HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARKANSAS BEGINS TARGETED MEDICAID PAYMENT REFORM INITIATIVE

HMA ROUNDUP: OHIO DUALS MOU TO BE FINALIZED, POSTED LATER THIS MONTH; NEW YORK SELECTS OXFORD EPO AS ESSENTIAL HEALTH BENEFITS PLAN; IN PENNSYLVANIA: NEW WEST MCO ROLLOUT BEGINS, CONSOLIDATION OF FINANCIAL MANAGEMENT SERVICES PROGRAMS DELAYED; ILLINOIS DUALS RFP AWARDS DEADLINE PUSHED BACK ANOTHER WEEK

OTHER HEADLINES: STATES MOVE FORWARD ON ESSENTIAL HEALTH BENEFITS, SELECTING BENCHMARK PLANS; MAINE CONTINUES PUSH TO REDUCE MEDICAID ELIGIBILITY; MASSACHUSETTS DOCTORS EMBRACING NEW PAYMENT MODELS, SURVEY SAYS; COUNTIES BACK AWAY FROM LOCAL MEDICAID EXPANSION IN REPUBLICAN STATES

HMA WELCOMES:
DOUG PORTER – OLYMPIA, WASHINGTON
PAUL NIEMANN – DENVER, COLORADO

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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: ARKANSAS BEGINS TARGETED MEDICAID PAYMENT REFORM INITIATIVE

This week, our *In Focus* section takes a look at Arkansas' Health Care Payment Improvement Initiative (the "Initiative"), which launched Monday, October 1, 2012. Arkansas' Medicaid program and two private insurers are implementing the Initiative with the goal of incentivizing improved care quality, efficiency, and economy. Under the Initiative, a single principal accountable provider (PAP) is identified for an episode of care, often the physician or other primary care provider. The PAP is held accountable for the entire episode of care for a given diagnosis and will either share in savings or be responsible for sharing excess costs based on the PAP's average cost for a specific condition over the performance period.

The Initiative is initially targeting five conditions: acute ambulatory upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit hyperactivity disorder (ADHD), and perinatal care. Arkansas Medicaid will target URI, ADHD and perinatal care. Blue Cross Blue Shield, the state's largest insurer, and QualChoice of Arkansas, the state's second largest insurer, will both target perinatal care and hip and knee replacements which both believe to be among the most costly conditions that affect the largest number of subscribers. Blue Cross will also target CHF.

Health Care Payment Improvement Initiative website: http://paymentinitiative.org

Medicaid Payment Improvement Program

Beginning this week, Medicaid will use episode-based data for URI, ADHD, and perinatal care to evaluate episodic costs and apply either positive or negative payment incentives to PAPs. These payments do not alter the current reimbursement system and are made retroactively. For each PAP, the average reimbursement across all eligible episodes for one of the above conditions will be calculated for a given performance period. Average reimbursements are adjusted for excluded episodes of care and other factors. This average reimbursement will be compared to thresholds established by Arkansas Medicaid. PAPs must meet established quality metrics to receive positive supplemental payments, and are required to report data to the state. In addition, PAPs will be provided with quality metrics to track that do not currently factor into supplemental payment calculation.

If a PAP's average episode reimbursement is lower than the "commendable," or lower, threshold, Arkansas Medicaid will make a positive supplemental payment to the PAP. If a PAP's average reimbursement is higher than the "acceptable," or higher, threshold, Arkansas Medicaid will assess a negative supplemental payment. We anticipate these negative supplemental payments may take the form of retroactive recuperative payments, or some other similar form of negative assessment. Supplemental payments are calculated as the difference between average reimbursement and the commendable or acceptable threshold, multiplied by the number of episodes included. Arkansas has included gain and risk sharing limits, to disincentivize underutilization and to limit providers' risk exposure . Both the gain and risk sharing limits for the three episodic conditions are set at

50 percent. Additionally, Arkansas Medicaid has implemented a stop-loss protection for ADHD providers, such that net negative supplemental payments will be capped at 10 percent of total Medicaid reimbursement. The state may apply additional stop-loss provisions if deemed necessary to ensure access to care.

Historical Medicaid Spending, Savings Estimates

In developing the Medicaid payment improvement program, the state's outreach to the provider community and other stakeholders included historical data, largely from FY 2009, on eligible episodes of care and average reimbursements under the program. That historical data is provided below.

FY 2009/2010 Data	Eligible Episodes of Care	Avg. Medicaid Reimbursement	Total Medicaid Spending
Ambulatory URI	123,339	$69	$8,510,391
Perinatal	21,199	$4,890	$103,663,110
ADHD	24,269	$3,807	$92,380,749
Total			**$204,554,250**
Estimated FY 2013 Savings			**$4,444,800**
Percent of Total			*2.2%*
Estimated FY 2014 Savings			**$9,333,462**
Percent of Total			*4.6%*

Sources: Arkansas Payment Reform Initiative Workgroup meetings, February – March, 2013. Historical data for URI, Perinatal based on FY 2009/2010 Medicaid claims. Historical data for ADHD based on Department of Human Services (DHS), Division of Medical Services. Workgroup presentations available here.

Based on the historical data and savings estimates provided by the state, we estimate total state savings across the three conditions in FY 2014 (the first full year of the program) of somewhere between 4 and 5 percent, or annual savings of nearly $10 million. We note that the estimated $200 million of annual Medicaid spending on URI, ADHD, and perinatal accounts for only 5 percent of roughly $4 billion in statewide Medicaid expenditures. Although savings projections are modest at this time, this program is a noteworthy example of a state pursuing Medicaid cost controls at the provider level in a partial risk arrangement, rather than in full risk-based managed care.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Elaine Peters

A managed care rate meeting was held on September 27th to discuss the draft rates developed by Milliman and Mercer and released earlier last week. As we discussed in last week's Roundup, rates for the non-Reform program were set at -1 percent, but that included the pass through effect of a significant reduction in fee-for-service hospital rates. Excluding this impact, the rate change is +3.9 percent and our impression from attending the meeting is that this change was satisfactory to the health plans. There were more questions regarding the proposed rate changes to the Reform program though we have not been able to estimate the magnitude of that rate change.

Other takeaways from the meeting:

- Reform rates are based on AHCA estimates of Hospital Rates provided as of July 1, 2012.
- Rates will be adjusted when final hospital rates, with all buy-backs, are known.
- Hospital rates will be finalized October 31, 2012.
- AHCA intends to apply these new rates to plans effective December 1, 2012.
- There will be a retroactive adjustment made with respect to the September – November 2012 rates paid in the interim at the 2011-12 rates.
- Particularly in District 10, hospital rates show a significant decrease from those in effect in fall 2011.
- There will be a primary care fee increase in January 2013 to 100 percent of Medicare — FFS implementation will be via an increase in the Medicaid fee schedule; managed care plans will receive add-on payments beginning in January 2013. Guidance will be forthcoming.
- Rates were developed to target an 87 percent loss ratio overall (85% TANF, 90% SSI and 87% duals).

Georgia

HMA Roundup – Mark Trail

The Georgia Department of Community Health (DCH) will hold a meeting on October 11 to discuss cost containment initiatives for the 2012/13 fiscal year. As a reminder, DCH must identify initiatives to achieve 5 percent savings in the coming year. HMA believes two areas for significant budget savings are likely to be considered: either a reduction to provider rates (which DCH previously indicated it was not inclined to pursue) or heightened utilization/care management approaches.

In the news

- **Hospitals respond to Norquist letter on provider tax**

  The battle over Georgia's hospital tax suddenly heated up last week, ignited by the attention-grabbing entrance of national anti-tax leader Grover Norquist. The Washington-based activist, in a letter to Georgia legislators, said renewing the hospital fee, which raises money for the state's Medicaid program, would kill jobs and raise health costs. He urged state lawmakers to oppose renewing what he called "a bed tax.'' Norquist is the author of an anti-tax pledge that has been signed by many of the nation's Republican lawmakers, including leading ones from Georgia. He said renewing the hospital tax would amount to "a violation" of that promise. Now, some major Georgia hospital organizations have fired back at Norquist and come out strongly in support of the tax, which expires in July. (Georgia Health News)

- **Mental health agency OKs tight 2014 budget**

  The state Department of Behavioral Health and Developmental Disabilities has approved a fiscal 2014 budget that includes reductions to service providers, the closing of a nursing home and probable job cuts. Like other state agencies, DBHDD is required to cut its budget 3 percent under orders from Gov. Nathan Deal's Office of Planning and Budget. The state has been struggling with sluggish tax revenues amid a slow economy. The current fiscal year also will take $27.8 million in cuts, but the fiscal 2014 reduction of the same amount will be much more difficult to absorb, agency officials said Thursday at their board meeting. (Georgia Health News)

Illinois

HMA Roundup – Matt Powers & Jane Longo

At Tuesday, October 2's Medicaid Advisory Committee (MAC) meeting, the Department of Healthcare and Family Services (HFS) announced a delay of roughly one week in the announcement of contract awards in the dual eligible financial alignment RFP. Contract awards are now to be announced by the end of next week, or early the week of October 15. HFS cited ongoing discussions with CMS on plan selection as contributing to the delay. Additionally, HFS announced it is now targeting a signed memoranda of understanding (MOU) with CMS on the duals demonstration sometime this month. This is an accelerated timeline from the last MAC meeting, at which time the department was targeting December for a signed MOU.

In the news

- **Illinois picks Blue Cross small group policy as benchmark for health overhaul law**

  Illinois officials chose a relatively lean small-group policy Friday as the benchmark plan for essential health benefits in the state, another milepost in implementing President Barack Obama's health care law. Gov. Pat Quinn's health care council approved Blue Cross Blue Shield's Blue Advantage plan as the benchmark at a meeting in Chicago. It will be submitted to the U.S. Department of Health and Human Services, which will take public comment. (Crain's Chicago)

New York

HMA Roundup – Denise Soffel

New York's Medicaid Global Spending Cap: The Department of Health provided a briefing on the Medicaid global spending cap — a cap on annual Medicaid spending increases that is tied to the medical consumer price index. One of the main motivations for the global cap was to remove Medicaid from the state budget process, which often resulted in distorted policy incentives. As a result of the global cap the Department has instituted much more disciplined oversight of spending, which is now monitored on a monthly basis against category-specific targets and reported publicly. The Department hopes this will shift responsibility for spending onto the provider community, potentially spurring creative solutions and provider collaboration. For the 2011-12 state fiscal year, the Medicaid program came in $14 million below the $15.3 billion target, a difference of less than 0.1 percent. These savings were achieved despite the fact that Medicaid enrollment was up by 154,000.

For the current fiscal year, the state share of Medicaid spending will be allowed to increase by $600 million. This increase must accommodate costs associated with both price and enrollment increases and also includes offsetting net changes for one-time revenue and spending actions, as well as ongoing savings generated by MRT initiatives. The Department believes that the key to staying within the Medicaid cap is working more closely with providers to change delivery of care patterns, including greater reliance on primary care, better management of the dual-eligible population, and continued shifts away from fee-for-service settings.

Medicaid Enrollment in NYS: One of the dramatic changes occurring in New York is the ongoing shift away from fee-for-service programs. In fiscal year 2011-12, while total Medicaid enrollment grew by 154,000, enrollment in Medicaid managed care increased by 230,000 as 76,000 beneficiaries moved from fee-for-service coverage. Medicaid enrollment reached 5.044 million in July 2012, an increase of 1.0 percent since March 2012. Medicaid managed care enrollment (including Family Health Plus and MLTC enrollment) reached 3.625 million, an increase of 2.4 percent over the same time period. Enrollment in Medicaid managed care now represents 72 percent of total Medicaid enrollment; 28 percent of the Medicaid population remain in fee-for-service arrangements.

Essential Health Benefits: On October 1, 2012, New York State formally submitted its selection of an Essential Health Benefits benchmark plan to Health and Human Services. New York selected the benefits of the state's largest small group plan, Oxford EPO, as the benchmark plan. In addition to the selection of a benchmark plan, the state has indicated the coverage areas in which benefits will be supplemented in order to meet ACA requirements. More details are available here.

In the news

- **Hospitals share concerns about loosening regs**

  New York state's two powerful hospital trade groups yesterday pushed back against any move by the state that would make it easier to put out a welcome mat for publicly traded hospital chains currently prohibited from operating in New York. Speaking at a

forum on access to capital hosted yesterday by the state Department of Health, Elisabeth Wynn, GNYHA's senior vice president for health finance and reimbursement, said the group was not opposed to nonprofit providers exploring relationships with private for-profit companies to manage services, such as information technology. However, "outsourcing without ceding the nonprofit's control of the mother ship is something we think is important," she said. (Crain's New York - Subscription Required)

- **Medicaid eyed for all ex-cons**

  Gov. Cuomo's administration is launching an aggressive plan to sign up thousands of ex-cons for taxpayer-financed Medicaid, which they'll receive once they leave prison, The Post has learned. Under the initiative, all inmates would automatically apply for the public health insurance for the needy while incarcerated, state Department of Health officials said. (New York Post)

Ohio

HMA Roundup – Alicia Smith

Dual eligible demonstration: According to a Department of Health Transformation (DHT) announcement last week, Ohio is currently in final negotiations with CMS regarding a memorandum of understanding (MOU) pertaining to the dual eligible demonstration project. DHT anticipates that the MOU will be posted for public comment later this month. DHT notes that it expects Ohio to be the second state in the country to finalize its MOU with CMS, following Massachusetts.

Non-dual managed care implementation delayed: A court has denied Amerigroup's request for an injunction to prevent the state from moving forward with readiness review with the MCOs that were selected to administer Ohio's non-dual Medicaid managed care program. The decision allows Ohio to move forward with the readiness reviews, though the state is not permitted to sign final provider agreements until after Amerigroup's appeal has been decided. Due to these delays, Medicaid will delay enrollment of individuals in the new plans until July 1, 2013.

Medicaid expansion: As a result of the federal mandate on individuals to purchase health insurance, Ohio Medicaid estimates 320,000 Ohioans who are currently eligible for Medicaid but not enrolled will enroll in January 2014, at an estimated two-year cost to the state of $700 million. The state will not consider the question of whether to expand Medicaid eligibility to 133 percent of the FPL until it is able to determine how to fund this expected increase in caseload. Link

In the news

- **Judge ends oversight of Ohio prisons health care**

  A federal judge on Tuesday ended the court's oversight of Ohio's prison medical system after finding that health care and services for the nearly 50,000 inmates have greatly improved over the last seven years. U.S. District Court Judge Sandra Beckwith had overseen the prisons' medical system since a 2005 settlement of a lawsuit brought by Ohio Justice and Policy Center, a Cincinnati-based prisoner rights group. The center had asked the judge to extend the settlement. (AP - San Francisco Gate)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

MBHO RFP: The following companies attended a bidders' conference last week related to the re-procurement of the North/Central Zone HealthChoice managed behavioral health program:

- CBHP/AmeriHealth Mercy
- Magellan
- ValueOptions
- Community Care Behavioral Health (CCBH) *(Incumbent)*

New West managed care roll-out: At Pennsylvania's monthly Medical Assistance Advisory Committee (MAAC) meeting on September 26, the Department of Public Welfare (Department) provided a number of updates on its Medicaid program — many of which proved controversial. Most notable is that the state is on schedule to implement the mandatory managed care program in the New West zone effective October 1 even though the voluntary managed care plan selection rate was only 37 percent for those who needed to make an active plan selection. The Committee's consumer advocates were very vocal that 63 percent (72,000) of those needing to make a plan selection were going to be auto-assigned. The consumers expressed concern over the possibility that a less than adequate provider network might be the cause, though it was not clear if this was actually the cause or if eligibles in the New West zone were just not willing to make an active plan selection. Pennsylvania allows eligibles to change plans monthly, so eligibles could change plans at a future time. The auto-assignments will be split evenly (18,000 apiece) across all four plans (Coventry Cares, Gateway Health Plan, UPMC and Amerihealth Mercy) to operate in the zone.

Co-pays: The Department also reported that it is moving ahead with the implementation of special co-pays for "Loophole" families (higher income families with disabled children). The changes will be effective October 1 for newly eligible families and November 1 for existing families. This change has met with considerable opposition from autism advocates, including demonstrations on the Capitol steps.

Financial management services: The Department had been planning to begin using a single contractor to manage financial management services (FMS) for persons with disabilities effective October 1 but delayed the start until January 1, 2013, citing a delay in receiving waiver amendments from CMS. We also note that as of September 26 the Department had been unable to finalize a contract with Public Partnerships LTD (PPL), the winning bidder. Nevertheless, the Department reported that they had completed a readiness review and that PPL was operationally ready. Currently, 37 companies manage the financial management services in Pennsylvania.

MLTC: In response to questions from the Committee, the Department reported that no plans for Managed Long Term care Services and Supports (MLTCSS) had been finalized. The Department did acknowledge that there have been internal conversations, but noted that no decisions or timeline has been determined.

Essential Health Benefits: The Department of Insurance reported that Secretary Consedine had submitted a letter concerning essential health benefits to CMS including a report done by Deloitte Consulting. The letter basically reiterates Pennsylvania's request for answers to questions regarding ACA requirements. Link

Revenue: Pennsylvania collected $2.4 billion in General Fund revenue in September, which was $43.9 million, or 1.8 percent, more than anticipated. Fiscal year-to-date General Fund collections total $6.1 billion, which is $10.7 million, or 0.2 percent, above estimate.

In the news

- **Lawsuit seeks restoration of Pennsylvania's General Assistance for the disabled**

  Advocates for the disabled on Monday sued the Commonwealth of Pennsylvania, demanding the restoration of the state's cash assistance program. The lawsuit, filed in Commonwealth Court, was filed on behalf of three former recipients of General Assistance, which had paid $205 a month to poor disabled people. Gov. Corbett and the legislature eliminated the program in June to save $150 million a year. (The Philadelphia Inquirer)

- **Highmark sues West Penn Allegheny over broken deal**

  Highmark Inc. sued West Penn Allegheny Health System on Monday, seeking to stop the health system from starting acquisition discussions with other companies and to protect the insurer's investment in the financially ailing health system along with its plans to build a $1 billion rival to UPMC. Highmark, the state's largest health insurance company, is asking Allegheny County Common Pleas Court to issue a temporary restraining order to prohibit West Penn Allegheny from talking to other possible acquirers and to declare that the health system's claims that Highmark violated their agreement are "improper, unjustified, and of no effect." Highmark also is demanding, in addition to or as an alternative, that West Penn Allegheny be forced to immediately repay $200 million in grants and loans provided by Highmark, the lawsuit states. (Pittsburgh Tribune-Review)

Texas

HMA Roundup – Gary Young

The Texas Department of Health and Human Services (HHSC) issued a Request for Information (RFI) for the Texas Medicaid Management Information System (TMMIS) and Fiscal Agent (FA) operations. The state is seeking information from interested parties and potential bidders that will be considered in anticipation of a planned RFP scheduled for release in July 2013. The current contractor for these services is the Texas Medicaid and Healthcare Partnership which is a coalition of contractors including ACS/Xerox, Accenture, Computer Associates, HMS and others. Responses to the RFI are due November 5, 2012. The RFI is available here.

Also this week, the HHSC announced a tentative contract award for Medicaid Drug Use Review to Xerox Heritage, LLC. Other attendees at the May 8th bidders' conference included Goold Health Systems, Govantage and Health Information Designs.

In the news

- **Medicaid waiver may bring in federal dollars for health initiatives**

  Travis County mental health services are something to be ashamed of, said state Sen. Kirk Watson, but change could come with additional federal funds. Watson said Tuesday that a new program to overhaul the health coverage program for the poor — the 1115 Medicaid waiver — could bring in up to $1.46 in federal dollars for every $1 the community invests. Some of the community's share for improving and expanding mental health services would come from Austin Travis County Integral Care, a local mental health and developmental disabilities provider. (Austin Statesman)

OTHER HEADLINES

Alabama

- **Alabama governor announces he doesn't plan to implement part of Affordable Health Care Act**

  Gov. Robert Bentley announced Monday that he won't implement part of the federal Affordable Health Care Act in Alabama. Bentley's aides said the Alabama governor sent a letter to Secretary of Health Kathleen Sebelius explaining that he's an opponent of the act. Bentley said he will not make a decision on establishing minimum benefits for those buying individual and small group policies in Alabama. He called it irresponsible to decide what Alabama's benchmark will be for essential health benefits without clear guidance from the federal government. (The Republic)

- **Alabama children's health insurance program, once national leader, pinching pennies**

  Alabama's public health insurance program for children, once a nationally recognized leader in reducing the ranks of the uninsured, opens the new fiscal year Monday on a shoestring budget as a leaner, less generous version of its former self. Copays and premiums are up, the drugs are generic, advertising is slashed, and accountants are watching every penny hoping enrollment doesn't balloon and children don't get too sick. The Alabama Legislature gave ALL Kids more than $15 million less than it requested, and the program has cobbled together a financial plan to try to make it through the year without cutting the amount that doctors and hospitals are reimbursed for providing care to 85,000 kids. Lowering provider reimbursements is a last resort, because it would shrink the number of doctors willing to accept ALL Kids insurance and limit access for all. (AL.com)

Arizona

- **Arizona fines provider of prison health care**

  The Arizona Department of Corrections has levied a $10,000 fine against Wexford Health Sources Inc., a new private medical-care provider for inmates that is accused of improperly dispensing medicine and wasting state resources. Wexford was hired after the Republican-controlled Arizona Legislature pushed to privatize inmate health care to save money. The DOC in strongly worded letters to Wexford alleges the company

forced the state to use public employees to fix its deficiencies. The amount of wasted tax dollars was not disclosed. Arizona houses close to 40,000 inmates. The Pittsburgh-based company took over inmate care July 1 after winning a $349 million, three-year contract. The company plans to appeal the fine. (The Arizona Republic)

California

- **Access, Capacity Concerns for CBAS**

  California's Community Based Adult Services program officially launches this week, the culmination of a long and contentious effort to first eliminate and then replace the Adult Day Health Care program. There were roughly 36,000 recipients of ADHC services when the governor first proposed eliminating it as a Medi-Cal benefit in January, 2011. After a long budget fight, the Legislature voted to end ADHC in May, 2011, with the proviso that a stripped-down replacement program would take its place. That plan was vetoed by the governor in June 2011, prompting a legal challenge by Disability Rights California. The settlement of that lawsuit in December 2011 led to creation of the new CBAS program. The concern among advocates now is for former ADHC beneficiaries who have been denied CBAS eligibility -- particularly the 2,431 people who are appealing those decisions. Advocates also have expressed concern that the new system won't have the capacity to help everyone in the CBAS program, since a number of adult day centers have closed, and many more are on the verge of closure. (California Healthline)

- **New Attention to on End-of-Life Care**

  Partnership HealthPlan of California, a health insurer covering roughly 200,000 Medi-Cal beneficiaries in six Northern California counties, has decided to offer the optional benefit of palliative care to its members. The state doesn't currently offer the enhanced benefit, in part due to budget concerns, but Richard Fleming, the regional medical director for PHP, said the cost of palliative care is offset by less necessity to provide other types of care that may not actually benefit the patient or the family. (California Healthline)

District of Columbia

- **Medicaid contractors seek $43M from D.C.**

  The District's major Medicaid managed care contractors are demanding a combined $43.2 million from the city, arguing that most of their large operating losses in recent years were caused by repeated contractual breaches by local Medicaid administrators. In a complaint filed with the contract appeals board Sept. 13, UnitedHealthcare Community Plan demanded $17.4 million, arguing the administration — under both mayors Adrian Fenty and Vincent Gray — delayed annual inflationary updates, misled executives about the impact of fee changes and intentionally set payments below legal floors to meet District budget goals. (Washington Business Journal)

Indiana

- **Court strikes down Indiana's Medicaid dental cap**

  Indiana's social services agency can't set a cap on the amount of money the state pays people on Medicaid for dental services if the treatment is medically necessary, a federal

appeals court has ruled. The 7th U.S. Circuit Court of Appeals in Chicago this week upheld a preliminary injunction granted by a federal judge in South Bend that blocked the Indiana Family and Social Services Administration from enforcing a $1,000 annual limit on dental coverage. The agency had established it as a cost-cutting measure in 2011. (AP - San Francisco Gate)

Maine

- **Maine Seeks to Cut Medicaid Eligibility**

  Maine Governor Paul LePage wants eliminate Medicaid eligibility for parents at the poverty line. LePage, a Republican, also wants to limit eligibility for seniors, the disabled and young people. In all, the governor's cuts would trim the rolls of MaineCare, the state's Medicaid program, by more than 23,000 people and reduce benefits for nearly 3,800 others. The governor argues the cuts are necessary because the rapid growth of the program, which is funded jointly by the federal government and the states, is squeezing Maine's budget. In 2011, Maine spent 28.6 percent of its budget on Medicaid, according to the Council of State Governments. The LePage administration says Maine has been too generous in the past, and that the proposed changes would bring the state closer in line to national averages on Medicaid funding and coverage rates. (Stateline)

Massachusetts

- **Mass. Medical Society survey: More doctors embracing new payment models**

  Doctors in Massachusetts may be looking a bit more favorably on new payment methods created under state and federal laws, according to a survey of 1,095 practicing physicians by the Massachusetts Medical Society. About 49 percent of respondents said they are likely to participate in a voluntary global payment system, in which doctors are paid a fixed rate to manage the care of a group of patients. That's up from 42 percent in 2011, the first year that questions about the new payment methods were included in the annual survey. Those who worked at community health centers were most open to the idea of global payments, and self-employed physicians were least likely to participate. (Boston Globe)

- **Steward cancels accord with Senior Whole Health**

  Steward Health Care System has canceled its contract with Cambridge-based health insurer Senior Whole Health, effective Jan. 1, meaning it will no longer assign its staff doctors to treat about 900 elderly, low-income patients who are plan members. Under a state law passed in 2000, low-income seniors who qualify for both Medicaid and Medicare — the government health insurance for poor and older people — can be insured through senior care option plans, which allow them to carry one insurance card rather than two. Senior Whole Health, formed in 2004, is the largest of several organizations administering senior care option plans in Massachusetts. (Boston Globe)

- **Partners HealthCare pledges $90 million for community health centers**

  Partners HealthCare plans to award community health centers $90 million over the next 15 years under a new grant program, part of a broad push to strengthen Massachusetts primary care providers. The state's largest hospital and physician organization is launching the initiative with its newly acquired insurer, Neighborhood Health Plan.

In the first round of grants, it will give $4.25 million to 49 community health centers across the state to help them adopt immediate improvements, such as upgrading technology that tracks patients' health and redesigning office procedures so caregivers can spend more time with patients. (Boston Globe)

Maryland

- **Md. Blues Chief Blasts Plan To Shift Hospital Costs To Insurers**

Negotiations to avert a breakdown in Maryland's unique system of regulating hospital prices have deteriorated into a stalemate between the state's largest insurer and the Maryland Hospital Association. CareFirst BlueCross BlueShield CEO Chet Burrell, speaking out for the first time about the talks, blames hospitals for their proposal to shift hundreds of millions in costs to CareFirst and other private insurers in an attempt to control rising Medicare spending. (Kaiser Health News)

New Hampshire

- **Judge rejects bid for dismissal of hospitals' Medicaid lawsuit**

A lawsuit filed last year by Exeter Hospital and nine other of the state's largest hospitals about changes in Medicaid policies and reimbursements will be allowed to continue. On Thursday, U.S. District Court Judge Steven McAuliffe ruled against the state's motion to dismiss the suit. In his ruling, McAuliffe said he had multiple questions that still needed to be answered about the case and that a hearing would be scheduled on Nov. 1. The 10 hospitals sued the N.H. Department of Health and Human Services over changes in Medicaid policies and reimbursements. One of the suit's core arguments is the state failed to provide hospitals with notice and an opportunity to comment on the reduced rates before they were finalized. The hospitals argue the state reduced reimbursements to accommodate state-budgetary preferences. (Seacoast Online)

North Dakota

- **North Dakota Submits EHB benchmark plan**

The North Dakota Insurance Department submitted an Essential Health Benefit (EHB) benchmark plan recommendation to U.S. Secretary of Health and Human Services (HHS) Sebelius on Friday, September 28, 2012. The plan submitted was the Sanford Health Plan. The submission also included supplemental benefits for pediatric dental and vision services as currently offered by the North Dakota Children's Health Insurance Program (CHIP). (North Dakota State PDF)

Rhode Island

- **Steward appears to be dropping Landmark deal**

A court filing this week indicates that Steward Health Care System plans to walk away from a deal to buy a struggling hospital in Rhode Island after a nearly 16-month courtship that required lawmakers to amend the state's hospital conversions law. The deal to acquire the 133-bed Landmark Medical Center in Woonsocket would have been Steward's first acquisition outside of Massachusetts, where the for-profit health system has snapped up six community hospitals since 2010. Landmark has been in receivership since 2008. (Modern Healthcare)

Wisconsin

- **DHS: Medicaid shortfall has shrunk to $35.5M**

  Wisconsin's projected Medicaid deficit has shrunk by nearly $337 million, state health officials said Friday. Department of Health Services officials estimated in June the Medicaid program would face a $372.3 million deficit in the coming year. DHS Secretary Dennis Smith said in a letter to the leaders of the Legislature's finance committee Friday that the agency now projects the shortfall will be $35.5 million. He also noted that fewer people than anticipated have joined the state's Family Care program since the Legislature lifted an enrollment cap in April. The Family Care program is designed to keep disabled and elderly people out of costly nursing homes. Smith pointed to changes to the BadgerCare Plus program that included higher premiums for some participants and making people ineligible if they have access to affordable health insurance through their employers. BadgerCare Plus provides health insurance for poor children, pregnant women and poor adults. The number of people receiving full Medicaid benefits dropped by 7,112 from January 2011 to August 2012, Smith added. (Appleton Post-Crescent)

National

- **Red-state counties back off Medicaid expansion talk**

  Texas counties made waves this summer after reports surfaced that they were interested in moving forward on their own with a Medicaid expansion at the local level — without Gov. Rick Perry's signoff. But now, they're backing off. Paul Beddoe, associate legislative director for health for the National Association of Counties, said some red-state county officials in states whose governors oppose the expansion believe they would "undoubtedly be better off if they could expand Medicaid." But they aren't looking to pick a fight with their state leadership, who would be required to work directly with the Centers for Medicare & Medicaid Services, he said. (Politico)

- **States Moving Ahead On Defining 'Essential' Health Insurance Benefits Under Federal Law**

  With a Monday target for submitting their lists of "essential health benefits" to the federal government, 16 states and the District of Columbia have made their choices and 16 more states are expected to do so in the next few weeks, according to consulting firm Avalere Health. The health law lists 10 broad categories of essential benefits, including preventive care, emergency services, maternity care, hospital and doctors' services, and prescription drugs. States have latitude within those categories, and so far nearly all have selected as a benchmark for minimum coverage one of the three most popular small group health plans available to residents now. Essential benefit requirements apply to individual and small group plans sold within and outside the new online, state-based exchanges scheduled to launch in 2014. The requirements also apply to benefits provided to the population that will be newly eligible for Medicaid coverage. These requirements do not apply to self-insured health plans, which is how most large companies cover their employees. By selecting among the most popular small group plans already being sold, states are trying to minimize disruption to the insurance marketplace. (Kaiser Health News)

- **Future U.S. healthcare customers to challenge insurers: report**

  As a result of the Patient Protection and Affordable Care Act, 30 million Americans are expected to gain access to health insurance through regulated exchanges in each state, more plans from employers, and an expansion of the federal Medicaid program for the poor. It will be easier and cheaper for these new customers, particularly on the health exchanges, to switch providers, said Vaughn Kauffman, a principal with PwC Health Industries, which prepared the report. (Reuters)

- **Administration Advises States to Expand Medicaid or Risk Losing Federal Money**

  The Obama administration is putting pressure on states to expand Medicaid, telling them they may lose federal money if they delay. Cindy Mann, the federal official in charge of Medicaid, said that while "there is no deadline" for expanding Medicaid, states would pay a price for delay. The federal payment rates "are tied by law to the specific calendar years noted," Ms. Mann said. So if a state defers the expansion of Medicaid to 2016, the federal government will pay 100 percent of the costs for only one year. After 2016, the federal share will drop to the levels specified by Congress, and states will be responsible for the remainder. (New York Times)

- **Many states not prepared for health-care law**

  Thirteen states and the District of Columbia have formally expressed their intention to set up health insurance exchanges. But many of the rest of the states are behind in their planning or have decided not to operate exchanges on their own, according to a report from the Health Research Institute, the research arm of PricewaterhouseCoopers's health-care consulting business. Even some of the 13 that plan to set up the exchanges might not be ready for enrollment by October 2013, the report said. If a state does not set up an exchange, the federal government will either partner with the state or be the sole operator in that state. (Washington Post)

- **States Race Toward Monday Deadline to Pick Their Benchmark Plans**

  According to a roundup by Avalere Health, as of Friday, 16 states have identified their proposed benchmark plans that will be the models for individual and small-group insurance coverage in each state's health insurance exchange. Another 17 have identified their potential benchmarks plans so the final tally of states that submit proposed benchmarks to HHS could still rise. The states identified by Avalere as having picked benchmark plans are California, Oregon, Washington, Utah, Colorado, Arkansas, Mississippi, Michigan, Virginia, Delaware, Maryland, Connecticut, Rhode Island, New Hampshire, Vermont and the District of Columbia. However, HHS officials also have told states that the deadline to pick a plan by the end of the third quarter of the year is a "soft" one since it was not set out as a formal regulation, according to a letter sent earlier this week by Kansas Insurance Commissioner Sandy Praeger to Gov. Sam Brownback. (CQ Healthbeat)

- **Study: States, Feds Recover Billions In Medicaid Drug Fraud Settlements**

  In just the first half of 2012, the federal government and states have recovered $6.6 billion, according to the report. Overcharging health programs, mainly in the form of drug pricing fraud in state Medicaid programs, was the most common violation during

the study period, from Nov. 2, 2010 through July 18 of this year. Unlawful promotion of drugs was associated with the largest penalties. Seventy-four settlements totaling $10.2 billion in financial penalties were reached between federal and state governments and pharmaceutical manufacturers during the study period. (Kaiser Health News)

- **Big Firms Overhaul Health Coverage**

  Two big employers are planning a radical change in the way they provide health benefits to their workers, giving employees a fixed sum of money and allowing them to choose their medical coverage and insurer from an online marketplace. Sears Holdings Corp. and Darden Restaurants Inc. say the change isn't designed to make workers pay a higher share of health-coverage costs. Instead they say it is supposed to put more control over health benefits in the hands of employees. The approach will be closely watched by firms around the U.S. If it eventually takes hold widely, it might parallel the transition from company-provided pensions to 401(k) retirement-savings plans controlled by workers and funded partly by employer contributions. For employees, the concern will be that they could end up more directly exposed to the upward march of health costs. Major consulting firm Aon Hewitt, a unit of Aon, is behind the insurance exchange that Sears and Darden will use, while rival Towers Watson & Co. in May bought Extend Health Inc., an online marketplace used by employers to hook retirees up with Medicare coverage. It plans to expand the marketplace to include active workers buying individual plans, starting in 2014. (Wall Street Journal)

- **HHS continues to support state efforts to build Affordable Insurance Exchanges**

  Health and Human Services (HHS) Secretary Kathleen Sebelius last week awarded a new round of Affordable Insurance Exchange Establishment Grants to Arkansas, Colorado, Kentucky, Massachusetts, Minnesota, and the District of Columbia. These awards will give states the flexibility and resources needed to create new health insurance marketplaces, known as Exchanges, for their residents. Arkansas, Colorado, Kentucky, Massachusetts, and Minnesota received awards for Level One Exchange Establishment Grants, one-year grants awarded to states to build Exchanges. The District of Columbia received a Level Two Exchange Establishment Grant, a multi-year grant awarded to states further along in building their Exchanges. (Healthcare.gov)

COMPANY NEWS

- **Pyramid Healthcare Acquires High Focus Centers**

  Clearview Capital Fund II, LP today announced that its portfolio company, Pyramid Healthcare, Inc., has acquired American Day CD Centers, LLC (d/b/a High Focus Centers). Headquartered in Summit, NJ, High Focus is the largest provider of structured outpatient substance abuse and psychiatric treatment programs serving adults, adolescents and their families in New Jersey. Founded in 1989, High Focus has enjoyed rapid growth due largely to its experienced management team and a superior focus on delivering quality treatment programs to its patients. The Company holds a Behavioral Health Care Accreditation from The Joint Commission ("TJC"). (Clearview Capital News)

- **Washington Post Branches Into Health Care**

  Washington Post Co. said Monday it would buy a majority stake in Celtic Healthcare Inc., a closely held provider of hospice and home health care in Pennsylvania and Maryland. Terms of the deal weren't disclosed, although one analyst, Sheryl Skolnick of CRT Capital Group, said average valuations suggests the deal could have been worth at least $50 million. Post Co. has a market capitalization of $2.7 billion. (Wall Street Journal)

- **Amerigroup to Divest Virginia Health Plan**

  Amerigroup Corporation announced today that it has entered into a definitive agreement to sell Amerigroup Virginia, Inc. to Inova. The sale, which is conditioned on the closing of the previously announced Amerigroup and Wellpoint transaction, will divest all of Amerigroup's managed care operations in the Commonwealth of Virginia. Inova is a not-for-profit health care system located in the Washington, D.C. metropolitan area, serving over two million people with over 1,700 licensed beds based in Northern Virginia. (Amerigroup Press Release)

- **MAXIMUS Awarded $23.5 Million Customer Relationship Management Contract for Oklahoma's SoonerCare and Insure Oklahoma Programs**

  MAXIMUS announced that it has signed a new contract with the Oklahoma Health Care Authority (OHCA) to operate a Customer Relationship Management (CRM) solution for the SoonerCare and Insure Oklahoma programs. The one-year contract includes five one-year renewal periods, for a total contract value of $23.5 million if all renewal periods are exercised. The contract was awarded on September 17, 2012 and the first contract term ends on June 30, 2013. (MAXIMUS News Release)

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
Early October, 2012	Arizona - Maricopa Behavioral	RFP Released	N/A
October 12, 2012	Wisconsin LTC	Contract awards	38,800
October 29, 2012	South Carolina Duals	RFP Released	68,000
October, 2012	Illinois Duals	Contract awards	136,000
October, 2012	Massachusetts Duals	Contract awards	115,000
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 15, 2012	Nevada	Proposals due	188,000
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 5, 2012	Idaho Behavioral	Proposals due	200,000
December 19, 2012	Nevada	Contract Awards	188,000
December, 2012	Arizona - Maricopa Behavioral	Proposals due	N/A
January 1, 2013	New Hampshire	Implementation (delayed)	130,000
January 1, 2013	Wisconsin LTC	Implementation	38,800
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	Ohio	Implementation	1,650,000
January 1, 2013	Vermont Duals	Proposals due	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January 15, 2013	Florida LTC	Contract Awards	90,000
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 Behavioral	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	Nevada	Implementation	188,000
July 1, 2013	Michigan Duals	Implementation	198,600
July 1, 2013	Idaho Behavioral	Implementation	200,000
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 Behavioral	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	Initial Proposal Released	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Deadline for Plans to submit applications	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	5/31/2012	7/1/2012	N/A[+]	N/A[+]	N/A[+]	N/A	1/1/2014
California**	Capitated	685,000	X	4/4/2012	5/31/2012	6/30/2012	X	3/1/2012	5/24/2012	4/4/2012	6/1/2013
Colorado	MFFS	62,982	X	4/13/2012	5/31/2012	6/30/2012			N/A		1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	5/31/2012	6/30/2012			N/A		12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	5/25/2012	6/29/2012			TBD		1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	4/6/2012	5/10/2012	X	6/18/2012	5/24/2012	October 2012	4/1/2013
Iowa	MFFS	62,714	X	4/16/2012	5/29/2012	6/29/2012			N/A		1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	5/31/2012	6/30/2012		Q2 2013	N/A	July 2013	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	2/16/2012	3/19/2012	X	8/20/2012	5/24/2012	Imminent*	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	4/26/2012	5/30/2012		Feb. 2013	TBD	March 2013	1/1/2014[#]
Missouri	Capitated[‡]	6,380	X		5/31/2012	7/1/2012			N/A		10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	4/26/2012	5/31/2012			5/24/2012		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	5/25/2012	6/30/2012			TBD		1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	5/2/2012	6/3/2012			N/A		1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	4/2/2012	5/4/2012	X	5/25/2012	5/24/2012	8/27/2012	4/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	5/31/2012	7/1/2012			N/A		7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	5/11/2012	6/13/2012		Certification process			1/1/2014
Rhode Island	Capitated	22,737	X		5/31/2012	7/1/2012		Apr-May 2013	TBD	6/1/2013	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	5/25/2012	6/28/2012	10/29/2012		TBD	7/30/2013	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	5/17/2012	6/21/2012			TBD		1/1/2014
Texas	Capitated	214,402	X	4/12/2012	5/31/2012	6/30/2012	N/A	N/A	TBD	N/A	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	5/31/2012	6/30/2012	Oct. 2012		TBD	July 2013	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	5/10/2012	6/10/2012		1/1/2013	TBD	2/28/2013	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	4/26/2012	5/30/2012		Feb. 2013	TBD	July 2013	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	4/26/2012	6/1/2012	X	8/23/2012	5/24/2012		4/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***5***				

** Massachusetts was scheduled to award on Friday, September 21, 2012. The state has said the selection process is ongoing and we expect awards any day.*

*** 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.

 # State's proposal refers to enrollment beginning in 2013, but CMS 9/5/2012 presentaion "Status of the Capitated Financial Alignment Demonstrations" refers to Michigan as a 2014 state.

HMA WELCOMES…

Doug Porter, Principal – Olympia, Washington

As we announced in late August, Doug Porter has joined HMA as of October 1, founding HMA's newest office in Olympia. Doug comes to HMA from the Washington State Health Care Authority where he has served as the Director, and head of Washington's Medicaid program for the past ten years. Under his leadership, the Medicaid program made nationally recognized advances in children's health insurance, managed care, program integrity, development of a new Medicaid Management Information System, related payment issues, and health care reform. Doug has led the Washington State program since December 2001, when it was part of the Department of Social and Health Services. In 2010, Governor Chris Gregoire announced a plan to merge Medicaid and the existing Health Care Authority, putting Doug in charge of the state's other large health care purchasing program, the Public Employees Benefits. That move, completed in 2011, helped streamline and standardize state health care programs, as well as bend the health cost curve, helping restrain annual medical cost inflation by eliminating waste and inefficiencies. Prior to his move to Washington State, Doug served as the Medi-Cal Director in California and was responsible for the largest and most complex Medicaid agency in the country. Earlier in his career, Doug was the Chief Operating Officer of the Jackson Brook Institute, a 106 bed full service psychiatric hospital, and the Deputy Commissioner for Programs for Maine's Department of Human Services. He earned his Bachelor of Science degree at St. Joseph's College in Standish, Maine.

Paul Niemann, Senior Consultant – Denver, Colorado

As of October 1, Paul Niemann joins HMA's Denver office. Paul comes to HMA from the Colorado Department of Health Care Policy and Financing (HCPF) where he has served as the Deputy Budget Director for the past three years, and as a Work Leader and Rates Analyst for three prior years. In these roles, Paul provided reports and directly managed the $90 million line item including case load and per capita cost projections, developed, wrote, and defended budget requests to the Governor's Office of State Planning and Budgeting and the Joint Budget Committee, and oversaw, certified, and defended the state's projections of its expenditures and federal fund needs for upcoming quarters. Prior to his work at HCPF, Paul was a lecturer in the University of Colorado at Denver Economics Department and taught Masters level classes on Health Care Economics and presented graduate level analyses, models and papers on various issues surrounding health care including adverse selection, valuation of medical care, risk selection, and payment methodology incentives. Paul earned his Bachelor of Arts and Bachelor of Science degrees at the University of Colorado at Denver, and his Master of Arts degree and his PhD in Economics at the University of California at Santa Barbara.

HMA Recently Published Research

Making the Connection: The Role of Community Health Workers in Health Homes

Deborah Zahn, MPH, Principal

The development of health homes creates a unique opportunity to develop and implement care management models that meet the complex needs of high-need and high-cost patients. Incorporating community health workers (CHWs) into care management teams is an effective—and cost-effective—approach to achieving the goals of health homes. The roles and tasks CHWs perform already align well with the six core services required of health homes. There are also readily available training resources to support their inclusion. Additionally, the care management PMPM payments that support health homes provide an opportunity and the flexibility to hire CHWs without having to rely on unsustainable grant funding. Health home providers can leverage this opportunity to build effective models that include CHWs working as part of their care management teams. These models can help achieve the Triple Aim of better health, better care, and lower costs. **(Link to Report - NYS Health Foundation)**

HMA Upcoming Appearances

Cain Brothers, General Catalyst Partners, Health Management Associates, Sentinel Capital Partners, and Nixon Peabody LLP Presents:
Investing in Health Care: Current challenges and opportunities

Greg Nersessian – Featured Speaker

October 11, 2012

New York, New York

Lansing Regional Chamber of Commerce
Top 10 Issues to Watch in Preparing for ACA Implementation

Janet Olszewski – Keynote Speaker

October 11, 2012

East Lansing, Michigan

2012 National Conference on Correctional Health Care:
Inmate Health Care and the Affordable Care Act: Opportunities and Challenges

Donna Strugar-Fritsch – Presenter

October 24, 2012

Las Vegas, Nevada