HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARIZONA ACUTE CARE MEDICAID MCO RFP

HMA ROUNDUP: WASHINGTON D.C. RELEASES MEDICAID MANAGED CARE RFP; CALIFORNIA RELEASES MEDICAID MANAGED CARE RFP FOR RURAL SERVICE AREAS; CALIFORNIA AGREES TO RATE SETTLEMENT STRUCTURE WITH HEALTH NET; OREGON WITHDRAWS DUAL ELIGIBLE DEMONSTRATION PROPOSAL; GEORGIA CONSIDERS ASO MODEL FOR ABD

OTHER HEADLINES: CMS ISSUES PRIMARY CARE RATE ADJUSTMENT FINAL RULE; STATES TO RE-VISIT AFFORDABLE CARE ACT STRATEGIES FOLLOWING LOCAL AND NATIONAL ELECTIONS; MANAGEMENT CHANGES AT CALOPTIMA, NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND; NEW HAMPSHIRE PROVIDERS RESIST MANAGED CARE CONTRACTING

HMA WELCOMES:
TONY RODGERS, NORTHERN CALIFORNIA
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NOVEMBER 7, 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: ARIZONA MEDICAID ACUTE CARE MCO RFP

This week, our *In Focus* section reviews Arizona's Acute Care and Children's Rehabilitative Services (CRS) request for proposals (RFP). The RFP, released last week by the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, rebids statewide contracts for acute care Medicaid benefits, as well as the state's CRS program, which provides services to nearly 25,000 children with specified chronic and/or disabling or potentially disabling health conditions. This RFP is also noteworthy in that awarded contractors will also serve the dual eligible population, whether under a dual eligible demonstration or as a dual eligible special needs plan (D-SNP).

Background

Arizona has a unique structure for it Medicaid managed care delivery system. All Medicaid beneficiaries that are not eligible for long term care services are covered under the AHCCCS acute care contract that is being re-bid and described below. This includes low income women and children, the elderly (including certain dual eligibles) and the disabled which in aggregate total approximately 1.1 million lives. If a Medicaid beneficiary qualifies for long term care services, they are covered by one of the plans participating in the Arizona Long Term Care System (ALTCS). This program was re-bid last year with UnitedHealth, Centene and Aetna administering the program currently. Finally, the state carves-out behavioral health services from all managed care contracts and administers these benefits through Regional Behavioral Health Authorities (RBHAs). There is currently an RFP underway for the RBHA contract in Maricopa county.

Key RFP Elements

- Plans may bid on any of the seven service areas (GSAs) for the acute care contracts. To be eligible for the CRS contract, a plan must bid on and be awarded an acute care contract in at least one GSA.
- As it has in the past, the acute care RFP stipulates requirements for both medical expense ratio (MLR) and an administrative cost percentage. The medical expense ratio standard is set at 85 percent, and the administrative cost percentage standard is set at 10 percent.
- The acute care RFP provides risk corridors on medical cost expenses. All profits between 0 and 3 percent would go to plans, profits between 3 and 6 percent are shared 50 percent with the state, and all profits above 6 percent accrue to the state. This effectively sets maximum cumulative profits to the plans at 4.5 percent. Plans would be responsible for all losses up to 3 percent, with losses beyond 3 percent falling fully to the state.
- Beginning in calendar year 2014, AHCCCS anticipates that capitation rates will be reduced by a withhold of no less than 1 percent under required payment reform efforts. The entirety of this withhold will be paid out to one or more plans according to performance measures, yet to be determined.

- AHCCCS is in the process of negotiating with CMS on a dual eligible capitated demonstration program. The state had anticipated a signed MOU with CMS by October 2012, prior to the release of this RFP, but this has not yet occurred. Without a signed MOU, AHCCCS has opted to require a second option for integrating care for dual eligibles if an agreement is not reached with CMS. AHCCCS will require plans to go down parallel tracks of becoming both a dual demonstration plan and a D-SNP. Beginning in January 2014, plans are required to offer a demonstration plan or a D-SNP. As noted in the timeline below, plans must submit a notice of intent to CMS under both options.
- Going forward, AHCCCS will not contract with D-SNPs that are not awarded Acute contracts in the counties they offer their D-SNP, or that do not hold a contract in the Arizona Long Term Care System (ALTCS) or the Maricopa County Regional Behavioral Health Authority (RBHA).

Selection Process and Scoring Criteria

The RFP does not provide complete scoring criteria but does indicate that the acute care RFP will be evaluated on the following four components, weighted in the order listed. However, no weighting percentages have been released. Capitation rates will be scored by GSA, with the other categories scored on a statewide basis.

- Capitation
- Program
- Access to care/network
- Organization

Additionally, the RFP includes several attestation requirements that are not scored but included in the readiness review process. Failure to meet requirements may limit or prohibit assignment of members to an awarded plan.

AHCCCS may limit GSAs awarded to any one plan. AHCCS will not make an award in a GSA to a plan that also has a management service agreement with another plan or contractor in the same GSA. Additionally, they will not make awards to two or more plans using same management service company in a GSA. In this instance, the contract award would go to the highest scoring bidder

Contracts by GSA (anticipated):

GSA	County/Counties	Max. awards	Covered Lives
2	Yuma, La Paz	2	50,463
4	Apache, Coconino, Mohave, Navajo	2	76,850
6	Yavapai	2	31,817
8	Gila, Pinal	2	47,588
10	Pima, Santa Cruz (gets 2/5 in Pima)	5	182,812
12	Maricopa	7	641,044
14	Graham, Greenlee, Cochise	2	31,787
	Total Statewide		**1,062,361**

RFP Timeline

A bidders' meeting will be held this Friday, November 9, with two rounds of questions and answers before proposals are due on January 28, 2013. Contract awards are expected to be announced by March 22, with contracts going live on October 1, 2013. Additionally, it is required that bidders submit a notice of intent to apply (NOIA) to CMS in November, 2012, both for the dual integration demonstration and as a D-SNP.

Timeline	Date
Prospective bidders meeting	November 9, 2012
First round Q&As due	November 14, 2012
First round Q&As answered	November 27, 2012
Dual Integration/D-SNP NOIA submission to CMS	November, 2012
Second round Q&As due	December 10, 2012
Second round Q&As answered	December 19, 2012
Actuarially sound capitated rates released	December, 2012
Proposals due	January 28, 2013
Contract awards	March 22, 2013
Implementation	October 1, 2013

Incumbent Acute Care Market

The acute care market currently is a mix of national and local health plans, with Aetna and UnitedHealth sharing roughly 50 percent of the market.

Acute Care Plan	Has D-SNP in AZ?	Enrollment	% of Total
Mercy Care Plan (Aetna)	Yes	285,609	27%
AP/IPA (UnitedHealth)	Yes	240,622	22%
Phoenix Health Plan		183,015	17%
Health Choice	Yes	172,515	16%
University Family Care (UPH)	Yes	67,235	6%
Maricopa Health Plan (UPH)		50,297	5%
Care 1st Arizona	Yes	46,787	4%
Bridgeway Health Solution (Centene)	Yes	16,281	2%
DES Foster Care		12,803	1%
Total Acute Care		**1,075,164**	

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

There were a number of interesting developments in California this week. Most noteworthy was an agreement reached between Health Net and the Department of Healthcare Services (DHCS) which for the first time creates risk corridors around the comprehensive managed care organization's Medi-Cal profitability (Medi-Cal uses risk corridors in its dental contract). The agreement has a number of elements worth noting including:

- Health Net agrees to settle all historical rate disputes over Medi-Cal payments
- Health Net's current contracts are extended five years beyond their current termination dates
- The creation of a settlement account, described below, applicable to all of Health Net's state-sponsored healthcare programs, including Medi-Cal, Healthy Families, Seniors and Persons with Disabilities, the dual eligibles pilot programs that currently are expected to begin in 2013, and any potential future Medicaid expansion under federal health care reform.
- Compensation owed to Health Net in the event that DHCS terminates any of its state-sponsored healthcare programs contracts prior to their scheduled expiration.

The settlement account will be created on January 1, 2013 with an initial balance of zero. For each subsequent annual period, Health Net's profitability within its state sponsored business will tracked relative to pre-established target levels. To the extent the company's results exceed or fall short of the pre-established target, the balance of the settlement account will increase or decrease according to an established formula. For example, in the first year, if Health Net's pre-tax margin is below 3.25 percent, the account will reflect a balance equal to the difference between 3.25 percent and the actual margin multiplied by 75 percent. In subsequent years the state's cost sharing obligation drops to 50 percent. In each year the balance will increase or decrease depending on Health Net's financial performance relative to the target margin in that year and the state's cost sharing percentage. Upon termination of the agreement, which is scheduled for December 31, 2019 (but may be extended by an additional three years at the state's discretion) the balance will be settled in cash up to a maximum amount owed by DHCS of $264 million. It's not clear at this time if this agreement requires and has received CMS approval. More detail on the arrangement in a form 8-K filed by Health Net. Link

Another interesting development in California involves a report from Inside Health Policy news that California government officials, providers and Medicaid plans are supporting a proposal to convert the federal matching obligation for Medicaid services from a fixed percentage per state to a per capita spending amount that is based on the national average spending level. The proposal is considered an alternative to a fixed block grant structure supported by Republicans and may be considered during deficit reduction ne-

gotiations. The idea recently received the support of former Senator Tom Daschle. It is worth noting that California would benefit under such a proposal because it's Medicaid payment rates are far below the national average.

Also of note, last week the California Health Benefit Exchange Board approved "Covered California" as the name for the new health insurance exchange which will be available to the public for early enrollment in October 2013, with coverage available to almost five million Californians effective January 2014.

On Tuesday, California voters passed Proposition 30 which raises $6 billion in taxes through a 0.25 percent increase in the sales tax and a one to three percent increase in the income tax for high income individuals and families. The measure, which is designed to generate an additional $6 billion in revenue will be used to fund spending on education. While it is anticipated that the state will continue to have a significant budget deficit, had this Proposition not passed there would have been significant additional pressure to reduce spending on Medi-Cal and other programs.

California DHS has issued a request for applications (RFA) for managed care organizations to serve Medi-Cal enrollees in 25 rural counties in the northern and eastern parts of the state not currently served by the state's managed care programs. This RFA expands managed care to all but three counties statewide. There are approximately 380,000 beneficiaries covered under this expansion with annualized expenditures of $2 billion. Applications must be submitted for two or more of the counties in the Expansion Region and the counties to be addressed in the application must be contiguous. A required letter of intent is due on November 19, 2012, with applications due on January 21, 2013. Notice of acceptance or denial of application will be announced on February 25, 2013, with contracts going live on June 1, 2013. Link to the RFA and additional documents here.

In the news

- **Health Net posts plunge in profit, strikes deal with California**

  Health Net Inc. said third-quarter net income plunged 71%, but its shares rose as the company resolved a dispute with California officials over reimbursement for government health programs. Health Net disappointed investors in August when it slashed its full-year profit outlook and reported higher-than-expected medical costs. On Monday, Chief Executive Jay Gellert said the company was making progress on its turnaround plans. He cited a wide-ranging agreement with California healthcare officials as a major step forward. The deal with the California Department of Health Care Services ended company litigation over government reimbursement. As part of the agreement, Health Net said, the state will extend four existing Medi-Cal contracts by five years and provide additional payments if the company incurs larger-than-expected losses as new government programs get underway next year. (Los Angeles Times)

Colorado

HMA Roundup – Joan Henneberry and Paul Niemann

All Payer Claims Database: Colorado launched its All Payer Claims Database on November 1 (www.cohealthdata.org) with an initial release of public reports that reflect three years of historical data. The APCD collects health insurance claims from Medicaid

and private payers including the eight largest health plans in the state, and is working with CMS to add Medicare claims. By 2014 the APCD will have claims data for 90 percent of the insured population. The APCD includes information on where care is delivered, actual amounts insurers and consumers pay for various services, and how often services are accessed. Future releases of the APCD will allow consumers, on the free public website, to compare risk-adjusted average prices and quality metrics for a wide variety of medical procedures by provider and payer. The launch comes about two years after the legislature authorized the creation of the APCD, which is administered by the Center for Improving Value in Health Care.

Budget Request: On November 1, 2012, the Governor's FY 2013-14 budget request was submitted to the state General Assembly. As a part of the request the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) proposed to strengthen Colorado's behavioral health system by expanding the Medicaid substance use disorder benefit; establishing a comprehensive statewide behavioral health crisis care system for persons, families, and communities; expanding community services for individuals with behavioral health needs to help avoid institutional placement; and, increasing the number of available beds for individuals who have been determined by the court to be Incompetent to Proceed. Both Departments requested funding to increase reimbursement rates to most Medicaid and community providers by 1.5%. The reimbursement increase will, at least in part, reverse some of the reimbursement reductions implemented starting in FY 2008-09 as a result of the state financial crisis. HCPF requested funding for the following: re-procurement of its MMIS system; implementation of technological changes to improve the operation of its customer contact center; and provision of a dental benefit for adults in the Medicaid program subject to an annual $1,000 cap on services. HCPF also requested to implement a dental administrative services organization (ASO) for the Medicaid children's dental benefit with new costs to be offset by savings from the ASO's services. DHS requested funding to develop, purchase, implement, and maintain a new data system to manage protection and advocacy services for at-risk adults and an Integrated Behavioral Health Services Data Collection System to consolidate the state's mental health and substance use disorder data and include physical health data.

Accountable Care Collaborative (ACC) Update: The Accountable Care Collaborative (ACC) began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently on track to achieve an enrollment level of 200,000 early in CY 2013. There are seven Regional Care Collaborative Organizations (RCCOs) that provide the following services:

- medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- care coordination among providers and with other services such as behavioral health, long-term care, single entry point (SEP) programs, and other government social services such as food, transportation, and nutrition; and
- provider support, such as assistance with care-coordination, referrals, clinical performance and practice improvement, and redesign.

Primary Care Medical Providers (PCMPs) are contracted with RCCOs and act as "health homes" for ACC members. The Statewide Data and Analytics Contractor (SDAC) builds and implements the ACC data repository, creates reports using advanced health care analytics, hosts and maintains a web portal, provides a continuous feedback loop of critical information, fosters accountability and ongoing improvement among RCCOs and providers, and identifies data-driven opportunities to improve care and outcomes.

The RCCO and the PCMP are both paid a per-member per-month (PMPM) amount and are responsible for providing enhanced care coordination services, improving health outcomes, and reducing unnecessary costs. The Department estimates a net savings of almost $6 million after the first full year of operations.

In the news

- **Now in control, Colorado Democrats want Medicaid expansion**

  Tuesday's election results ensure that implementation of Obamacare will proceed on a fast track in Colorado and Democratic lawmakers want to move ahead with Medicaid expansion that could bring health coverage to nearly a quarter million low-income Coloradans. "We would like to push to get health care to as many people as possible because that's going to reduce the costs for everyone," said Rep. Mark Ferrandino, D-Denver, who is expected to take the reins of the Colorado House in January after Democrats recaptured control of it on Tuesday. Gov. John Hickenlooper is more circumspect. While he supports expansion of health care, Hickenlooper refused to say whether he'll support Medicaid expansion. (Health Policy Solutions)

Florida

HMA Roundup – Gary Crayton

The Agency for Health Care Administration (AHCA) issued a hospital rate setting notice on October 31, 2012 with the finalized appropriation of intergovernmental transfers (IGTs) available for hospital exemptions and buy-backs. The appropriated amount of IGTs, roughly $367 million, is less than the $390 million hospitals and local governments wanted to put up in IGT funds. The IGTs allow hospitals to buy back, or reduce the impact of, reductions in hospital Medicaid rates. This IGT finalization was the last step in the hospital rate setting process and individual hospital rate sheets should be released sometime in the next week. Additionally, this is a critical step in setting HMO rates for FY 2012-13 , which should be released in coming weeks. HMOs will be paid under these new rates for the first time in December 2012, with retroactive rate adjustments made for September through November. Overall, it is expected that HMO rates may be slightly up statewide, with variation from region to region.

In the news

- **Fla. proposes charging medically needy monthly fee**

  State health officials are moving tens of thousands of Medicaid patients with serious medical conditions into managed care plans, but health care plans are worried the patients won't be able to afford the proposed monthly premiums. The state pays the monthly medical bills of patients with high health care costs under the Medically

Needy program even if they make too much money to normally qualify for Medicaid. Patients must meet a share of the cost each month that varies based on their income. The state spends more than $900 million a year to provide services for at least one month to more than 250,000 people a year. But under a new Medicaid privatization plan, the state is asking those patients to start paying roughly $120 a month to receive services. If they can't pay, they are kicked out of the program after a 90 day grace period and have to go through the red-tape of re-qualifying. Advocates worry the change could lead to lapses in care in care for a population with serious chronic health conditions such as cancer, heart disease and HIV. At a public meeting on the issue in South Florida this month, representatives from health care plans warned patients won't be able to pay the proposed $120 monthly costs in a down economy, leaving health care plans on the hook. (Associated Press)

Georgia

HMA Roundup – Mark Trail

The Georgia Department of Community Health (DCH) indicated that it has decided not to transition aged, blind and disabled (ABD) Medicaid beneficiaries into managed care plans, at this time. Instead, the state intends to implement an administrative services only (ASO) program for ABD beneficiaries using mandatory enrollment but with a non-punitive opt-out provision. As a reminder, a consultant's report released earlier this year had recommended ABD beneficiaries be enrolled in Medicaid managed care plans. However, feedback from advocates and provider groups led the administration to delay its re-procurement of the PeachCare program and a decision on the ABD delivery system change. Subsequent to further discussions, the state has decided to move forward with an ASO (non-risk based) model. An RFP will be conducted to select the ASO vendor with implementation tentatively scheduled for October 2013.

In the news

- **Health care law lives – and Ga. faces big choices**

  Georgia's Republican governor and Republican legislative leaders will have two decisions to make, both set up by the health reform law: Will the state expand its Medicaid program? And will Georgia run its own health insurance exchange? Several states had been waiting for the national election results before making these major health care decisions, Bill Custer, a health insurance expert at Georgia State University, told GHN on Wednesday. The election "is a finish line, but it's also a starting line,'' he said. (Georgia Health News)

- **State Eyes Major Medicaid Change**

  State officials, in an abrupt shift, are moving toward creating a case management system for hundreds of thousands of Medicaid beneficiaries who are "aged, blind and disabled.'' This summer, the Department of Community Health, citing the uncertainty about Medicaid's future, stepped away from a proposal to place beneficiaries residing in nursing homes, as well as those with disabilities, into managed care plans. But now, the Medicaid agency appears to envision a lighter form of managed care for those beneficiaries. The state's decision may be at least partly linked to the financial crunch that

Medicaid faces. The agency replied to a query from Georgia Health News on the case management proposal with an emailed statement. "DCH is currently reviewing opportunities to provide case management and care coordination services to the fee-for-service (FFS) population within a FFS payment model," the statement said. (Georgia Health News)

Illinois

HMA Roundup – Jane Longo & Matt Powers

We are hearing that contract awards in the dual eligible integration demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI), are imminent and could be announced yet this week. As previously reported, contract awards have been perpetually delayed over the past weeks, at least in part due to ongoing negotiations with CMS.

Next Friday, November 16, the Illinois Medicaid Advisory Committee is scheduled to meet in Chicago and Springfield. The agenda includes updates on the Cook County early Medicaid expansion waiver, as well as the state's care coordination innovations project. The meeting is scheduled for 10 am.

In the news

- **Illinois moves ahead on health insurance exchange**

  Illinois officials are reviewing five bids to build the state's health insurance exchange.. The Illinois Department of Insurance has received proposals on the exchange contract from Infosys, CGI, Deloitte Consulting, Xerox and Cognizant Technologies Solutions. The company that wins the bid would be required to design and build a website with "no wrong door" for consumers -- a user-friendly site that would seamlessly guide them to Medicaid, the children's health insurance program or private insurance, depending on each consumer's eligibility. The exchange would need to share data with Illinois' Medicaid agency. Consumers would be able to find out whether they're eligible for new federal subsidies to help pay premiums, or whether they qualify for Medicaid. (Chicago Tribune)

Massachusetts

HMA Roundup – Tom Dehner

The Massachusetts Executive Office of Health and Human Services (EOHHS) announced last week the Integrated Care Organizations (ICOs) selected in the dual eligible integration procurement. The following plans will move onto the readiness review process. Network Health was the only statewide awardee. Centene, UnitedHealth, and Senior Whole Health were unsuccessful bidders.

- Blue Cross and Blue Shield of Massachusetts HMO Blue Inc. (BCBSMA)
- Boston Medical Center HealthNet Plan (BMCHP)
- Commonwealth Care Alliance (CCA)
- Fallon Total Care, LLC (FTC)

- Neighborhood Health Plan (NHP)
- Network Health, LLC

County	BCBSMA	BMCHP	CCA	FTC	NHP	Network Health
Barnstable	X	X		X		X
Berkshire		X				X
Bristol	X	X		X		X
Dukes						X
Essex	X		X	X	X	X
Franklin	X	X	X			X
Hampden	X	X	X	X		X
Hampshire	X	X	X	X		X
Middlesex	X	X	X	X	X	X
Nantucket						X
Norfolk	X	X	X	X		X
Plymouth	X	X	Partial	X		X
Suffolk	X	X	X	X	X	X
Worcester	X		X	X		X

Oregon

HMA Roundup

In a memo dated October 30, Oregon announced that it will no longer pursue a dual eligible financial alignment demonstration with CMS. The state determined that the financial alignment demonstration may not be financially viable for the state's Care Coordination Organizations (CCOs) under the anticipated rate structure. This is due, at least in part, to low Medicare fee-for-service costs in the state and the existing Medicare Advantage plans serving dual eligibles in Oregon. CCOs and their affiliated Medicare Advantage plans will not need to submit a notice of intent to apply (NOIA) as a CMS financial alignment demonstration plan. The state will continue to explore an arrangement with CMS and CCOs that aligns financial incentives for better care coordination for the dual eligible population.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Revenue: Pennsylvania collected $2 billion in General Fund revenue in October, which was $71.5 million, or 3.6 percent, more than anticipated. Fiscal year-to-date General Fund collections total $8.1 billion, which is $82.2 million, or 1 percent, above estimate.

Financial management services: Following a competitive procurement Public Partnerships, LLC, a division of Public Consulting Group, was selected by the Department of Public Welfare to handle payroll services to approximately 22,800 Medicaid enrollees who receive home-and community-based services through the Office of Developmental

Programs and Office of Long Term Living in Pennsylvania. It is expected that the new service plans will be in place with PPL by Jan. 1, 2013.

In the news

- **UPMC for You Scores Impressive Membership Gains in Northwest Pa.**

  UPMC for You, the top-ranked Medical Assistance program in Pennsylvania, is also the resounding top choice of Medical Assistance recipients living in northwest Pennsylvania. Beginning Oct. 1, 2012, Medical Assistance recipients in 13 northwest Pennsylvania counties were able to select from four available managed care organizations (MCOs) as part of an expansion of HealthChoices, Pennsylvania's mandatory Medical Assistance program. Of the more than 37,000 new eligible recipients who actively selected among the four MCOs, 71 percent chose UPMC for You. In addition, over 99 percent of UPMC for You's existing members in northwest Pennsylvania chose to stay with UPMC for You during this open enrollment period. The 13-county region is now known as the "New West" region. The total number of UPMC for You members in northwest Pennsylvania (including those who were automatically assigned), exceeds 54,000, which represents more than 40 percent of the total market share in the New West region. (UPMC Press Release)

Vermont

HMA Roundup

Earlier this week, the Department of Vermont Health Access (DVHA) released an RFP for managed care organizations to offer qualified health plans and stand-alone dental plans for sale through the Vermont Health Benefit Exchange, Vermont Health Connect. Through this RFP, the Commissioner of DVHA will select the qualified health plans to be offered on Vermont Health Connect for qualified individuals and qualified employees of qualified employers. The RFP is open to all health insurance organizations licensed in Vermont that are interested in providing coverage for health services to individuals and small businesses through Vermont Health Connect. Proposals are due January 8, 2013.

Washington, D.C.

HMA Roundup – Theresa Sachs

On November 2, 2012 the District of Columbia issued a Medicaid managed care RFP. This is a re-procurement of the current program, which covers approximately 170,000 Medicaid beneficiaries in the District through three plans – United Healthcare, MedStar and DC Chartered Health Plan. DC Chartered was recently placed into receivership by the District and will not be eligible to win a contract unless it emerges from receivership prior to the date the contracts are awarded. Three plans will be selected to participate in the program with the contract running through April 30, 2018, though the District has the option to extend the agreement by up to four additional years. Respondents are required to submit a price bid that falls within the District's actuarially sound range. Within the RFP scoring methodology, price represents 15 points out of a maximum 200 allowable points. Proposals are due December 3, 2012.

OTHER HEADLINES

Arkansas

- **Beebe hints at cuts to address looming Medicaid shortfall**

  Two weeks before unveiling his plan to balance a $4.7 billion budget for the upcoming fiscal year, Gov. Mike Beebe suggested Wednesday that spending hikes will be sparse and cuts likely to address a Medicaid shortfall. The Beebe administration is scheduled to present the governor's Fiscal 2013-14 budget on Nov. 15 during fall budget hearings being held in advance of the regular legislative session that convenes Jan. 14. (Arkansas News)

Idaho

- **Idaho Medicaid Expansion Questioned**

  Like their counterparts in other states across the country, Idaho policymakers are considering whether to expand Medicaid in line with the demands of President Obama's health care law. Two recent reports sound caution about such a step, giving ample reason for the state to delay the expansion or reject it entirely. (Heartland Institute)

Kansas

- **Kansas shortens waiting list for in-home medical care**

  Kansas has updated its roster of disabled residents who have requested state-funded, in-home medical care and is now better equipped to provide that care more quickly and efficiently, officials in the governor's office said Monday. The waiting list was cut by more than a third, from 3,423 to 2,197 people, after a company hired by the state, AnswerNet, spent the last few months trying to reach out to those on the lists, Lt. Gov. Jeff Colyer and Aging and Disability Services Secretary Shawn Sullivan said. (Kansas City Star)

Kentucky

- **Kentucky violated bidding process in awarding Medicaid contracts, Passport says**

  In another bump for the state's transition to Medicaid managed care, Passport Health Plan filed a formal protest of the process that resulted last month in the awarding of state contracts to four companies in the Jefferson County region now served exclusively by Passport. Passport's complaint concerns the way the state Cabinet for Health and Family Services divided the region's 170,000 Medicaid recipients among the four companies. The protest letter says that Passport officials learned Wednesday that it initially will be assigned only 27 percent of the region's Medicaid recipients while the contracting process and a cabinet official previously indicated it would get 41 percent. (Courier-Journal)

Maine

- **Maine governor sees 'games' over Medicaid cuts**

  Gov. Paul LePage said Thursday the federal government is playing "political games" over cutbacks his administration is seeking in the state's Medicaid program, or

MaineCare. LePage said the federal Department of Health and Human Services has once again extended its time frame to decide whether to approve waivers for MaineCare reductions that were approved by the Legislature earlier this year. The cuts include elimination of coverage for 19- and 20-year-olds and reduced coverage for non-pregnant and non-disabled adults. The federal DHHS was supposed to provide answers by Thursday, but last week it requested more information from the state, effectively extending the deadline by 90 days, LePage said. The governor said that the delays could the state money, $2.2 million for each month that passes without approval of the cuts. (Associated Press)

Michigan

- **Simple economics behind merger push for Henry Ford, Beaumont**

The planned merger of Henry Ford and Beaumont health systems into a single, $6.4-billion nonprofit entity -- a deal to combine 10 hospitals, 200 patient care sites and 41,000 employees -- would mean better patient care, a financially stable employer and even more research money and clinical trials, leaders from the hospital systems said Wednesday. But the main reason behind the planned merger, at its heart, is simple economics: Combined, the two hospital systems would become more efficient and better positioned to face sweeping changes in health care reform, threatened budget cuts to Medicaid and Medicare, and an aging demographic that promises older, sicker patients as Medicare reimbursements shrink. (Detroit Free Press)

New Hampshire

- **Hospitals, other providers withhold participation in Medicaid managed care program, putting state in a bind**

The promised $16 million in savings that New Hampshire was supposed to see though a new Medicaid managed care program is quickly evaporating, because three vendors have not been able to set up networks with providers - especially hospitals - that are already upset with the Medicaid rates they are currently receiving. Most of the state's hospitals have refused to sign on to participate in the managed care program while their lawsuit continues over cuts made in Medicaid payments, in conjunction with requiring larger institutions to pay more than $100 million in a Medicaid enhancement tax to allow the state to balance its budget in the current biennium. (New Hampshire Business Review)

National

- **After Election, Governors Face Medicaid Decision**

Now that President Obama has been re-elected and Congress has no chance of repealing the health care law, much of its implementation will be affected by the decisions of state officials. Starting next year, 30 states will have Republican governors — the most control either party has had in a dozen years. Many of those GOP governors are philosophically opposed to the 2010 health care law, including the idea of expanding Medicaid. And thanks to the Supreme Court's ruling on the overhaul, states will be able to decide whether to broaden the program in their states. So far, six GOP governors, all of whom remain in power, have said that they would not expand the health program for

the poor. Others have been waiting for the results of the election to decide. For those governors who haven't committed, what to do about Medicaid will likely figure high on their agendas come January. And now that it is clear that Obama will press ahead on implementing the overhaul, state officials are already hearing pleas to make a decision. (CQ Healthbeat)

- **Health Care Issues On The Ballot: The Final Tally**

  Four states—Alabama, Florida, Montana and Wyoming—had provisions to block the federal health law's requirement that almost all Americans have insurance or pay a penalty. All four provisions were put on the ballot before the Supreme Court ruling in June that the "individual mandate" was permitted under Congress' taxing authority. While three of these provisions passed (in Alabama, Wyoming and Montana) states can't override federal law: citizens of those states will still be subject to the mandate. Meanwhile, Missouri voters approved Proposition E, which prohibits state officials from creating a health insurance exchange. (Kaiser Health News)

- **President's Win Is Reprieve For 'Obamacare'**

  President Barack Obama's victory cements the Affordable Care Act, expanding coverage to millions but leaving weighty questions about how to pay for it and other care to be delivered to an increasingly unhealthy, aging population. The administration's immediate job is launching online insurance marketplaces, known as exchanges, and managing the law's expansion of the state and federal Medicaid program for low-income patients even as a budgetary showdown looms. Only 13 states and the District of Columbia have said they'll open exchanges offering subsidized coverage from private insurers. Republican governors in Texas, Louisiana and many other states halted exchange preparations before the election. Many also balked at the Medicaid expansion after the Supreme Court gave states the ability to opt out of that aspect of the health overhaul. Romney's defeat, the promise of billions in federal subsidies and the prospect of federal regulators running exchanges in the absence of state leadership should push most governors into line, analysts said. (Kaiser Health News)

- **OB/GYNs And ER Docs Excluded From Health Law's Medicaid Pay Hike**

  Obstetricians, gynecologists and emergency room physicians won't be eligible for higher Medicaid pay rates for primary care doctors that start in January under the Affordable Care Act, the Obama administration ruled late Thursday. Instead, the higher Medicaid rates, which will be in effect for two years, are reserved for family doctors, internists and pediatricians, because those specialties are specifically listed in the 2010 law, the Centers for Medicare and Medicaid Services said. The OB/GYNs and ER doctors sought to be included after regulators released preliminary rules in May saying that internal medicine and pediatric sub-specialists, such as pediatric cardiologists, would be eligible for the higher pay when providing primary care. (Kaiser Health News)

COMPANY NEWS

- **CalOptima Names New CEO, CFO**

  Thursday, CalOptima announced that Michael Schrader had been named the agency's new Chief Executive Officer after an intensive search. Mr. Schrader has extensive experience in leadership positions among plans in the ACAP family. Earlier in October, CalOptima made Michael Ewing's interim appointment as Chief Financial Officer permanent. Ewing leads the Finance, Human Resources and Facilities departments and will continue to oversee all financial matters in his new role as CFO. For more, see CalOptima's statements on the hirings of their new CEO or CFO.

- **Reynolds Steps Down as CEO of NHPRI**

  Mark Reynolds, President and CEO of ACAP-member plan Neighborhood Health Plan of Rhode Island, announced that he would leave NHPRI in mid-November to lead CRICO, a group in Massachusetts that provides malpractice insurance. James Hooley, former CEO of Neighborhood Health Plan and a member of NHPRI's Board of Directors, will serve as interim CEO while Neighborhood conducts a national search for a new CEO.

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
November 1, 2012	Vermont Duals	RFP Released	22,000
November, 2012	Illinois Duals	Contract awards	136,000
November 15, 2012	Nevada	Proposals due	188,000
November 20, 2012	New Mexico	Proposals due	510,000
November, 2012	Michigan Duals	RFP Released	198,600
November, 2012	South Carolina Duals	RFP Released	68,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
November, 2012	Washington Duals	RFP Released	115,000
December 1, 2012	Texas Rural STAR+PLUS	RFP Released	110,000
December 3, 2012	District of Columbia	Proposals due	165,000
December 5, 2012	Idaho Behavioral	Proposals due	200,000
December 19, 2012	Nevada	Contract Awards	188,000
December, 2012	Virginia Duals	RFP Released	65,400
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	Vermont Duals	Proposals due	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January 8, 2013	Arizona - Maricopa Behavioral	Proposals due	N/A
January 15, 2013	Florida LTC	Contract Awards	90,000
January 21, 2013	California Rural	Applications due	280,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	District of Columbia	Contract Awards	165,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
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	Idaho Duals	RFP Released	17,700
March, 2013	Michigan Duals	Contract awards	198,600
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, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Ohio Duals C, WC, SW	Implementation	48,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June 1, 2013	California Duals	Implementation	500,000
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Ohio	Implementation	1,650,000
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
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
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
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
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	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	685,000**	X	3/1/2012	4/4/2012		6/1/2013
Colorado	MFFS	62,982					1/1/2013
Connecticut	MFFS	57,569					12/1/2012
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	Oct.-Nov. 2012		4/1/2013
Iowa	MFFS	62,714					1/1/2013
Idaho	Capitated	17,219	March, 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	Nov.5th 2012	X	4/1/2013
Michigan	Capitated	198,644					1/1/2014#
Missouri	MFFS‡	6,380					10/1/2012
Minnesota	Capitated	93,165					4/1/2013
New Mexico	Capitated	40,000		Cancelled - as of August 17, 2012			
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					1/1/2013
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12		4/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon	Capitated	68,000		Certification process			1/1/2014
Rhode Island	Capitated	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	Nov. 2012		7/30/2013		1/1/2014
Tennessee	Capitated	136,000					1/1/2014
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	Dec. 2012		July 2013		1/1/2014
Vermont	Capitated	22,000	1/7/2013	3/11/2013	4/1/2013		1/1/2014
Washington	Capitated/MFFS	115,000		Feb. 2013	July 2013	MFFS Only	1/1/2014
Wisconsin	Capitated	17,600	X	8/23/2012	10/1/2012		4/1/2013
Totals	**20 Capitated 6 MFFS**	**2.4M Capitated 485K FFS**	***5***			***2***	

** 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…

Tony Rodgers, Principal – Bay Area

Tony rejoins our HMA team as a Principal working out of the San Francisco Bay area in California. He has over 30 years of healthcare executive management experience in public and private health plans, hospital systems, county, state and federal health care agencies. In March 2010, Tony was appointed by the Secretary for Health and Human Services to the position of CMS Deputy Administrator, Center for Strategic Planning. He was charged with establishing this new Center within CMS. The Center is responsible for CMS long range strategic planning, business planning, policy research and formulation, health system performance analysis, healthcare coverage research, program insight reports, and strategic management decision support. Previously, Tony was appointed by Governor Janet Napolitano to the position of Agency Director of the Arizona Health Care Cost Containment System (AHCCCS). In this role he was responsible for the Arizona Medicaid and Children Health Insurance Program. The agency administered multiple sources of governmental and private funds and had regulatory oversight of contracted Medicaid managed care health plans and health care providers. Additionally, Tony was General Manager at WellPoint Health Networks, CEO at LA Care Health Plan, and Chief Executive at Maricopa Integrated Healthcare System. He also has been a member of numerous public commissions and Boards of Directors. Tony holds a Master of Science Public Health degree and BA degree in Economics and Political Science from UCLA. He has held visiting professor appointments at Arizona State University, the W.P Carey School of Business and at UCLA School of Public Health.

Sherry Snyder, Senior Consultant – Harrisburg

Sherry Snyder joined HMA as a Senior Consultant in the Harrisburg office. Sherry has over 30 years of experience in mental health and substance abuse programs at the county, region and state level. She recently served as the acting Deputy Secretary for the Office of Mental Health and Substance Abuse Services in Pennsylvania where she was responsible for the management of a $3.8 billion budget and a staff of approximately 4,000. In this capacity she oversaw a comprehensive statewide behavioral health system, including county based mental health services, six state mental hospitals, a county based Medicaid managed care program, a Behavioral Health Fee-for-Service Program and a state administered drug and alcohol program. Sherry began her career as a mental health case manager. Subsequently she worked in various positions where she had responsibility for developing programs for adults with serious mental illnesses, implementing a statewide system of care management for publically funded drug and alcohol services, convening a consortium of mental health and drug and alcohol systems stakeholders to develop recommendations for program standards, staffing and credentials, training requirements and adolescent issues for dual diagnosis services, chairing the Technical Evaluation Committee for the implementation of mandatory behavioral health managed care in Southwest Pennsylvania, overseeing of mental health and substance abuse services in fourteen county/joinder mental health programs and for supervising a free standing unit with 11 staff. Sherry has also assisted in the consolidation of Pennsylvania state mental hospitals. Sherry earned her Bachelor of Science degree at Juniata College.

HMA Recently Published Research

Key Lessons from Hospitals with Low Readmissions

Sharon Silow-Carroll, MSW, MBA, Managing Principal

Jennifer Edwards, DrPH, Managing Principal

Health Management Associates, with support from The Commonwealth Fund, examined hospitals that achieved exceptionally low readmission rates to identify clinical and operational strategies, as well as the organizational, cultural, and environmental factors that lead some hospitals to create or adopt "best practices" and achieve greater success. We studied four hospitals within the top 3 percent in terms of low readmission rates for at least two of the following: heart attack, heart failure, and pneumonia, as reported to CMS. **Link**

Delivery of Very Low Birth Weight Infants in Georgia: Improving Performance

Donna Strugar-Fritsch, BSN, MPA, CCHP, Principal

Lori Weiselberg, MPH, Senior Consultant

Mark Trail, M.Ed, Managing Principal

The Georgia OBGyn Society contracted with Health Management Associates (HMA) to conduct an analysis of factors contributing to the state's low performance on the national maternal-child health measure related to very low birth weight infants and their delivery hospital within the state's Regional Perinatal System (RPS). The RPS designates and funds six Regional Perinatal Centers (RPCs) across the state. HMA conducted extensive research, including a literature review, interviews with state and national maternal child health and region perinatal system experts, a survey of the state's OBGyn physicians, and analysis of four sources of data on VLBW births to Georgia residents. **(Link to Report - Presented to OBGyn Society of Georgia)**

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. This brief explores options for incorporating community health workers (CHWs) into care management teams as an effective—and cost-effective—approach to achieving the goals of health homes. The brief assesses the roles and tasks CHWs perform that align with the six core services required of health homes and discusses how care management PMPM payments can provide the flexibility to hire CHWs without having to rely on unsustainable grant funding. **(Link to Report - NYS Health Foundation)**

HMA UPCOMING APPEARANCES

Metropolitan Chicago Healthcare Council APRN/PA Educational Summit: *Billing, Reimbursement & Documentation*

Linda M. Follenweider – Presenter

November 30, 2012

Naperville, Illinois