HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CALIFORNIA RURAL MEDICAID MANAGED CARE EXPANSION RFA

HMA ROUNDUP: FLORIDA FINALIZES MEDICAID MCO RATES FOR FY13; DUAL ELIGIBLE DEMO MOU TIMING UPDATES IN CALIFORNIA, ILLINOIS; UPDATED TIMELINE FOR NON-RISK ABD PROGRAM IN GEORGIA; OHIO, INDIANA GOVERNORS ANNOUNCE THEY DO NOT INTEND TO BUILD STATE-BASED EXCHANGES

OTHER HEADLINES: KAISER FAMILY FOUNDATION/URBAN INSTITUTE REPORT ESTIMATES STATE SPENDING ON ACA MEDICAID EXPANSION; HHS ISSUES PROPOSED RULES FOR MEDICAID EXPANSION, INSURANCE MARKET REFORMS

COMPANY NEWS: WELLPOINT ACQUISITION OF AMERIGROUP RECEIVES DOJ APPROVAL; PROVIDENCE SERVICE CORP. CEO TO RETIRE; ACADIA ACQUIRES INPATIENT PSYCH FACILITIES

UPCOMING HMA WEBINAR: THE ECONOMICS OF THE MEDICAID EXPANSION

NOVEMBER 28, 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

---

ATLANTA, GEORGIA • AUSTIN, TEXAS • BAY AREA, CALIFORNIA • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
OLYMPIA, WASHINGTON • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Edited by:
Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: CALIFORNIA RURAL MEDICAID MANAGED CARE EXPANSION RFA

This week, our *In Focus* section reviews the request for applications (RFA) issued by California's Department of Health Care Services (DHCS) to expand Medi-Cal (the State's Medicaid program) to 25 counties in the eastern and northern parts of the State. Under this non-competitive bid, DHCS has stated its intent to contract with any plan proposing to serve at least two contiguous counties that meets all of the pass/fail criteria in the application process. Contracts are to go live as early as June 1, 2013. Below, we review the scope of the applications and highlight some of the key application criteria plans will have to meet. Additionally, we have provided by-county mandatory and voluntary enrollment populations and their current estimated fee-for-service (FFS) spending.

Link to RFA and supporting documents:
http://www.dhcs.ca.gov/provgovpart/Pages/MMCDRuralExpRFADwnld.aspx

RFA Overview

Medi-Cal currently operates managed care programs in 30 counties, predominantly in the western and southern parts of the State. This RFA will expand managed care to 25 counties, leaving only three counties—Lake, San Benito, and Imperial—without managed care programs. The 25 counties represent roughly 170,000 new mandatory Medi-Cal managed care enrollees, more than 50,000 dual eligibles who may voluntarily enroll, and close to 62,000 other voluntary enrollees. This total eligible population of roughly 282,000 accounts for an estimated $1.53 billion in annual FFS Medicaid spending.

Key Application Highlights and Criteria

Applicants must apply to serve a minimum of two contiguous counties and may submit separate applications for multiple contiguous county groupings. DHCS may negotiate alternative county groupings after the application process to ensure sufficient coverage. Successful applicants will provide services under two contracts, a primary contract for federally-reimbursed services and a secondary contract for State-only services. Contracts will go live no sooner than June 1, 2013 for a contract term of five years, with three optional extensions of one year each.

All applicants were required to submit a letter of intent to apply by November 19, 2012 in order to be considered for the application review process.

The narrative application will be evaluated on a pass/fail basis with regards to each narrative requirement. Applicants must pass all of the requirements to be accepted. Several of the requirements indicate a preference for experience in the Medi-Cal program. There are a total of 25 pass/fail narrative sections to be evaluated. Additionally, the RFA indicates that DHCS will give special consideration to plans meeting all of the following requirements:

- Demonstrated experience serving Medi-Cal beneficiaries, including diverse populations;
- Support in form of letter or resolution from the Board of Supervisors of the counties included in the application;

- Support in form of letter or resolution from the plan's governing board or any entity with financial investment in the plan;
- Successful experience with expansion of managed care into a rural area within the past five years; and
- Plan has the lowest administrative costs.

Timeline

Applications are due to DHCS by January 21, 2013 with acceptance notices expected roughly one month later on February 25, 2013.

Timeline	Date
RFA Released	November 5, 2012
Letter of Intent to Apply Due	November 19, 2012
Deadline for Questions	December 3, 2012
Q&A Responses Posted	December 17, 2012
Applications Due	January 21, 2013
Notice of Acceptance/Denial	February 25, 2013
Implementation	June 1, 2013

As per the timeline above, the deadline for LOIs to be submitted was on November 19, 2012. At this time, no list of LOI submissions is available online. However, the RFI respondent table below may provide insight into the likely applicants and their targeted service areas.

RFI Interested Entities

The following plans submitted responses to DHCS' RFI in July 2012, indicating their interest in serving all or a selection of counties under the rural expansion. As noted above, since the time of the RFI, the number of counties has been reduced to 25 and Imperial and San Benito counties are no longer included in the RFA.

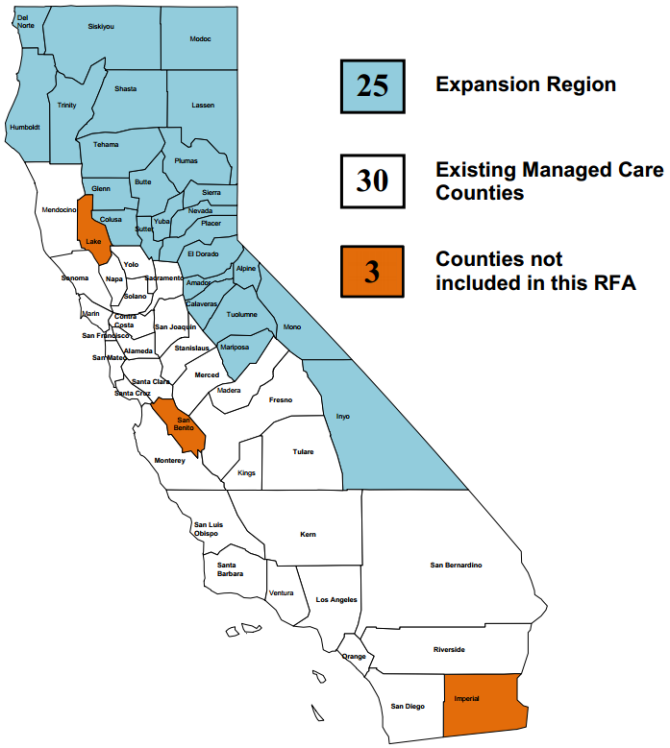
Plan Name	26 Contiguous	Imperial	San Benito	Northern	Central	Border	Other
Anthem Blue Cross	X	X	X	X	X	X	
Care1st	X	X	X	X	X	X	
Blue Shield	X	X	X	X	X	X	
Centene	X	X	X	X	X	X	
Humana	X	X	X				
UnitedHealth	X	X	X				
Meridian Health Plan	X			X	X		
Wellcare	X						
Community Health Group		X					
Molina Health Care		X					El Dorado, Placer
Central CA Alliance for Health			X				
Partnership Health Plan							Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity

Source: http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/MMCDProvRespBreakdown%20v.2.pdf

Population and FFS Spending

County	Mandatory	Voluntary Duals	Voluntary Other	Total Eligible	Annual FFS Spend	Excluded Pop.
Alpine	110	39	45	194	$906,221	2
Amador	2,573	695	852	4,120	$19,538,802	255
Butte	28,075	8,473	10,211	46,759	$265,743,181	2,459
Calaveras	4,065	929	1,159	6,153	$29,531,752	335
Colusa	2,534	621	738	3,893	$14,380,776	623
Del Norte	4,760	1,337	1,633	7,730	$39,376,945	270
El Dorado	10,198	2,833	3,590	16,621	$87,635,722	1,762
Glenn	4,061	952	1,237	6,250	$28,469,436	777
Humbolt	14,157	4,767	5,637	24,561	$139,334,635	1,506
Inyo	1,864	495	575	2,934	$16,853,352	431
Lassen	2,767	730	927	4,424	$21,162,509	221
Mariposa	1,563	463	571	2,597	$13,190,469	165
Modoc	1,033	358	390	1,781	$11,796,658	186
Mono	795	110	150	1,055	$4,530,211	296
Nevada	5,995	1,839	2,205	10,039	$61,203,905	952
Placer	16,032	5,129	6,270	27,431	$159,430,796	2,549
Plumas	1,518	625	755	2,898	$18,427,505	188
Shasta	21,540	7,251	9,175	37,966	$227,157,362	1,577
Sierra	197	124	132	453	$3,748,952	34
Siskiyou	5,410	1,982	2,290	9,682	$43,153,779	549
Sutter	13,075	3,413	4,091	20,579	$96,634,037	2,222
Tehama	9,682	2,656	3,221	15,559	$76,734,797	1,289
Trinity	1,388	574	708	2,670	$12,708,612	95
Tuolumne	4,156	1,431	1,806	7,393	$52,582,074	381
Yuba	12,387	2,587	3,206	18,180	$84,075,408	1,452
Total RFA Counties	**169,935**	**50,413**	**61,574**	**281,922**	**$1,528,307,897**	**20,576**

RFA Counties Map



HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

On November 26, 2012 the California Department of Health Care Services (DHCS) released two draft documents that provide additional details around the integration of long-term services and supports (LTSS) and care coordination for the duals demonstration. Specifically, the documents outline the State's LTSS and its care coordination standards. In conjunction with the release of these documents, DHCS noted that it expects the duals demonstration memorandum of understanding (MOU) to be completed in December at which point readiness review will begin for the participating health plans.

Also this week, MemorialCare Health System in Southern California announced an agreement to purchase specific assets of Universal Care and will file an application for its newly-formed Seaside Health Plan to become a California licensed health plan. Seaside is organized to support managed Medi-Cal members and prepare for the California Children's Services (CCS) demonstration project that addresses the needs of children with certain diseases and ongoing medical conditions. MemorialCare includes six top hospitals—Long Beach Memorial, Community Hospital Long Beach, Miller Children's Hospital Long Beach, Orange Coast Memorial, and Saddleback Memorial Laguna Hills and San Clemente; medical groups—MemorialCare Medical Group, MemorialCare PromptCare and the Independent Practice Association (IPA) Greater Newport Physicians; MemorialCare HealthExpress retail clinics; and numerous outpatient health centers throughout Los Angeles and Orange counties.

In the news

- **Letter from Congress Focuses on Healthy Families Transition**

  California's effort to move approximately 860,000 children from the Healthy Families program has drawn national attention. Twenty-two members of the House of Representatives, including House Speaker Nancy Pelosi (D-San Francisco), last week sent a letter to state health officials, urging caution in the Healthy Families transition to Medi-Cal managed care. The transition is slated to begin Jan. 1 when almost half the Health Families kids -- about 415,000 -- make the switch. The state still needs CMS approval for the plan. (California Healthline)

- **Health Care Special Session Slated for January**

  California's legislative special session on health care won't take place until January, according to officials at the California Health and Human Services agency. Gov. Jerry Brown (D) told legislators in August he will convene a special session in the Legislature "to continue [the] important work of implementing the Affordable Care Act," Brown wrote in a letter to California legislators. The session was expected to be convened in December. The special session will be held concurrently with the regular legislative session that begins Jan. 7. (California Healthline)

Colorado

HMA Roundup – Joan Henneberry and Paul Niemann

Pharmacy and Dispensing Fee Changes: The Medical Services Board gave preliminary approval to a new Medicaid pharmacy rule that changes the way the Medicaid agency pays for pharmaceuticals and dispensing fees. The goal is to reimburse for drugs at cost and to implement a more fair way to reimburse for dispensing drugs. In testimony before the Board, the Department of Health Care Policy and Financing acknowledged they have been overpaying on the drug costs and underpaying on dispensing fees. The proposed rule calls for most pharmacies to be paid for Average Acquisition Costs and for dispensing fees to be based on volume. The Department intends to conduct a "cost of dispensing fee" survey every two years, beginning in summer 2013. They will conduct annual surveys of the pharmacies to collect data on volume of drugs dispensed. Although there has been extensive stakeholder engagement and research prior to the presentation of the rule, representatives from chain and independent pharmacies testified against the change in methodology and asked for more time to review data. The rule will come before the Board again in December for final consideration.

CHP+: Effective January 1, 2013, children of State employees will be eligible to enroll in CHP+ provided they meet income and eligibility requirements. Other changes to CHP+ include a rule change that allows children to be passively enrolled into a Health Maintenance Organization (HMO) if there is more than one HMO option in their county. Choosing an HMO will no longer occur when the family fills out the application; the HMO selection question will be removed from both the online and the paper applications. After a child has been determined eligible for CHP+, the parent or guardian will have 90 days to choose the HMO by calling MAXIMUS, Inc. if they were not placed in the one they wanted.

Health Benefit Exchange Board Meeting: After much discussion and debate, the COHBE Board voted 8 – 0 with one abstention to accept staff recommendations (Link here) for how to use waiting periods to encourage health plan participation and discourage frequent entrance and exit in the Exchange market. The board expressed a desire to ensure a balance of participation of as many plans as possible, particularly in the initial critical years, and helping plans that do participate to be successful long-term in spite of the risks of the initial years. The Board felt that staff's recommendation accomplished that balance as well as anything, so voted to support it. The one abstention was from a Board member who felt there should be a legal review and opinion before making a final decision.

Additionally, the Board voted 9 – 0 to approve the staff recommendation that there be a five-member Appeals Board and process to review instances where carriers should be permitted exceptions to the waiting period rules based on specific circumstances. The only change to the staff's recommended Appeals Board structure was to explicitly state that no Appeals Board members should be insurance industry representatives and, changed from three staff and two Board members to two staff and three Board members, at least one of whom should be a business representative. They noted that they would create at a later time a charter and decide if the Appeals Board should be given actual authority to make determinations about exceptions, or if they would require the Appeals

Board to bring recommendations back to the full board as other advisory groups currently do.

In the news

- **Colorado health insurance exchange expects nearly 1 million customers**

  Colorado's health exchange - due to come online in October, 2013 - is expecting 960,000 customers within three years of startup. The health exchange bill was passed by the legislature and signed into law in 2011. Proponents expect more than half of the customers to use the exchange to cut the cost of their insurance with federal tax credits. Others are expected to buy insurance on the exchange because it will simplify the current, often mind-numbing experience of having to sort through insurance plans with hundreds of variations. (TimesCall)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Final 2012/2013 managed care rates for both non-reform and reform programs were released on November 15, 2012. The final non-reform rate increase across all of the regions and all of the plans for the non-reform program is 2.4 percent, ranging from an 8.1 percent cut in Region 10 to a 13.1 percent increase in Region 8A. The average increase of 2.4 percent compares to the draft rate estimate of -1 percent that was released in September. The biggest change since the draft rates were issued is that the impact of county-funded intergovernmental transfers mitigated the impacted of budgeted hospital cuts more than was forecasted in the draft rates. The State is targeting an 87 percent MLR across all of the regions, which would be consistent with 2011 actual results. The updated non-reform rates will be paid in the next payment cycle and will be retroactive to September 2012. The reform rates reflect an increase of 3.2 percent in the reform pilot areas. The reform rates will also be paid in the next payment cycle but will only be paid for the December enrollment. Retroactive payments to September 2012 will be processed with the payment for the January enrollment.

In the news

- **Florida will pay Medicaid docs at new Obamacare rate**

  Starting Jan. 1, Florida will start paying Medicaid primary care doctors at new, higher rates required by the federal Affordable Care Act, a state spokeswoman said Tuesday. Shelisha Coleman, spokeswoman for the state Agency for Health Care Administration, said some budgetary details need to be worked out with the Legislature and the governor's office, but there was no question that payments will be made. The law requires that for the next two years Medicaid must pay primary care doctors at higher rates. According to a study by the Kaiser Family Foundation, Florida primary care doctors in 2008 were paid 55 percent of Medicare rates, meaning a $50 payment would be increased to $90 under the new system. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The Department of Community Health's (DHC) ABD task force met on Tuesday to provide an update on current delivery system changes under consideration for the aged, blind and disabled population statewide. As we have discussed in the past, the state continues to move toward a non-risk-based model for care coordination, administered statewide by a single vendor. DCH anticipates conducting a competitive selection process beginning in 1Q13, with vendor selection completed by the second quarter and implementation slated for January 2014.

Georgia's unemployment rate fell to 8.7 percent in October from 9 percent in September 2012. The jobless rate has dropped from 9.7 percent a year ago. But it still remains considerably higher than the national rate, currently 7.9 percent. Georgia gained 68,000 jobs, or 1.7 percent, from October 2011.

In the news

- **Health care, budget to be top issues in upcoming Assembly**

  Healthcare concerns, especially issues over the implementation of the Patient Protection and Affordable Care Act, also known as "Obamacare," and the budget are likely to be two of the top issues facing the upcoming 2013 session of the Georgia General Assembly, according to local lawmakers. The legislative session convenes Jan. 14 at the state Capitol, but many of the legislators will be attending the Dec. 9-11 28th Biennial Institute for Georgia Legislators, to be held at the University of Georgia Conference Center in Athens. The event is billed as a session for legislators to explore state issues prior to the upcoming General Assembly session. (Douglas County Sentinel)

- **Grady could have big loss in Medicaid stand-off**

  After years of struggling to climb out of huge deficits and make a modest profit, Grady Memorial Hospital is bracing for a possible $45 million blow that could jeopardize its ability to provide critical care to thousands of uninsured Georgians. Starting in 2014, the federal government plans to cut in half over five years an $11 billion program that helps safety net hospitals such as Grady — many located in some of the nation's poorest urban neighborhoods — defray the cost of caring for uninsured patients. It was assumed the expansion of Medicaid called for by the Affordable Care Act would offset the loss by assuring health coverage to millions of poor, previously uninsured Americans that would at least partially pay for their care. But the U.S. Supreme Court's June ruling on state challenges to the law made the Medicaid expansion optional for states. The Catch-22 has left hospital officials in states that don't plan to expand Medicaid - including Georgia - fearing they will face the cuts while still treating huge numbers of uninsured patients. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo and Matt Powers

On November 27, 2012, the Illinois legislature returned to session. It is possible that legislation will be introduced on the Medicaid expansion. Authorizing legislation needs to ac-

complish three things: (1) lift the moratorium on eligibility expansions, (2) establish the new eligibility category, and (3) set the newly eligible Medicaid benefit package.

At the Illinois Department of Healthcare and Family Services (HFS) Medicaid Advisory Committee (MAC) meeting on November 16, 2012, HFS discussed the dual eligible awards announced the previous week. HFS is hoping to have a memoranda of understanding (MOU) finalized with CMS by end of calendar year; however, it could slip into 2013. As of right now, September 1, 2013 is the tentative start date for voluntary enrollment of dual eligibles into the program, with January 1, 2014 as the start date for passive enrollment. Additionally, HFS is pursuing a waiver to mandate certain duals with long-term supports and services (LTSS) needs to enroll in a health plan for Medicaid LTSS services but still be able to opt out for Medicare services into Medicare FFS or a Medicare Advantage plan.

Additionally, at a recent MAC meeting, the State presented a fact sheet on the Enhanced Eligibility Verification (EEV) program. Under legislation passed this summer, HFS was required to contract with a vendor to verify eligibility and make recommendations to State caseworkers on whether an individual's eligibility should be continued. MAXIMUS Health Services, Inc. was awarded the contract, with HMS as a subcontractor. A link to the fact sheet is available here: Illinois EEV Project Fact Sheet (pdf)

Indiana

HMA Roundup – Cathy Rudd

On November 15, 2012, Governor-elect Mike Pence sent a letter to outgoing Governor Mitch Daniels indicating that he does not believe the State should set up its own Exchange nor does he believe Indiana should pursue a federal-state partnership Exchange. His letter estimates the cost of running an Exchange to be approximately $50 million per year. As a reminder, Daniels had previously deferred the decision on setting up the Exchange to the new governor.

New York

HMA Roundup – Denise Soffel

Consumer's Guide to Managed Long-Term Care: The Department of Health (DOH) has recently published a Consumer's Guide to Managed Long-Term Care (MLTC) in New York City. The guide provides contact information for all the MLTCs operating in New York City, including PACE plans, partial-capitation plans, and Medicaid Advantage Plus. It also provides a score card for each of the plans, grading them on a three-point scale on 10 different variables, including measures for preventive care, improvement and stability, and satisfaction with care. Overall, PACE plans receive the highest scores; partial capitation plans have the lowest scores. The consumer guide can be found on the Health Department web site. Link

Waiver Request to Establish a Storm Recovery Grant Program: DOH submitted a request to CMS to amend its current Federal-State Health Reform Partnership (F-SHRP) Section 1115 waiver to finance a storm recovery grant program. Damage to the health care infrastructure in New York City was extensive. The funds are requested to "provide

emergency cash relief to assist numerous Medicaid providers that have been seriously impacted by Hurricane Sandy." The request for $427 million is Phase 1 of a two-phased approach and is intended to provide an immediate injection of cash to providers impacted by the storm. Phase 2 would focus on longer-term relief for implementation of a comprehensive restructuring plan.

Phase 1 funding includes three levels of cash relief, based on the extent of damage a facility incurred. The cash flow amount is based on DOH estimates of providers' actual average weekly Medicaid payments.

- Facilities that are currently closed and may be decommissioned for the foreseeable future are eligible for three-week cash relief.
- Facilities that were temporarily damaged or lost power or had a significant surge of patients from evacuated facilities are eligible for two-week cash relief.
- Facilities that were not damaged but received a significant volume of evacuated patients are eligible for one-week cash relief.

The table below indicates the amount of funding requested for various types of health care facilities.

Provider Type	Total Funding ($ millions)
Hospitals	197.4
Nursing Homes	79.5
Office for Persons with Developmental Disabilities	54.9
Clinic	31.8
Office of Mental Health	22.0
Home Health (including personal care, ALP, and hospice)	20.0
Office for Alcohol and Substance Abuse Services	4.4
Transportation	2.4
Other	15.0
TOTAL	427.3

Health Home Update: New York State has been in active discussions with CMS regarding implementation of the second and third phases of its Health Home initiative. The State has submitted revisions to its state plan that reflect the program's evolution since implementation of Phase 1 in January 2012. The State continues to operate under the assumption that its original phase-in plan will be approved by CMS, with Phase 2 implementation (13 counties) effective April 1, 2012 and Phase 3 (39 counties) effective July 1, 2012. Billing for Health Home services in Phase 2 and 3 counties cannot begin until CMS has approved the state plan amendment and will require a retroactive rate adjustment for all Health Home services currently being provided.

New York Health Exchange Level 2 Grant Application: On November 20, 2012, New York submitted a Level 2 Exchange Establishment Grant application to CMS. The grant request of $190 million is to support the establishment and on-going development of New York's Exchange through December 31, 2014. This comes on top of the two Level

One awards received by the state, one for $95.5 million on August 23, 2012, and one for $48.5 million on February 22, 2012. New York submitted its Exchange Blueprint to CMS in October of this year, and the state is actively pursuing the establishment of a state-based Exchange that will be ready for operation in October 2013.

NYS has prepared a detailed 5-year budget of Exchange activities, running from 2011 – 2015, totaling $428 million. This includes $125 million in information technology costs, $67 million in staff-related costs, and $236 million in non-IT contractual services (including customer service and back-end operations, outreach and marketing, consumer assistance services and in-person assistors, and an all-payor claims data base). New York received an Early Innovator grant, which they are using to develop the Exchange IT system. Working with CSC, they are building a system that will incorporate six tracks: eligibility, verification, enrollment, plan management, privacy and security, and monitoring and reporting. The Exchange also relies on contractors to accelerate the establishment and implementation process, including support for call center and back-end operations, provided by MAXIMUS, as well as in the areas of market research and policy simulation modeling.

Ohio

HMA Roundup – Alicia Smith

On November 15, 2012, Governor John Kasich sent a letter to Gary Cohen, Director of CMS' Center for Consumer Information and Insurance Oversight indicating that Ohio will not pursue a state-based or partnership Insurance Exchange. Ohio will also continue to regulate its health insurance market and determine Medicaid and CHIP eligibility as it has done historically.

In the news

- **Rise in Medicaid costs slows**

  Reforms of the tax-funded Medicaid program under Gov. John Kasich's administration might be helping rein in costs for the health-care program that insures 2.4 million poor and disabled Ohioans. According to the latest state financial reports, total Medicaid spending is up 2 percent in the fiscal year that began July 1, but that is 2.4 percent less than projected. More precisely, Medicaid spending in this fiscal year has been $5 billion, nearly $121 million less than anticipated. (The Columbus Dispatch)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Pennsylvania's unemployment rate was 8.1 percent in October 2012, down one-tenth of a percentage point from the September rate of 8.2 percent. Pennsylvania added 7,500 jobs in October, bringing the State's jobs count to a total of 5,752,200, the highest level since November 2008.

In the news

- **Cash-strapped Pennsylvania nursing homes are increasingly on edge**

  Across the state, counties that still own nursing homes are saying that declining medical assistance payments have cut into revenue, while costs, including pay and benefits for employees, continue to rise, requiring them to make tough choices on whether to cut back service or find new sources of money. (Tribune-Review)

- **Highmark change catches families off guard**

  When health insurer Highmark Inc. eliminated the costly "private duty" nursing benefit that had been included in its individual health plans, effective Oct. 1, the change threw a handful of families for a loop. Highmark's underwritten individual products -- DirectBlue, PPOBlue high-deductible plan, Advance Blue and Simply Blue -- are used by about 50,000 Western Pennsylvanians. Because the health plans are "medically underwritten" (which means an applicant's health history is investigated before the policy is offered), "this audience is relatively healthy," Highmark spokesman Aaron Billger said. As a result, "we found that virtually no one was using private-duty nursing. By removing the benefit, this reduced premiums by about 0.4 percent." (Pittsburgh Post-Gazette)

OTHER HEADLINES

Alabama

- **Alabama Medicaid faces $30M shortfall, says Public Health director**

Alabama's top health officer says state Medicaid is facing a major funding shortfall. The director of the Alabama Department of Public Health, Dr. Don Williamson, says federal changes will add $30 million to the state's Medicaid funding needs for 2014. The Anniston Star reports that state officials didn't know about the additional cost when voters approved using $437 million from a state fund to plug the Medicaid budget in September. Williamson says the state is looking at the additional money just to keep the program where it is without fundamental changes in the program. About 900,000 Alabamians are now eligible for Medicaid. That's about one in every six residents of the state. Williamson has said Alabama Medicaid will likely switch to a managed-care system to save money. (AL.com)

Connecticut

- **Increased Medicaid demand felt across Connecticut**

The larger-than-expected demand for Medicaid health coverage for needy adults, a contributor to Connecticut's latest budget shortfall, is being felt across the state, according to a review of Department of Social Services statistical reports. Average monthly caseloads in cities and towns during the last three years show the state's three largest cities have the greatest jump in numbers of residents seeking coverage under Medicaid for Low Income Adults or LIA. Nearly 84,000 people across Connecticut are enrolled in Medicaid LIA, thousands more than anticipated. Ben Barnes, the state's budget director, recently told members of the legislature's Appropriations Committee that LIA caseloads for the month of October were 5.4 percent higher than originally budgeted. In addition, demand for other Medicaid services, such as hospital and nursing home care, also has climbed. The Department of Social Services' overall Medicaid budget this fiscal year is nearly $224 million in the red. (Associated Press)

Kansas

- **Still no word from federal officials on KanCare**

With little more than a month remaining before the scheduled launch of KanCare, state officials say they still have not heard from federal authorities when - or if - they will receive the needed approvals for Gov. Sam Brownback's plan to remake the Kansas Medicaid program. KanCare enrollment packets are being mailed to the state's Medicaid enrollees and officials have said they expect all to have received them by the end of this month. CMS officials have a policy of not commenting publicly on the status of 1115 waiver negotiations. Kansas officials have scheduled a statewide teleconference for Wednesday that can accommodate up to 500 participants to describe the proposed program, which would put virtually all the state's 380,000 Medicaid beneficiaries into managed care plans run by three private insurance companies. They also are expected to take comments and questions from Medicaid providers and enrollees. (Kansas Health Institute)

Michigan

- **Michigan legislation would revamp health care claims tax**

  Legislation introduced this month in the Michigan Senate would revamp and potentially increase the state's controversial 1% tax on paid health care claims. Under the legislation, S.B. 1359, the Michigan Department of Treasury would have authority to boost the rate if the amount generated by the tax during the prior year is less than $400 million. During the first six months of 2012, the tax generated $109 million in revenue, according to the Self-Insurance Institute of America Inc. (Business Insurance)

Minnesota

- **Minnesota Facing Bigger Bill For State's Health Insurance Exchange**

  Minnesota's state health insurance exchange will cost $54 million in 2015 to operate, according to the Gov. Mark Dayton administration. The cost comes in at greater than earlier estimates of $30 to $40 million. The state would not have to find the money until 2015, when the state exchanges are required to be financially self-sustaining. But the cost rises to a projected $64 million in 2016. State officials are still weighing how the exchange will pay for itself. Options include user fees, a sin tax, and selling ads. (Kaiser Health News)

Missouri

- **Missouri Republicans are unlikely to expand Medicaid**

  GOP lawmakers are reluctant to spend one dollar in state money for every 19-plus dollars of new federal money if that means expanding Medicaid eligibility in line with the president's health care overhaul. The state has no extra money to spare, they say, so any expansion will likely result in cuts somewhere else, like education. It's a stance that's not playing well with their hometown hospitals, though, who say they badly need more Medicaid dollars as money they get from Washington for caring for low-income patients starts to go away. And now those hospitals are issuing a stark warning: Failure to act could result in some hospitals closing their doors for good. (Kansas City Star)

New Hampshire

- **State's projected savings dwindle as Medicaid project is delayed yet again**

  Another delay in the start of managed care for Medicaid patients could leave a $16 million hole in this year's budget as hospitals and mental health care centers dispute Medicaid reimbursement rates and question the quality of patient care under a new system. But most of the state's hospitals and mental health care centers have yet to sign managed care contracts. Officials in both communities are raising concerns about doing so, especially because several New Hampshire hospitals are suing the state in federal court over current Medicaid reimbursement rates. The hospitals have said those rates are unacceptably low and that the managed care contracts will cut them further. (Concord Monitor)

New Jersey

- **N.J. bill seeks to limit cuts by insurers**

  One of the four private insurance companies that manage the state's Medicaid program is seeking to cut reimbursement rates for home care to the elderly and the sick, but some lawmakers want to limit their authority to do so. State Sen. Loretta Weinberg said she hopes that the Senate will pass legislation next week to require that managed-care companies get written approval from the Department of Human Services to lower homecare reimbursement rates and that a public hearing be held first. Weinberg introduced the legislation in response to pleas from home-health agencies, which expressed concern in September when Horizon NJ Health — the largest of the four managed-care companies that administer the state's Medicaid system — said it would decrease the hourly reimbursement rate for home care from $15.50, to $13.95, a 10 percent drop. Following complaints, Horizon reconsidered and is now planning a 4.5 percent cut. (NorthJersey.com)

North Carolina

- **Budget tweak could put mentally ill on the street**

  Democratic Gov. Bev Perdue and Republicans who control the North Carolina legislature agree it would be tragic for about 1,400 people with serious mental illnesses to lose their homes Jan. 1 because of a one-word change to the state budget. But as the New Year's Day deadline draws near, neither side has indicated how they plan to fix the problem. Advocates for people with mental illness are concerned that many of those affected will get kicked out of group homes in the middle of winter. The issue began when federal Medicaid officials determined the state had not been using the proper criteria to determine who qualifies for monthly checks to cover personal services such as help preparing meals or taking baths. In response, legislators mandated changes under which thousands of people with mental illness living in adult care homes and group homes would no longer qualify for benefits. (News Observer)

Oklahoma

- **Critics decry Oklahoma governor's Medicaid expansion numbers**

  When she rejected federal funding to expand the state's Medicaid system under the Affordable Care Act, Gov. Mary Fallin said buying into the program that would have extended coverage to thousands of uninsured Oklahomans could have cost the state up to $475 million through 2020. But critics of the governor's decision say that her estimate is greatly overstated and includes money the state still may have to pay anyway without making a single additional person eligible for health care coverage. State participation in the Medicaid expansion would have costs, but Fallin's critics point to figures that put the estimated gross cost of Medicaid expansion for seven years between 2014 and 2020 at $157.9 million. Federal government figures suggest the costs could be as low as $120 million - about a quarter of Fallin's number. (Tulsa World)

Texas

- **Texas health care facing big changes, tough spending decisions**

  Gov. Rick Perry has promised to fight tooth and nail against implementing the Affordable Care Act. But that doesn't mean big changes aren't coming to Texas health care, and it won't save lawmakers from facing tough spending decisions. Perry has refused to expand Medicaid, the health care program for the poor. And last week he announced Texas will not set up a federally mandated health care exchange, an online system that allows people to find affordable insurance and lets them know if they are eligible for discounts or subsidies. For the 2014-205 budget cycle, the Texas Health and Human Services Commission that runs the Medicaid program has asked the Legislature for an additional $6.7 billion. Republican leaders, meanwhile, have already pledged to increase the entire state budget by only $7 billion. The Legislature passed an omnibus bill last year that prompted officials to apply for what is called a transformation waiver. The new state law allows doctors, clinics and hospitals to work together more closely and for state officials to pay hospitals more for providing better, more efficient care. Federal officials granted a waiver allowing the experiment. The state is currently supervising the creation of Regional Healthcare Partnerships across the state that will allow for coordinated care as well as improving access and quality. These partnerships will also provide greater compensation to hospitals that develop innovative ways that lower costs and improve treatment. The biggest changes are coming to the Rio Grande Valley, where the state is implementing managed care for Medicaid. That means people in the program must now sign up with private companies who will manage their benefits rather than state officials. A key part of implementing managed care was overhauling how the state reimburses hospitals for the indigent. The new waiver makes sure that hospitals continue to receive funding for treating indigent, single adults who do not qualify for Medicaid in Texas. (Dallas News)

Wisconsin

- **Firm that gives rides for Medicaid patients to end contract with state**

  LogistiCare, the Atlanta-based company providing medical rides for Wisconsin's Medicaid patients since last year, will terminate its three-year contract with the state in February, officials announced Wednesday. The company is providing more rides than expected, especially in the Milwaukee area where volume is double what was projected, CEO Herman Schwarz wrote in a letter to state officials Friday. Clients complained of long waits and no-shows, especially in southeast Wisconsin. (Wisconsin State Journal)

National

- **States Face Higher Medicaid Costs Even if They Don't Expand Program, Kaiser Report Finds**

  State officials who are hoping to avoid high Medicaid costs from the health care law by not expanding the program might be in for an unpleasant discovery: Other Medicaid-related mandates in the overhaul will mean higher state spending regardless of whether a state expands, according to a state-by-state analysis the nonpartisan Kaiser Family Foundation released Monday. The report shows that if all states expand coverage, as allowed under the 2010 health care law, they would collectively spend $76 billion more

from 2013 to 2022 on Medicaid than if the measure had never been enacted. That's only about $8 billion more than states would pay under the law if none of them expand. Most of the increase in Medicaid spending over the decade will come even if a state chooses not to broaden coverage. That's because millions of people who are already eligible for the program are expected to sign up in 2014 when there's likely to be massive campaigns to tell people about the new law. States also will have to spend more money updating their IT systems, changing their enrollment and eligibility procedures and helping people understand the new system, which is supposed to allow for seamless coverage. The report also suggests that state costs for expansion would be modest compared to the amount that the federal government would pay. That $8 billion in additional investment would allow states to draw $800 billion more in federal funding than they would get under the law, if no states expanded. Moreover, the report finds that some states would actually save money on the expansion, considering that they would have fewer uncompensated care costs to fund. States and localities bear about 30 percent of the costs of uncompensated care when uninsured patients don't pay all of their medical bills. The report estimates that nationally, state and local spending on uncompensated care would decline by $18 billion — turning the total $8 billion cost to states under expansion into $10 billion in savings. (CQ Healthbeat)

- **Obama Administration Rolls Out Proposed Rule on Insurance Market Changes**

  The long-anticipated next steps in a complicated regulatory dance involving the federal government, states and health insurers were laid out by the Obama administration on Tuesday, and federal officials acknowledged that there is much more work ahead. The 131 pages of proposed rules overhauling individual and small-group coverage in the health insurance market carry out the health care law's overarching aim of making sure that, beginning in January 2014, sick people who have been denied coverage in the past are able to buy health policies. And the states, which are responsible for regulating insurance, will have to adopt the Department of Health and Human Services regulations. States also will have to make sure that coverage is priced fairly and is accessible. (CQ Healthbeat)

- **Essential Health Benefits Proposal Gives States Flexibility, Expands Prescription Drug Requirements**

  After months of delay, the Centers for Medicare and Medicaid Services on Tuesday released a proposed rule that establishes the essential benefits that health insurance plans must offer under the health care law. The proposed rule also included standards on how the actuarial value of plans would be determined. Separately, the Centers for Medicare and Medicaid Services issued a guidance to states on the types of benefits that Medicaid programs must include if they expand coverage under the health care law. Under the essential benefits proposed rule, health plans in the individual and small-group markets — both in and outside of the new exchanges — would have to provide coverage in the 10 categories of services that the health care law requires. (CQ Healthbeat)

- **HHS Proposes Coverage Rules for Medicaid Expansion**

  Amid a flood of new Affordable Care Act (ACA) regulations following President's Obama's reelection, the U.S. Department of Health and Human Services (HHS) has outlined for the first time the coverage that states must offer new Medicaid enrollees if they decide to expand the program under the law. Most of the newly eligible enrollees will be childless adults, a population not covered by many states' current Medicaid programs. So, if states expand, they'll have to design a new benefit plan for that new population. HHS also explained how states can make sure those new Medicaid plans satisfy the ACA's requirements for essential health benefits (minimum coverage limits in 10 core areas) that will apply to all health insurance plans. Here's how they can do it, according to a letter that Cindy Mann, director of the HHS Center for Medicaid and CHIP Services, sent to state Medicaid directors Tuesday:

  - First, as under the Social Security Act, states can choose a Medicaid benchmark plan as a baseline for the new population's coverage, as they have already done for existing Medicaid plans. The potential benchmarks are: the federal employee health plan, the state employee health plan, the largest HMO plan in the state or a state-designed plan that is approved by HHS.
  - Conveniently, three of those potential Medicaid benchmarks (the federal employee plan, the state employee plan and the HMO plan) are also essential health benefits benchmarks under other HHS guidance. So, if a state selects one of those as its Medicaid benchmark, HHS will consider the broader essential health benefits requirements to be met.
  - If a state goes with a state-designed, HHS-approved plan, however, the state will still select an essential health benefits benchmark and then add any coverage from that benchmark to its new Medicaid plan that's needed to ensure the essential health benefits requirements are met.

  States can begin submitting their Medicaid benchmarks in the first quarter of 2013. The new Medicaid coverage plans will be in effect during the first year of the expansion (through Dec. 31, 2015), and then HHS will evaluate whether any changes need to be made. (Governing Magazine)

COMPANY NEWS

- **U.S. allows WellPoint-Amerigroup deal after unit sale**

  WellPoint Inc can move forward with its $4.5 billion purchase of health insurance rival Amerigroup Corp after Amerigroup alleviated antitrust concerns by selling operations in Virginia, the U.S. Justice Department said on Wednesday. Without the sale, the combined company would have had a monopoly in the northern Virginia suburbs outside Washington, the Justice Department said. The companies announced the deal in July, betting the U.S. government would expand its Medicaid program for the poor as part of President Barack Obama's health insurance overhaul. The Justice Department said it was concerned about consolidation in northern Virginia because WellPoint and Amerigroup were the only two providers of Medicaid managed care plans there. The sale of Amerigroup's Virginia unit to Inova Health System Foundation ensured that competition in the market will continue, the department said. The Virginia Attorney General's office worked with federal officials on their review. (Reuters)

- **Providence Service Corporation Announces Executive Leadership Changes**

  The Providence Service Corporation, a leader in home and community based social services and non-emergency transportation services management, today announced that Fletcher Jay McCusker, the Company's Chief Executive Officer, will retire from the Company to pursue other interests by the end of the year. Effective immediately, Warren Rustand, currently Providence's Lead Director, has been appointed Interim Chief Executive Officer. Mr. McCusker will also step down from his role as Chairman of the Board of Directors and as a director. Christopher Shackelton, Managing Partner at Coliseum Capital Management, one of the Company's largest shareholders, and a director of the Company, will become Chairman of the Board. (Providence Service Corp. Press Release)

- **Acadia Healthcare Announces Two Agreements to Purchase Eight Inpatient Psychiatric Facilities with Over 600 Beds**

  Acadia Healthcare Company, Inc. announced two agreements to purchase an aggregate of eight inpatient psychiatric facilities with approximately 600 beds. The Company has agreed to purchase Behavioral Centers of America, LLC, which is headquartered in Nashville, TN, for total consideration of $145 million in cash. BCA operates three inpatient psychiatric facilities and one psychiatric hospital within a hospital. The facilities are located in Ohio, Michigan and Texas and have 278 licensed inpatient beds, over 90% of which are acute inpatient beds. The facilities produced revenues of $60.5 million for the twelve months ended September 30, 2012. Acadia expects to complete the transaction, which is subject to customary closing conditions, in late December 2012. The Company also has agreed to acquire AmiCare Behavioral Centers, headquartered in Fayetteville, AR, for total consideration of $113 million in cash. AmiCare operates four inpatient psychiatric facilities in Arkansas that have 330 licensed inpatient beds, nearly 70% of which are acute inpatient beds. The facilities produced revenues of $61.7 million for the twelve months ended September 30, 2012. Acadia expects to complete the trans-

action, which is subject to customary closing conditions, in late December 2012. (Acadia Healthcare Press 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
TBD	South Carolina Duals	RFP Released	68,000
TBD	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
TBD	Michigan Duals	RFP Released	198,600
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
TBD	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	Massachusetts Duals	Implementation	115,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
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	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
September 1, 2013	Illinois Duals	Implementation	136,000
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
TBD	Michigan Duals	Implementation	198,600
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	11/9/2012		Fall 2013
Iowa	MFFS	62,714					1/1/2013
Idaho	Capitated	17,219	Mar-13	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	4/1/2013
Michigan	Capitated	198,644	TBD	TBD	TBD		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	TBD	TBD	TBD		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	Early 2013		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	TBD	TBD	TBD	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.

UPCOMING HMA WEBINAR

The Economics of the Medicaid Expansion

Friday, November 30, 2012 – 2:00 PM Eastern

Leading independent Medicaid policy and financing experts Jack Meyer, Vern Smith, and Kathy Gifford offer objective perspective on the direct and indirect fiscal considerations of the Medicaid expansion under the Affordable Care Act (ACA). **(Register here)**

HMA RECENTLY PUBLISHED RESEARCH

Key Lessons from Hospitals with Low Readmissions

Sharon Silow-Carroll, MSW, MBA, Managing Principal
Jennifer Edwards, DrPH, Managing Principal

HMA, 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. HMA 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**

HMA UPCOMING APPEARANCES

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

Linda M. Follenweider – Presenter

November 30, 2012

Naperville, Illinois