Health Care, a program they depend on for medical care, physical therapy, exercise, counseling, socialization and other support. Meanwhile, Democrats in the Legislature have worked for months to come up with an alternative to shuttering the nearly 300 Adult Day Health Care centers around the state, which are intended to help keep adults living at home and out of more expensive taxpayer-funded institutions, such as nursing homes and hospitals. (San Francisco Chronicle)

Florida

HMA Roundup – Gary Crayton / Elaine Peters

The Florida Agency for Health Care Administration (AHCA) posted the new Florida hospital rates on Friday, July 15 for 2011-12 (available here). The managed care legislation passed earlier this year (HB 7109) revised the hospital rates from being established twice a year (January 1st & July 1st) to once a year (July 1st of each year). Hospitals can submit data for rate-setting revisions through September 30, 2011, when rates will be locked in for the coming year. We note the following observations on the new rate-setting rules:

- The agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs, as defined by the agency.
- Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.
- Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect.
- Errors in cost reporting or calculation of rates discovered after September must be reconciled in a subsequent rate period.
- The agency may not make any adjustment to a hospital's reimbursement rate more than five years after a hospital is notified of an audited rate established by the agency. This requirement is remedial and shall apply to actions by providers involving Medicaid claims for hospital services.
- Hospital rates shall be subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

In the news

- **Groups urge federal officials to reject Florida's Medicaid plan**

  More than 100 groups and nonprofits have signed a letter to federal officials, urging Medicaid administrators to reject Florida's plan to move Medicaid patients into managed care. Florida's proposal has come under fire from patient advocates, who say the state's pilot program in South Florida was a failure. In addition, many elder-law attor-

neys have protested that the first group to enter managed care will be nursing-home residents, who they say are the frailest of all Medicaid patients. (Orlando Sentinel)

Georgia

HMA Roundup – Mark Trail

Georgia's Department of Community Health released a notice of intent on Friday, July 15 to award the Medicaid redesign contract for Medicaid and CHIP design solution consulting services to Navigant Consulting.

As noted last week, the next Governor's Exchange Committee meeting is set for August 16, 2011.

In the news

- **State proposes increases in Medicaid co-pays**

  A plan to double existing co-pays for inpatient hospital services to $25 is also among the changes proposed by the Georgia Department of Community Health that would save the state an estimated $4.2 million. Co-pays for prescription drugs, vision care and other services would also climb under the plan outlined at a department board meeting Thursday. Children ages 6 and older enrolled in PeachCare would be the most dramatically affected by the changes, which would take effect Sept. 1, since those families don't currently have co-pays. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The Medicaid Advisory Committee's (MAC) subcommittee on the state's patient centered care model (PCCM) met this Tuesday, July 19. The focus of the subcommittee is on the PCCM program's role in the state Medicaid reform requirement that 50% of Medicaid enrollees be in a care coordination program. Agenda and materials made available prior to the meeting are available here and here.

In the news

- **Feds halt Illinois Medicaid reform**

  The federal government says Illinois cannot ask Medicaid recipients to prove how much they earn or where they live. The federal Centers for Medicare and Medicaid Services, or CMMS, which manage these programs, told Illinois' Medicaid managers in June that two of 15 reforms violate federal rules that prohibit states from changing criteria for those seeking Medicaid. The reforms, passed earlier this year and signed by Gov. Pat Quinn, require Medicaid recipients to prove that they are earning within 300 percent of the federal poverty level — $67,050 for a family of four — and live in Illinois. (Statehouse News Online)

- **Cuts to meals for Illinois elderly worry advocates**

  Budget cuts to programs that deliver meals to homebound seniors in Illinois may force some frail elderly into nursing homes, a more expensive option for both the individuals and the state, advocates say. Illinois lawmakers so far have protected most money for

home health services, despite the state's serious financial problems. But they've whittled back programs that don't receive federal matching money, such as home-delivered meals. The state's recently passed budget includes a cut of $2.2 million in funding for home-delivered meals and other services for aging residents, a reduction of nearly 14 percent from the previous year. Meanwhile, the need is increasing along with the elderly population. Illinois saw a 22 percent increase in residents age 85 and older from 2000 to 2010, according to U.S. Census data. (Chicago Tribune)

Indiana

HMA Roundup – Cathy Rudd

The state of Indiana posted an RFI for a data quality consultant for the Exchange on July 11. The consultant will look at using the Exchange to provide quality and comparison information about insurance carriers and providers. Responses are due on July 21. (Link to RFI)

The Health Finance Commission met on July 13 with discussion focused on the Exchange. Meeting minutes have not yet been released, but an agenda is available here.

In the news

- **Deep cuts helped Indiana achieve $1.2 billion surplus**

  Cuts in education spending and even deeper reductions in state agencies' budgets allowed Indiana to close the fiscal year with nearly $1.2 billion in its main bank account. That's a surplus that amounts to 9 percent of what the state spent in the 2011 fiscal year. However, Gov. Mitch Daniels said it's not enough of a cushion to consider spending increases next year. (Courier Press)

Massachusetts

HMA Roundup – Tom Dehner

The behavioral health RFP was amended last week to allow bidders with accredited behavioral health subsidiaries to qualify under the accreditation requirements of the contract.

The Massachusetts Health Connector Board met on Thursday, July 14. Meeting minutes, the Health Connector's Quarterly Report, and a National Health Care Reform Planning Update are available here.

In the news

- **New Blue Cross Blue Shield contract produces "modest" savings, study finds**

  Blue Cross Blue Shield of Massachusetts' "alternative quality contract," which Governor Deval Patrick has held up as a potential model for controlling health care costs, produced "modest" savings in its first year while yielding improved quality of care in some areas, according to a new study in this week's New England Journal of Medicine. The contract gives doctors a fixed amount for each patient regardless of how much care the patient requires, and includes incentives for meeting quality measures. These types of so-called global payment systems are supposed to encourage coordination of care

and lessen unnecessary treatment because physicians are financially at risk if they exceed the budget -- and can keep some of the extra if they come in below budget. During 2009, the first year the contract was used, average medical spending increased for enrollees treated by both doctors paid under the AQC and by doctors paid in the traditional way -- a separate fee for each procedure or visit. But the increase was 1.9 percent smaller for enrollees in the AQC group. (Boston Globe)

Texas

HMA Roundup – Dianne Longley

Senate Bill 7 (SB7), the Medicaid reform bill that authorizes the managed care expansion into the South Texas region, was signed by the Governor on Monday.

In the news

- **Perry signs bill allowing Texas healthcare "compact"**

  Governor Rick Perry signed into law on Monday a Republican-backed measure that would eventually allow Texas to enter into a "health care compact" with other states to seek flexibility in operating Medicaid and Medicare. Oklahoma and Georgia have passed a similar measure, aiming to turn Medicaid and Medicare dollars into block grants. The compacts idea is a challenge to the Obama-backed Patient Protection and Affordable Care Act of 2010, which Republicans say is too costly for states. (Reuters)

OTHER HEADLINES

Alabama

- **Alabama cuts Medicaid drug costs by examining pharmacy receipts**

  Last September, Alabama won federal approval for a new way to set drug prices for Medicaid beneficiaries. Since then, the state has launched its new pricing method, and expects to shave 6 percent off its prescription drug bill this year. In January, Oregon received federal approval to do the same thing. Alabama's new pricing method, known as "average acquisition cost," is based on what the pharmacies actually pay. To find out that information, Alabama hired a contractor to conduct a twice-yearly random-sample survey of about 350 of the state's 1,350 drug stores. Over the course of two years, every pharmacy will be sampled. They are asked to hand over one month's worth of receipts for all of their drug purchases and file updates to those prices weekly. The federal government has hired the same contractor and has committed to a similar survey schedule. (Stateline)

Alaska

- **AK working on changes aimed at reducing the increase in Medicaid costs shouldered by state**

  The state of Alaska is implementing changes to its Medicaid program aimed at tempering the ever-rising costs. Health and Social Services Commissioner William Streur said recommendations from a joint administration-legislative task force could save the state

several million dollars in its first year and rise to $20 million or more in years. Medicaid is intended to help lower-income citizens with medical costs. The eight recommendations agreed upon by the group include increasing generic substitutes for brand-name drugs and establishing a pilot program of medical homes that would address chronic health problems, with a goal of reducing hospitalizations and emergency room visits. (The Republic)

Arkansas

- **Officials scale back initial plans for Medicaid overhaul**

  State officials said they have scaled back their goals for the first phase of a planned overhaul of the state Medicaid system, choosing to target specific areas rather than the entire system during the project's first year. Members of a legislative panel prodded the officials to begin providing concrete details of their plans. On May 2, the U.S. Department of Health and Human Services gave Arkansas conditional approval to prepare a proposal for Medicaid reforms that Gov. Mike Beebe has said will move the state away from a fee-for-services system and toward a payment system in which partnerships of health care providers would be reimbursed based on results. Arkansas Department of Human Services Director John Selig now says that by July 1 of next year the state hopes to reform the payment structure for treating certain illnesses. (Arkansas News)

Maine

- **LePage pushes for Medicaid eligibility changes**

  Gov. Paul LePage says he will push for a significant change in Maine's version of the Medicaid program, MaineCare, by reducing eligibility to the level in place in most states, a move that opponents say will throw about 30,000 Mainers off the program. (Bangor Daily News)

Montana

- **Federal officials left to set up Montana health insurance exchange, Lindeen says**

  Although federal health officials this week pledged flexibility in working with states setting up a new Internet clearinghouse to shop for health insurance, Montana still won't be able to design its own system, state Auditor Monica Lindeen said last Thursday. Lindeen, the state's insurance commissioner, said since the 2011 Legislature refused to approve legal authority for Montana to prepare its own health insurance exchange, the federal government will be the one setting up Montana's exchange. (Missoulian)

New Jersey

- **Big shifts lie ahead for N.J. Medicaid**

  Rather than cut benefits or kick people out of programs, the state is turning to private HMOs to care for the aged, blind, disabled and chronically ill, according to Commissioner Jennifer Velez of the state Department of Human Services. The HMOs will coordinate care better, eliminate duplicated services and reduce costs, she said — with better outcomes. Four private HMOs approved by the state are working overtime this

summer to enroll 45,000 people and take over the reimbursement of millions of dollars to thousands of providers. Meanwhile, doctors, wheelchair suppliers, home health-care agencies and medical day-care programs for adults and children are joining HMOs many had previously avoided — and they're hoping the private HMOs will be as reliable as the state when it comes to regular payments. (NorthJersey.com)

New Mexico

- **State mum on $100M contract for Medicaid IT system**

The New Mexico Human Services Department won't say much about its contract negotiations with a firm to administer the state's computerized Medicaid claims system: Not the firm's identity or how many firms bid on the multimillion-dollar deal. The state's Medicaid computer claims system is overdue for an upgrade, officials said, especially with major provisions of the nation's new health care law going into effect in 2014, when an additional 130,000 to 170,000 New Mexicans are expected to enroll in the Medicaid program. Given the future influx of recipients and the new law, the state must enhance the IT system, adding electronic eligibility and claims status inquiries and responses. It also is contemplating making optional improvements such as Web-based provider enrollment, a Web portal for Medicaid enrollees and a Web-based claims-entry system, all to be performed by the new contractor. (Santa Fe New Mexican)

Ohio

- **Ohioans will get a health exchange**

Although Lt. Gov. Mary Taylor repeatedly has ripped the new federal health-care law, the Kasich administration still plans to fully implement it in Ohio. Gov. John Kasich said yesterday that plans are moving forward to create a statewide marketplace or exchange for health insurance, as mandated by the Affordable Care Act. Kasich said the state has received federal money to plan for building an exchange, in which individuals and small businesses that don't have insurance could find coverage beginning in 2014. He said Taylor, who also heads Ohio's Department of Insurance, is to apply soon for a second round of federal cash. (Columbus Dispatch)

Utah

- **Utah leaders pushing feds for quick approval for state Medicaid waiver**

State government officials signed a letter addressed to federal officials on Tuesday, hoping to push their Medicaid waiver request along in a "timely fashion." The original waiver, which seeks flexibility in reforming the system locally, among other changes to Medicaid, was submitted to the U.S. Centers for Medicare and Medicaid Services on July 1. Utah Gov. Gary Herbert said the state's plan "makes sense," is "innovative and homegrown," and is the result of much collaboration from stakeholders. (Deseret News)

Virginia

- **Medicaid pulls back on mental health for kids, teens**

Virginia's Medicaid program is further tightening controls on some child and adolescent mental health services this week because of soaring payments to private provid-

ers. Between 2006 and 2010, spending for emotionally disturbed youngsters grew by nearly 400 percent on day treatment and by more than 200 percent for short-term in-home treatment. That added up to $321.1 million for the two programs in the fiscal year ending last summer, up from $85.5 million in 2006. The increase was due in part to a recent push to treat children at their homes and schools when possible, rather than in institutions and group homes. However, loose regulations and lax monitoring also created loopholes that some private providers exploited. (Virginian Pilot)

Washington

- **State hospitals sue to block $260M budget cut**

  The Washington State Hospital Association went to court Monday in an attempt to block $260 million in budget cuts that the group considers an illegal diversion of funds by the Legislature. The $260 million is the WSHA's estimate of the reduction in reimbursement rate the state intends to pay for Medicaid services during the 2011-13 budget cycle that began July 1. The association says that its members agreed to an increase in fees hospitals would pay the state in 2010 - part of a "safety net" bill aimed at capturing a larger reimbursement of federal money for Medicaid, which in turn was to increase payments to hospitals, avoid budget cuts approved in 2009, and boost reimbursements in the future. It wants the money preserved for low-income Medicaid patients and services for children in the state-subsidized Apple Health program. (The Olympian)

United States

- **Home care cutbacks put strain on elderly**

  States are reducing how much time a nurse can spend making house calls and ending meal deliveries for the homebound. Many also are gutting adult day-care programs that give seniors a safe place to spend their days while relatives work. Aging and disability services in three out of four states have been reduced during the past two years or face cuts, even though demand is increasing. Texas lawmakers underfunded Medicaid by nearly $5 billion in the state budget, a move that home health advocates say leaves the elderly and adults with disabilities unsure how their care at home will be provided. California eliminated funding for about 330 adult day centers, a move that will affect some 35,000 seniors who use them for medical care and socializing. Lawmakers are hoping to restore about $85 million to transition seniors into an as-yet undetermined alternate program - about half the amount cut from the budget. Minnesota is considering cuts to home-health aides and a program that allows disabled people to live on their own. (Boston Globe)

- **States save by moving vets from Medicaid's rolls to VA's**

  A growing number of states are shifting health care costs to the federal government by finding military veterans who receive Medicaid and signing them up for medical benefits through the U.S. Department of Veterans Affairs. Arizona, California and Texas are among the states that are working to replicate a program first launched in Washington State. That program, begun in 2003, has moved some 9,500 veterans from the state's Medicaid rolls to the VA's. Washington State has avoided paying $27 million in health care bills this way — enough to make a small dent in a strained state budget.

And veterans generally find that the benefits offered through the VA are more generous that what they were getting through the state. (Stateline)

- **States See Robust Revenue Gains in First Half of 2011, New Report Says**

  States' tax revenues grew by 9.3 percent in the first quarter of 2011, according to Census Bureau data analyzed in a new report by the Rockefeller Institute of Government. That marks the fifth consecutive quarter of growth, following declines during and after the Great Recession. Preliminary data for April and May indicate continuing and growing strength in revenues through the second quarter of 2011. Local tax revenues, however, declined for the second straight quarter, dropping 0.6 percent, due primarily to the lagged impact of falling house prices on property tax collections. And despite the continued recent growth, states' tax collections remain slightly lower than they were in the first quarter of 2008. Recent evidence of weakness in the national economy raises the specter of uncertain fiscal conditions for states in the future, according to the report. (Rockefeller Institute)

PRIVATE COMPANY NEWS

Clearview Capital acquires Pyramid Healthcare

Clearview Capital has acquired Pyramid Healthcare Inc., an Altoona, Penn.-based provider of drug/alcohol and mental health treatment for adults and adolescents. No financial terms were disclosed. Pyramid Healthcare has 21 facilities throughout Pennsylvania. www.clearviewcap.com

Essence Group Closes $61 Million Private Investment Round

Essence Group Holdings Corporation (EGHC) today announced it has raised $61 million in a private funding round that includes new investors Camden Partners and Kleiner Perkins Caufield & Byers. The proceeds represent one of the largest private-sector investments to date in the accountable health care movement. EGHC's solutions, offered through the company's Lumeris technology and business services subsidiary, include sophisticated software and specialized services that deliver previously unattainable collaboration among health plans, hospitals, physicians and patients. (Business Wire)

Nuance Communications (Nasdaq: NUAN) has acquired Webmedx, an Atlanta–based provider of transcription services for hospitals and healthcare clinics. No financial terms were disclosed. Webmedx has raised nearly $40 million in total VC funding, with current shareholders including firms like Ferrer Freeman & Co. www.nuance.com

HMA WELCOMES…

Denny Litos, Principal

Denny is a seasoned hospital executive with 24 years of experience serving in hospital administrations. Most recently, Denny served as the President and Chief Executive Officer of two large hospital systems; the first was Ingham Regional Medical Center (IRMC) in Lansing, Michigan, followed by his tenure of five years at Doctors Medical Center in Modesto, California. He has led each of these complex teaching hospitals by focusing simultaneously on strategic planning, operations, board and physician relations, community partnerships, and patient care in both outpatient and inpatient settings. Prior to his appointment as President and CEO of IRMC, Denny served as the Executive Vice President and Chief Operating Officer, and also as the Senior Vice President of Network Operations. During his time as President and CEO of IRMC, Denny also held the position of President and CEO of the Ingham Regional Healthcare Foundation. Through the foundation, he initiated multiple health education and disease prevention programs in the community and funded clinic operation costs for a free clinic supported by physician volunteers.

Denny earned his bachelor's degree in Business Administration from Wayne State University, a master's degree in Management at Central Michigan University, and a master's degree in Healthcare Administration at Trinity University.

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. Notable events this week include delays in the Washington and Massachusetts Behavioral RFP releases, the inclusion of New Hampshire's plan to implement Medicaid managed care and the pending announcement of contract awards in Louisiana scheduled for Monday, July 25.

Date	State	Event	Beneficiaries
July 25, 2011	Louisiana	Contract awards	892,000
July 30, 2011	Kentucky RBM	Contract awards	N/A
August 1, 2011	New Jersey LTC	Implementation	200,000
August 9, 2011	Massachusetts Behavioral	Proposals due	386,000
August 15, 2011	Kentucky RBM	Implementation	N/A
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
September 15, 2011	Washington	RFP Released	880,000
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 15, 2011	New Hampshire	RFI Released	N/A
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

Health Reform: "DNA Profile"

National Update from Health Management Associates

Health care reform creates both opportunities and challenges for providers of all types: hospitals, FQHCs, physician groups and others. To take advantage of the opportunities and to mitigate the challenges, timely and accurate information on what health reform means to individual providers within their own service area is essential. Information on specific and potential policy changes and opportunities, community impacts and institutional financial performance must all be assembled, integrated and made practicable at the individual organizational level. HMA has developed a comprehensive, strategic summary for individual hospitals, hospital systems and state hospital associations called the Health Reform DNA Profile. There are two integrated parts, The Community Profile and the Financial DNA Profile. (Link to more)

Accountable Care in the Safety Net

National Update from Health Management Associates

Accountable care has emerged as a critical delivery system redesign companion to expanded coverage within federal health reform. Accountable care calls for providers to organize to provide a full continuum of services to patients and populations, to commit to improving quality while controlling cost, and to be rewarded as they succeed. However, the principles of accountable care are based upon CMS-supported demonstrations and lessons learned primarily in Medicare populations served by highly organized and integrated health systems. The "safety net" differs in the patient populations it serves, the structures and relationships between its providers, and its funding, which is mainly concentrated in Medicaid and local government reimbursement. Thus, the federal emphasis on the development of accountable care will need to be tailored for the safety net. CMS appears to understand this imperative and has created a "safety net unit" within the Center for Medicaid and Medicare Innovation, which is committed to seeding new approaches to integrated delivery and accountable care for current and future Medicaid populations. (Link to more)

California Exchange: "As Ambitious As You Can Be"

National Update from Health Management Associates

Led by its newly appointed Board, the California Health Benefit Exchange continues to make progress toward January 1, 2014 - the date by which millions of Californians will be seeking health coverage through its competitive marketplace. Since the first organizational meeting in April 2011, the Exchange Board has met several times and is steadily working on the critical items that must be in place before the organization can turn its attention to developing the coverage products that will be offered to Californians. Among the most pressing issues are the recruitment and retention of its first Executive Director and the preparation and submission of the Level 1 Establishment Grant to the federal government. (Link to more)

UPCOMING HMA APPEARANCES

Health Services Finance Officers (HFSO) Annual Meeting: "Development of Medical Homes with Integrated Services and Expanding Role of FQHCs"

Mark Trail, featured speaker

August 2, 2011

Charleston, West Virginia