HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: NEW MEXICO'S CENTENNIAL CARE RFP RELEASED

HMA ROUNDUP: COLORADO TO REBID MMIS AND BEHAVIORAL HEALTH CONTRACTS; NEW YORK MLTC WAIVER GETS CMS APPROVAL; MASSACHUSETTS COOP AWARDED $88.5 MILLION FEDERAL LOAN

OTHER HEADLINES: ARKANSAS, KANSAS, KENTUCKY FACE EXCHANGE DESIGN DECISIONS; GEORGIA, MINNESOTA GOVERNORS TALKING MEDICAID BLOCK GRANTS; NEW HAMPSHIRE MCO CONTRACTS GAIN FEDERAL APPROVAL; AMERIGROUP APPEALS OHIO MCO AWARDS

HMA WELCOMES:
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BARBARA LEADHOLM – BOSTON, MASSACHUSETTS

SEPTEMBER 5, 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: NEW MEXICO'S CENTENNIAL CARE RFP RELEASED

This week, our *In Focus* section reviews the Centennial Care Request for Proposals (RFP) released by New Mexico's Human Services Department (HSD) on August 31, 2012. New Mexico submitted its final Centennial Care waiver proposal to CMS on August 17, 2012, proposing to consolidate its numerous federal waiver populations as well as the fragmented managed care and fee-for-service structures that serve New Mexico's roughly 512,000 Medicaid lives. We previously reviewed the draft waiver proposal to CMS in our May 9, 2012 Weekly Roundup, available here.

Centennial Care Waiver Overview

New Mexico currently contracts with four managed care plans for its Medicaid population, two managed care plans for its dual eligible and nursing facility population, and one additional managed care plan for behavioral health services. As of July 2010, more than 67 percent of New Mexico Medicaid beneficiaries were enrolled in comprehensive managed care. In addition, the State manages seven additional waiver populations under separate federal 1915(c) and 1115 waiver authority. The State's plans to consolidate and reorganize the Medicaid program under this new waiver will be known as Centennial Care and includes the following key components:

- Reprocure and reduce the number of Medicaid managed care plans.
- Carve in behavioral health, home and community-based (HCBS) services, and institutional services.
- Incorporate payment reforms including bundled payments and incentives for Medicaid managed care plans.
- Implement cost-sharing and co-pays for inappropriate ER use and non-generic drugs.
- Begin mandatory managed care enrollment for Medicaid-eligible Native Americans.

Major Changes to Centennial Care as of August 31, 2012:

- On August 17, 2012, New Mexico's final Centennial Care waiver proposal indicated that the State would abandon its capitated dual eligible demonstration proposal and instead include the dual eligible population in the Centennial Care waiver. Plans awarded contracts under the RFP must already be or become a statewide Special Needs Plan (SNP) or Medicare Advantage plan. Dual eligibles enrolled in a program of all–inclusive care for the elderly (PACE) plan are excluded from the Centennial Care RFP population.
- For the Native American Medicaid population, MCOs under contract for Centennial Care will be required to offer contracts to all Indian Health Services (IHS) and Tribal 638 providers. These providers, however, will not be required to contract with the plans, and all of these providers, contracted or not, will be reimbursed, at a minimum, at the established U.S. Office of Management and Budget (OMB) rates. As of January 2012, there were a total of 88,319 Native Americans enrolled in Medicaid in New Mexico.

Key RFP Elements

HSD's Centennial Care RFP (available here) seeks bids from managed care plans to provide physical health, behavioral health, and long-term care services to at least 510,000 Medicaid beneficiary lives in New Mexico. The State anticipates an additional 170,000 Medicaid lives to become eligible and enroll beginning in 2014 due to the Affordable Care Act's Medicaid expansion, bringing total covered lives under the RFP to nearly 700,000.

- HSD intends to award contracts to no more than five plans, unless it determines that a higher number of plans is in the best interest of the State. Contracts will be awarded for a five-year term (2014 through 2018).
- As mentioned above, plans must currently be, or become, certified as a SNP plan or Medicare Advantage plan.
- Also mentioned above, MCOs must offer contracts to Native American providers, although the providers will not be required to accept contracts to be reimbursed by the MCOs for services provided to Native American Medicaid enrollees.
- Centennial Care beneficiaries will enroll in or be auto-assigned to a plan on an annual basis, with a 90-day plan change period.
- The Centennial Care contract includes a profit sharing provision, under which any profits above three percent of net capitation revenue will be shared 50 percent with the State.
- HSD has established an 85 percent Medical Loss Ratio (MLR) requirement, with the flexibility to raise or lower the MLR over the course of the five-year contract.
- MCOs will hold aside 1.5 percent of capitation payments for a Delivery System Improvement Fund. This withhold can be earned back by meeting Delivery System Improvement Targets, as outlined in the table below. The four targets, accounting for 25 points each (100 points in total), will determine what percentage of the withheld capitation payment the plan will earn back.

Year One (2014) Objectives	Target	Points (out of 100)
Payment Reform	HSD approval for implementation of adult diabetes project, asthma project, bundled rates project.	25
Health Homes	Minimum of eight Health Homes in network, with a minimum of four Behavioral Health Homes.	25
Patient-Center Medical Homes	Minimum of five percent of MCO members served by PCMHs (including non-NCQA accredited).	25
Emergency Room Diversion	Minimum of 10 percent reduction in non-emergent use of ER.	25

Evaluation Criteria

The table below summarizes the scoring weights for each of the evaluation criteria. Full details on the scoring of the cost component of the proposal will be released on September 17, 2012. The cost component accounts for nearly 20 percent of the total scoring.

Evaluation Criteria	Points	%
Mandatory Requirements	Pass/Fail	N/A
Experience and Qualifications	75	3.7%
Provider Network/Agreements	150	7.4%
Benefits and Services	125	6.2%
Care Coordination, Transition, Assessments, and Care Plans	275	13.6%
Information Systems and Claims Management	200	9.9%
Patient Centered Programs	150	7.4%
Native Americans	75	3.7%
Member and Provider Services	100	4.9%
Quality Assurance and Utilization Management Program	100	4.9%
Reporting Requirements	100	4.9%
Compliance Program/Program Integrity	75	3.7%
Financial Management	100	4.9%
Readiness	100	4.9%
Cost Proposal	400	19.8%
Total Points Available	**2,025**	**100.0%**

RFP Timeline

The table below summarizes the overall timeline for the Centennial Care RFP.

Timeline	Date
RFP Released	**August 31, 2012**
Pre-proposal conference	September 13, 2012
Data book, cost proposal template/scoring released	**September 17, 2012**
Actuarial bidder conference	September 27, 2012
Deadline for questions regarding RFP	October 1, 2012
Questions & Answers published	October 22, 2012
Proposals Due	**November 20, 2012**
Notify bidders not meeting mandatory requirements	November 26, 2012
Final bidders selected	December 21, 2012
Notice of intent to award	**January 7, 2013**
Protest deadline	15 days from award
Implementation date	**January 1, 2014**

Current Medicaid Market

New Mexico's current Medicaid managed care program for the majority of the Medicaid population, Salud!, serves more than 390,000 Medicaid lives. Salud! members are enrolled in plans offered by Blue Cross Blue Shield, Molina, and two local plans, Lovelace Community Health Plan and Presbyterian Health Plan. The CoLTS managed long-term care program, as of SFY2010, served more than 37,000 dual eligibles and those with nursing facility level-of-care needs. CoLTS members are enrolled in plans offered by Amerigroup and UnitedHealth. Individuals in both Salud! and CoLTS with behavioral health needs receive these benefits through a separate behavioral health managed care plan, as do those Medicaid recipients in the fee-for-service population, for a combined Medicaid behavioral health population of roughly 431,000. Optum Health currently holds the behavioral health contract. The total Medicaid population in New Mexico was roughly 512,000 as of January 2012.

	Salud!	CoLTS	Behavioral Health
	TANF Medicaid	*Dual Eligible, Nursing Facility*	*Salud!, CoLTS, FFS*
SFY2010 Enrollment	390,571	37,555	430,969
Managed Care Plans	Blue Cross Blue Shield	Amerigroup	Optum Health
	Molina	UnitedHealth	
	Lovelace Community HP		
	Presbyterian HP		

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

Colorado is conducting a procurement process for the State's Medicaid Management Information System (MMIS). The Department of Health Care Policy and Financing has posted a draft Request for Proposals (RFP) and many other documents for reference during the vendor review process. The goal is to replace the legacy MMIS with a service delivery model that is both flexible and adaptable and that will provide easy access to data and comprehensive reporting capabilities. The State seeks fiscal agent services with the expectation of excellent customer service and improved operational automation for providers and the Department. A Pre-RFP Vendor Conference is scheduled for September 18, 2012. Written comments on the draft RFP are due by September 29, 2012. The draft RFP and related documents are available here.

The Department is also beginning a process to rebid its behavioral health services for 2014. A resource website is being developed to provide information about the existing program structure, possible new directions, and to gather input for use in development of the RFP. The Behavioral Health Services Rebid Info website will be updated throughout the procurement process and may be found here.

Massachusetts

HMA Roundup – Tom Dehner

Tufts Medical Center, its physician network, the New England Quality Care Alliance, and Vanguard Health Systems have collectively formed and sponsored the Minuteman Health Initiative, and were awarded an $88.5 million loan from CMS' Consumer Operated and Oriented Plans (COOP) initiative. The Minuteman Health Initiative expects to begin offering insurance coverage in Eastern and Central Massachusetts in 2014, both through insurance brokers in the individual and small-group insurance markets, and as a qualified health plan in the Massachusetts Health Connector insurance exchange. CMS has awarded 20 COOP loans across the country.

Michigan

HMA Roundup – Esther Reagan

From the *HMA Michigan Update:*

Managed Care

In the April 2012 edition of The Michigan Update we reported that McLaren Health Plan was to purchase CareSource Michigan. This purchase has now been finalized, and the enrollment reports for August reflect the much expanded service area of McLaren, up from 30 counties to 53, and McLaren's increased membership as a result of the added CareSource enrollees.

Dual Eligible Integration Demonstration

The Department of Community Health (DCH) submitted a dual eligible integration proposal to CMS in April 2012, which CMS posted for public comment. Based on questions and comments from CMS, the Department has been working on refinements to the proposal that provide more operational detail since that time. There are several issues that require more detailed development, one of which relates to the coordination of physical and behavioral health care. The proposal would continue separate contracts, using risk-based reimbursement, with Prepaid Inpatient Health Plans (PIHPs) for behavioral health services and with Integrated Care Organizations (ICOs) for acute and long-term care. The submitted proposal would utilize a "Care Bridge" model to bring coordination and accountability between the PIHPs and ICOs. There is also an issue related to region configuration. The current geographic regions used for the Medicaid Health Plan and the PIHP contracts are different, so there is discussion regarding changes to one or both of these regional configurations for consistency. In addition, the appropriate number of regions for the duals demonstration may be smaller than for either Medicaid Health Plan or PIHP contracting.

New York

HMA Roundup – Denise Soffel

In a letter dated August 31, 2012, CMS informed the New York Department of Health (DOH) of the approval of the state's waiver request to establish the managed long-term care (MLTC) program, which will expand mandatory Medicaid managed care enrollment to dual eligible individuals over age 21 who receive community-based long-term care services in excess of 120 days. Additionally, the waiver will provide dual eligible individuals ages 18 to 21, as well as nursing home eligible non-dual individuals age 18 and older, voluntary enrollment into the MLTC program. In addition, the waiver permits the state to expand eligibility to ensure continuity of care for individuals moving from an institutional long-term care setting to receive community-based long term care services through the managed long-term care program. This only approves part of the state's waiver request, and CMS will continue to review New York's request to transition the state's Section 1915(c) waiver, the Long-Term Home Health Care Program, into the MLTC program.

Pennsylvania

HMA Roundup – Izanne Leonard–Haak

Pennsylvania collected $1.8 billion in General Fund revenue in August, which was $32.3 million, or 1.8 percent, less than anticipated, Secretary of Revenue Daniel Meuser reported today. Fiscal year-to-date General Fund collections total $3.6 billion, which is $33.2 million, or 0.9 percent, below estimates.

Although no formal announcement has been made, news articles have alluded to the fact that the Pennsylvania Department of Public Welfare (DPW) is negotiating with a firm to pick up financial management services for at least some of the approximately 21,000 disabled and elderly who need such services. In January 2012 DPW issues an RFA seeking a vendor or vendors for three areas of the state, Western, Central and Eastern. Currently, 37 different providers perform such payroll functions across the state. The change is part of an agency effort to streamline services. In response to questions from a *Philadelphia Inquirer* reporter, DPW spokeswoman Carey Miller recently noted that DPW is negotiating with a Massachusetts company, Public Partnerships Ltd., to take over all of these financial management services in January.

In the news

- **Insurance Department Announces Updated Highmark Filing**

  The Pennsylvania Insurance Department today announced that UPE/Highmark has filed updated information regarding its proposed change of control and affiliation with West Penn Allegheny Health System. Significant developments and changes in the proposed transaction include a UPMC contract extension. The original filing anticipated that contracts between Highmark and the University of Pittsburgh Medical Center (UPMC) would be terminated effective June 30, 2012, with a one-year run out period. Those contracts have now been extended and the supplemental filing describes the impact of that extension. (PA Insurance Dept. Press Release)

OTHER HEADLINES

Arkansas

- **Unanswered Questions Surround State Health Insurance Exchange**

When the health insurance exchange begins its open enrollment period on Oct. 1, 2013, the state of Arkansas expects to be ready. But until then, the 18 members of the Arkansas Federally Facilitated Exchange Partnership Planning steering committee are working to answer a number of questions involving the exchange, including how to get the word out about the program, which insurance companies are going to be in the exchange, and what procedures are going to be covered in the health exchange policies. In the next few months, the committee has to submit a blueprint to the U.S. Department of Health & Human Services outlining how it is going to handle the consumer protection functions of the exchange and how the committee will certify and monitor the health plans that are sold through the exchange, Arkansas Insurance Department spokeswoman Alice Jones said in an email to Arkansas Business. (Arkansas Business)

Georgia

- **Hospitals wonder what's next after Gov. Deal's Medicaid decision**

Kurt Stuenkel, president and CEO of Floyd Medical Center, worries that both Medicare and Medicaid reimbursement will be cut in the wake of Gov. Nathan Deal's decision to reject the expansion of Medicaid prescribed by the Affordable Care Act. Deal's spokesman noted Wednesday that the governor might agree to expand Medicaid if the federal government gave Georgia a "block grant" of money and the freedom to tailor the program as it saw fit — none of which is currently in the health care law. Without that flexibility, Deal believes the state could not afford the expansion. Word of Deal's decision set off a wave of anxiety among hospital officials and patient advocates in the state, with one saying that the governor is "certainly putting hospitals at risk" and another calling the decision a mistake. (Rome News-Tribune)

Indiana

- **Health insurance marketplace becomes central issue in Indiana governor's race**

Fifteen months from now, Hoosiers will be able to browse an online marketplace intended to give them apples-to-apples comparisons as they shop for insurance under the health care law. The key question now, though, is who will be that marketplace's operator — in charge of determining who can participate and what standards they have to meet, as well as technical details such as how the plans offered on the market are compensated for selling their product to sicker customers. It's become a central issue in Indiana's race for governor, where the three candidates are debating whether it would be wise for the state to be heavily involved in designing that marketplace even while federal officials still sort out the rules they would have to abide by, and figure out the alternatives. (Evansville Courier & Press)

Kansas

- **Governor faces another decision on health reform implementation**

State insurance regulators are preparing a recommendation for Gov. Sam Brownback on what basic benefits should be available to Kansans who seek health insurance through the new online purchasing exchange that federal officials expect to be operational here within about 16 months. A three-hour hearing to collect public input on what should constitute the state's "essential health benefits" benchmark plan is scheduled for today, Wednesday, September 5, 2012. Spokesmen for Brownback this week said they were unable to say whether the governor would pass on making a recommendation regarding essential benefits as he did on returning the exchange grant. (Kansas Health Institute)

Kentucky

- **Next Step for Kentucky's Health Insurance Exchange: Picking a Model Plan**

The confusing process of setting up Kentucky's health insurance exchange should get clearer later this month. The Affordable Care Act requires states to set up exchanges in which residents can compare and purchase health plans. Governor Steve Beshear chose to set up the state exchange earlier this year, rather than let the federal government operate the system. So far, Beshear has created a new state office to house the exchange and he's named an executive director. And by the end of this month, the state must choose an existing health plan that will be the benchmark for the exchange. To be listed on the exchange, all other health plans will have to provide similar or better service than the benchmark. (WKYU News)

Maine

- **Maine Seeks Federal Court Review of Medicaid State Plan Amendment**

Maine asked CMS to review the SPA on an expedited basis and to approve the SPA by September 1, 2012. Maine explained to CMS that an expedited decision was needed so that Maine could achieve its budget savings as directed by the Legislature and achieve a balanced budget as required by the Maine Constitution. Although Maine explained to CMS that it preferred not to resort to the courts, Maine made it clear to CMS that Maine would suffer irreparable injury absent CMS's expeditious review of the SPA or CMS's commitment to pay Maine for its costs while the SPA was pending, which CMS could later recoup by adjusting Medicaid reimbursements to Maine. In a letter dated August 31, 2012 CMS indicated that it will not issue an expedited decision on Maine's SPA and did not address paying Maine's costs while the SPA is pending before CMS, foreclosing the possibility of advancing resolution of this issue without resort to litigation. (Maine Attorney General's Office)

Minnesota

- **Dayton administration seeks to check Medicaid costs in proposal**

Gov. Mark Dayton's administration is seeking a broader scope and freer rein in spending Minnesota's federal Medicaid funds, a move the administration says could save the state more than $150 million in the next five years. The proposal, unveiled by the administration last week and awaiting federal approval, is based on a budget law enacted

last year by Dayton and GOP legislative leaders. Both sides say the waiver proposal could improve services to the poor or disabled while checking the state's cost to do so. For GOP legislators, the waiver proposal is part of a national push for greater state autonomy in spending federal health dollars. Republican vice presidential nominee and House Budget Chairman Paul Ryan has proposed to turn Medicaid into a program for which states would receive lump-sum federal grants. (St. Cloud Times)

New Hampshire

- **Fed govt approves NH Medicaid care plan**

Gov. John Lynch says the federal government has approved New Hampshire's plan to implement Medicaid managed care across the state. The Executive Council voted in May to approve contracts with the three organizations to start the first phase of the program, which will cover health care services for existing Medicaid beneficiaries. The Legislature voted to implement managed care for Medicaid, the federal-state health insurance plan for children, seniors and people with disabilities. (Boston Globe)

Ohio

- **Insurer appeals ruling on state Medicaid contracts**

Legal action could once again delay Ohio's awarding of contracts to five health plans selected to manage care for Medicaid patients. In court filings last week, attorneys for Amerigroup said the state scoring of contract bids was flawed, equating the process to "a game of liar's poker." Amerigroup was the last of 11 health plans in initial scoring but moved up to sixth after "protests" prompted a review of bid proposals. Contracts were awarded to the top five insurers. In response, state attorneys argued that Amerigroup was "a three-time loser" and dubbed its filing "a disappointed-bidder appeal." Further delays in implementing contracts, they said, would push back the state's new Medicaid managed-care program for another six months, to the end of 2013. (Columbus Dispatch)

Texas

- **Xerox Eyed in Texas Medicaid Probe**

Texas authorities are investigating whether Xerox Corp. played a role in allowing dentists to allegedly overbill the state's Medicaid system by millions of dollars. Like many states, Texas contracts with Xerox to process forms submitted by dentists, who seek a determination about whether procedures they intend to perform are covered by Medicaid, a federal-state program that insures lower-income people. The company evaluates whether the planned procedures are medically necessary. The Texas Health and Human Services Commission says it is concerned that Affiliated Computer Services Inc., which Xerox acquired in 2010, didn't dedicate enough trained staff to vet dentists' Medicaid requests, allowing dentists to receive payments for procedures not covered by the program. (Wall Street Journal)

National

- **2 Campaigns Differ Sharply on Medicaid, Seeking Vast Growth or Vast Cuts**

  Few other issues present a starker difference between the Republican and Democratic tickets. President Obama, through the health care law that was a centerpiece of his domestic agenda, seeks a vast expansion of Medicaid, which currently covers more than 60 million Americans — compared with 50 million in Medicare — and costs the states and the federal government more than $400 billion a year. Mr. Romney and Mr. Ryan would take Medicaid in the opposite direction. They would push for the repeal of the health care law and replace the current Medicaid program with block grants, giving each state a lump sum and letting them decide eligibility and benefits. (Currently, the federal government sets minimum requirements, like covering all children under the poverty level, which some states surpass. It also provides unlimited matching funds.) The grants would grow at the rate of inflation, with adjustments for population growth. Critics say annual increases would not keep up with rising health care costs. (New York Times)

- **Ex-Obama advisers seek health care cost control**

  Some of President Barack Obama's former advisers are proposing major changes aimed at controlling health care costs as political uncertainty hovers over his health law. Under the proposal, the major public and private players in each state would negotiate payment rates with service providers such as hospitals. The idea is to get away from paying for each individual test and procedure. Negotiated rates could be based on an entire course of treatment. Payments would have to fit within an overall budget that could grow no faster than the average rise in wages. The spending limits would be enforced by an independent council, but crucial details need to be spelled out. In Massachusetts, for example, budget-busting providers will be required to file plans with the state laying out how they'll amend their spendthrift ways. The federal government would provide grants to states interested in developing their plans. (Yahoo! News)

- **HHS awards new grants for health care co-ops**

  The Health and Human Services Department announced more than $160 million in loans Friday to help establish new insurance plans under President Obama's healthcare law. The new loans went to two organizations — one in Massachusetts and one in Tennessee — to establish new, non-profit insurance carriers. The new products, known as co-ops, must reinvest their profits toward providing better care or lowering premiums, and would have to follow the same rules as traditional insurers. (The Hill)

Company News

- **Ascension plans to acquire Marian Health System**

  Ascension Health Alliance, St. Louis, has signed a memo of understanding to acquire Tulsa, Okla.-based Marian Health System and its three regional divisions, according to a news release. The deal between the two Roman Catholic providers could be finalized by the end of the first quarter of 2013, officials said. Financial terms weren't disclosed.

Marian includes 36 affiliated hospitals and more than 150 clinics in Wisconsin, Minnesota, Oklahoma and Kansas. The system is comprised of Ministry Health Care in Milwaukee, St. John Health System in Tulsa, and Via Christi Health in Wichita, Kan. The latter is already affiliated with Ascension Health. (ModernHealthcare)

- **Pamlico Capital Acquires HEALTHCAREfirst from The Riverside Co.**

  HEALTHCAREfirst, headquartered in Ozark, Missouri, announced today that Pamlico Capital has acquired the company from The Riverside Company. Members of management have re-invested in partnership with Pamlico Capital to complete the acquisition. Terms of the acquisition were not disclosed. HEALTHCAREfirst is the leading technology and services company dedicated exclusively to serving Home Health Care and Hospice Care agencies. (CNBC)

- **Gentiva Health Services Acquires Washington Home Health and Hospice Provider**

  Gentiva Health Services, Inc., the largest provider of home health and hospice services in the United States based on revenue, today announced the acquisition of the home health and hospice businesses of Family Home Care Corporation based in Spokane, Washington. Founded in 1966, Family Home Care is recognized as one of the leading providers of home health and hospice services in the Washington and Idaho markets. (The Herald)

- **Marquette hospital sale to for-profit company OK'd**

  Michigan Attorney General Bill Schuette says he has approved the $483 million sale of the nonprofit Marquette General Hospital to the for-profit Duke Lifepoint LLC. Schuette said Thursday that an eight-member team examined the deal. He says the deal lets the Upper Peninsula hospital pay off $100 million in long-term debts and unfunded pension liabilities. He says it also provides $23 million for Superior Health Foundation, which is responsible to enforce Duke Lifepoint's promises. (Associated Press)

- **Acadia Healthcare Announces the Acquisition of Timberline Knolls, a 122-Bed Inpatient Behavioral Healthcare Facility**

  Acadia Healthcare Company, Inc. today announced the acquisition of Timberline Knolls, a 122-bed inpatient behavioral healthcare facility located near Chicago in Lemont, Illinois. Total consideration paid to purchase Timberline Knolls' operations and a related transaction to purchase the real estate was $90 million in cash. The facility produced revenues of approximately $33 million for the 12 months ended June 30, 2012, and is Acadia's first facility in Illinois. (Acadia Healthcare Press Release)

- **2 giants - HealthPartners, Park Nicollet - plan to merge**

  Two of the Twin Cities' (Minnesota) most prominent health care systems, HealthPartners and Park Nicollet, have signed an agreement to join operations, marking the biggest merger in the local health care market in two decades. If approved by state and federal regulators, the merger would create the state's second-largest hospital system by revenue, behind the Mayo Clinic in Rochester, and combine two organizations with storied traditions in Twin Cities medical care. (Minneapolis Star Tribune)

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
September 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
September, 2012	Nevada	RFP Released	170,000
September, 2012	Illinois Duals	Contract awards	136,000
September, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
October 29, 2012	South Carolina Duals	RFP Released	68,000
October, 2012	Michigan Duals	RFP Released	198,600
October, 2012	Virginia Duals	RFP Released	65,400
November 1, 2012	Vermont Duals	RFP Released	22,000
November 20, 2012	New Mexico	Proposals due	510,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
November, 2012	Washington Duals	RFP Released	115,000
December, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
January 1, 2013	New Hampshire	Implementation (delayed)	130,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 1, 2013	Florida LTC	Contract Awards	90,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Vermont Duals	Proposals due	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
February 28, 2013	Vermont Duals	Contract awards	22,000
February, 2013	Michigan Duals	Proposals due	198,600
February, 2013	Washington Duals	Proposals due	115,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
March, 2013	Idaho Duals	RFP Released	17,700
March, 2013	Michigan Duals	Contract awards	198,600
April 1, 2013	California Duals	Implementation	500,000
April 1, 2013	Illinois Duals	Implementation	136,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals NE, NW, NC, EC	Implementation	67,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	Ohio Duals C, WC, SW	Implementation	48,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Michigan Duals	Implementation	198,600
July 30, 2013	South Carolina Duals	Contract awards	68,000
July, 2013	Virginia Duals	Contract awards	65,400
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behav.	Implementation	N/A
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Hawaii Duals	Implementation	24,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
October 1, 2014	Florida acute care	Implementation	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	Contract Award Date	Enrollment effective date*
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	N/A	1/1/2014
California	Capitated	685,000	X	4/4/2012	X	6/30/2012	X	3/1/2012	4/4/2012	3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012				1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012				12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012				1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	Sept. 2013	4/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012				1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012		Q2 2013	July 2013	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012	X	8/20/2012	9/21/2012	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012		Feb. 2013	March 2013	7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012				10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012				4/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012		CANCELLED as of August 17, 2012		
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012				1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012				1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	8/27/2012	4/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012				7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012		Certification process		1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012		Apr-May 2013	6/1/2013	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012	10/29/2012		7/30/2013	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012				1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012		Late 2012	Early 2013	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012	Oct. 2012		July 2013	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012		1/1/2013	2/28/2013	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012		Feb. 2013	July 2013	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012	X	8/23/2012		4/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***5***			

** Several states have reported that CMS will not begin any Capitated Duals Demonstrations until at least April 1, 2013*

*** 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.*

[+] Acute 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 Welcomes…

Susan Mathieu, Senior Consultant – Denver, Colorado

On August 27, Susan Mathieu joined HMA as a Senior Consultant in the Denver office. Susan has spent the last two years with the State of Colorado, Department of Health Care Policy and Financing in the Medical and CHP+ Program Administration Office as a Program Development Specialist. In this role, Susan was responsible for the state's Medicaid expansion to Adults without Dependent Children, including all aspects of the program design (from concept paper and the 1115 waiver proposal) to successful execution and implementation (from selecting stakeholders and running monthly Advisory Committee meetings to ensuring program objectives were operationalized through eligibility and claims payment systems). Susan also Co-Led the department's team on Health Homes for Individuals with Chronic Conditions initiative, and analyzed the ACA for the Medicaid Director to ensure awareness of opportunities and understanding of new requirements. Prior to moving to Denver, Susan was a Consultant at Alicia Smith & Associates in Washington, DC (where she worked with Juan). As a consultant, Susan provided project management, technical assistance, and advisory services to many states and territories, including Georgia, Hawaii, Missouri, Tennessee and the Virgin Islands regarding their Medicaid and CHIP programs. Susan earned her Bachelor of Arts degree at Middlebury College, and her Master of Public Policy degree at Georgetown University.

Dan Castillo, Principal – Southern California

On September 4th, Dan Castillo joined HMA as a Principal in the Southern California office. Dan comes to HMA from Schaller Anderson LLC where he has served as the Chief Executive Officer for the CHOC Health Alliance, a physician-hospital consortium between Children's Hospital of Orange County and a pediatric network of over 1,000 primary and specialty physicians. CHOC Health Alliance is the largest of twelve Healthy Families and Medi-Cal managed care health networks in Orange County, and provides care for over 114,000 pediatric enrollees. In his role at CHOC Health Alliance, Dan oversaw multiple departments and functions including Compliance, Care Coordination, Case Management, Utilization Management, Provider Relations, quality, HEDIS, contracting, credentialing, claims administration, member services, systems integration, and the overall financial health of the network. Prior to joining Schaller Anderson, Dan served as the Administrative Manager responsible for the Medical Services Initiative Program for the County of Orange Health Care Agency, and led the adult safety net health plan for the county, covering approximately 50,000 enrollees per year. Earlier in his career, Dan was the Administrator of the South Counties Pediatric Critical Care Medical Group, a pediatric hospitalist and intensivist group covering 17 hospitals between LA and Orange County, and also the Administrator at two other medical practices, the Newport Children's Medical Group, and the Alamitos Dermatological Medical Clinic. Dan earned his Bachelor of Science degree, and his Master in Health Administration at the University of Southern California.

Barbara Leadholm, Principal – Boston, Massachusetts

On September 5th, Barbara Leadholm joined HMA as a Principal in the Boston office. Barbara comes to HMA from the Commonwealth of Massachusetts where, most recently, she has been serving as the Special Assistant to the Office of Behavioral Health at MassHealth/Medicaid. Prior to this assignment, Barbara served as the Commissioner of the Massachusetts Department of Mental Health, and was responsible for leading and overseeing the public mental health system, including the provision of services for 22,000 adults with serious mental illnesses and children with serious emotional disturbances. She also managed the transformation of the service system to enhance person centered planning, consumer rights, recovery and rehabilitation, and greater integration throughout the continuum of inpatient and community services. Before joining the Department, Barbara was Vice President Health Plan Solutions at Magellan Health Services and was responsible for the development, implementation, and ownership of the firm's public sector behavioral health product and its integration with physical health care. During her career at Magellan, she also served as the Vice President, Health Plan Account Services, the General Manager of Massachusetts Care Management Center, and in various other leadership roles. Earlier in her career, Barbara worked in the Massachusetts Department of Mental Health as an Area Director and as an Assistant Commissioner responsible for Policy and Planning. Barbara earned her Bachelor of Science degree at University of Wisconsin, her Master of Science degree in Nursing at Boston College, and her Master of Business Administration degree at Boston University.

HMA Recently Published Research

Implications and Options for State-Funded Programs Under Health Reform

Theresa Sachs, Managing Principal, Business Development
Diana Rodin, Consultant

A number of states and the District of Columbia currently administer health coverage programs for low-income uninsured individuals who either exceed maximum Medicaid income eligibility thresholds or who are not categorically eligible for the Medicaid program, such as childless adults. The majority of individuals currently covered through these programs will be eligible for other coverage pursuant to the Affordable Care Act (ACA). This issue brief, from SHARE grantee Theresa Sachs and her research team at Health Management Associates, reviews the objectives and structure of 11 health coverage programs in six states and documents the legal, technical, and policy issues that states are already addressing, or need to address, as they review options for transitioning program enrollees to new coverage options under the ACA. The authors also present possibilities for new uses of state dollars freed up by the infusion of federal funds in 2014. **(Link to Report – State Health Access Data Assistance Center)**

Health Homes for Medicaid Beneficiaries with Chronic Conditions

Mike Nardone, Principal
Alicia Smith, Principal
Eliot Fishman, Principal

This brief profiles four states that were the first to receive federal approval to implement a state option under the Affordable Care Act to implement health homes for Medicaid beneficiaries with chronic conditions. Almost half of the nine million people who qualify for Medicaid on the basis of disability suffer from mental illness, and 45 percent have three or more diagnosed chronic conditions. Health homes provide an important tool for states trying to manage and coordinate care more comprehensively for high-need, high-cost beneficiaries. Many states have demonstrated interest in the health homes option, and some have received federal approval for their programs. The states profiled in the brief are Missouri, Rhode Island, New York and Oregon. **(Link to Brief – Kaiser Family Foundation)**

HMA Upcoming Appearances

HMA Seminar: FQHCs in the New Paradigm of Accountable Care

"Change in the Organization and Financing of Care Delivery under ACA"

Doug Elwell - Speaker

"Population-Based Model of Care and the Role of the FQHC"

Art Jones, MD - Speaker

"Transitions and Collaborations in the Care Model: Primary Care Coordination with Behavioral Health, Inpatient, Emergent, Specialty, Home Health and Long-Term Care"

Terry Conway, MD and Linda Trowbridge - Speakers

"Governance Models for Accountable Care in the Safety Net"

Catherine Rudd, JD - Speaker

"How Do We Assure the 'Triple Aim'?"

Art Jones, MD - Speaker

"The Path to Moving toward Integrated Care Models: How Do We Get Started?"

Pat Terrell – Speaker

September 14, 2012

Chicago, Illinois

Current Issues Series at Denver University

"Election 2012 Issues: Health Care Policy"

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado