HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS ISSUES DUAL INTEGRATION GUIDANCE

HMA ROUNDUP: FEDERAL EXCHANGE RULES RELEASED; CALIFORNIA BASIC HEALTH PLAN BILL STILL ALIVE, ON HOLD UNTIL AUGUST; FLORIDA REVIEWING PUBLIC HOSPITAL FUNDING; ABD ROLLOUT CONTINUES IN ILLINOIS; INDIANA GETS SET TO REBID PBM CONTRACT

OTHER HEADLINES: KENTUCKY AWARDS MANAGED CARE BIDS TO COVENTRY, CENTENE AND WELLCARE, RENEWS WITH PASSPORT; KANSAS MEDICAID REFORM GAINS MOMENTUM; BCBS SAYS MICHIGAN CLAIMS TAX WOULD COST CONSUMERS $100M; UTAH PURSUES CMS WAIVER FOR ACOS; VERMONT ISSUES DUAL ELIGIBLE INTEGRATION RFP

HMA WELCOMES: MELISSA CORRADO JOINS OUR NEW YORK OFFICE

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JULY 13, 2011

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

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IN FOCUS: CMS DUAL INTEGRATION GUIDANCE

This week, our *In Focus* section reviews three announcements made last Friday, July 8, by the Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office. The most prominent announcement was that of a demonstration program to test two new financial models – a capitated model and a managed fee-for-service model – to coordinate care for individuals enrolled in both Medicare and Medicaid. We review these two models, as well as the next steps for states. Second, the administration announced a demonstration program to improve care quality for nursing facility patients. Last, CMS announced a technical resource center to provide assistance to states in integrating care for dual eligible individuals.

Combined state and federal spending for dual eligible individuals exceeds $300 billion annually, with close to half of that in Medicaid spending ($120 billion in FY 2007[1]). Dual eligible individuals make up 15% of Medicaid enrollees, but consume 39% of Medicaid spending; they comprise 16% of Medicare enrollees, while consuming 27% of Medicare expenditures.[2] The ability to coordinate care and achieve meaningful savings within this population represents a significant opportunity to reduce overall health care expenditures for both states and the federal government. The Medicare-Medicaid Coordination Office, headed by former Indiana Medicaid Director, Melanie Bella, has repeatedly reiterated their commitment to aggressively pursue care coordination and integration in the dual eligible population.

In our previous *In Focus* sections, we have highlighted the design of the CMS dual integration grants, as well as reviewed proposals from California, Michigan and Tennessee. For copies of the overview, California and Michigan weekly (March 30, 2011) or the Tennessee proposal weekly (June 22, 2011), please contact Greg Nersessian at gnersessian@healthmanagement.com.

Dual Integration Financial Models

In December 2010, CMS announced the State Demonstrations to Integrate Care for Dual Eligible Individuals, a competitive solicitation for proposals to design person-centered models that coordinate primary, acute, behavioral and long-term supports and services for Medicare-Medicaid enrollees. In reviewing the initial state proposals for dual integration projects, CMS has confirmed that a key factor in the implementation of care integration and care coordination models for dual eligible individuals will be the ability to test and apply new payment and financing models. In a letter to state Medicaid directors, issued Friday, July 8, 2011, CMS offers two financial models that the federal government is highly interested in implementing in cooperation with state Medicaid agen-

[1] Kaiser StateHealthFacts.org, "Distribution of Medicaid Spending for Dual Eligibles by Service (in millions), 2007"

[2] CMS State Medicaid Directors Letter, July 8, 2011. Available at: https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

cies. These payment and financing models are intended to promote better care and align incentives for improving care, as well as lowering costs to both States and the federal government. We note that these models are not only available to the 15 states[3] awarded $1 million dual integration project design grants, but to any other state that demonstrates it can meet the established standards and conditions, as well as be ready to implement a demonstration financial model by the end of 2012.

Capitated Model

The first proposal put forth in the CMS letter is intended to take advantage of state experience in utilizing capitated managed care models within the Medicaid population. CMS notes that of current dual eligible care coordination systems, the most integrated programs utilize a capitated funding arrangement, citing the success of the Program of All Inclusive Care for the Elderly (PACE) and managed long-term care programs in Medicaid.

Under this design model, states, CMS, and health plans will enter into a three-way contract, under which managed care plans will receive a blended capitated rate for the full continuum of benefits provided across both Medicare and Medicaid. Blended rates will be set to target aggregate savings to both states and the federal government. CMS states that managed care plans will be required to meet established quality thresholds. Plans will be bid through a joint procurement by states and CMS, and the state Medicaid directors letter indicates a preference toward plans that have demonstrated the capacity to provide Medicaid and Medicare services to plan enrollees.

While this model creates a significant potential for an expanded dual eligible population in managed care, we note a major limitation of the CMS capitated model design: voluntary or opt-in/opt-out enrollment for the Medicare benefit. As long as Medicare benefit enrollment is voluntary and enrollees may opt-in and opt-out an any time, we believe there is a significantly reduced chance that states or managed care plans will participate in this model. In most of the CMS approved dual integration design proposals, states proposed mandatory Medicare benefit enrollment, or at least instituted opt-out requirements. It will be key to watch if the CMS capitated model supersedes state design proposals and eliminates the mandatory enrollment requirements, or if CMS relaxes the voluntary Medicare benefit enrollment requirement. We note that the 15 states awarded CMS design grant funding are not guaranteed implementation of their dual integration proposals and this issue may prove a sticking point between states and CMS.

Managed FFS Model

The second financial model proposed in the letter to state Medicaid directors builds on the existing FFS delivery system, expanding on the foundation of care coordination many states have already built into their Medicaid FFS payment systems. CMS highlights primary care delivery systems with a heavy focus on care coordination, such as accountable care organizations (ACOs) and Medicaid health home models.

[3] California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin

Under a managed FFS model, CMS will establish a retrospective performance payment system, under which states will receive performance payments based on Medicare savings net of federal Medicaid costs. This model requires upfront investment in care coordination, with savings determinations made by the CMS Office of the Actuary. This model may prove appealing to states who have already invested in their Medicaid care coordination infrastructure, as well as states that have historically been less inclined to pursue arrangements within the capitated managed health care plan structure.

Next Steps for States and Timeline

Interested states are asked to submit a letter of intent to CMS by October 1, 2011. This deadline provides a 15 month window within which states must work with CMS to design and implement a new payment and financing model by the end of 2012. For states pursuing the capitated model, this means we could expect to see CMS and states jointly issuing RFIs and RFPs for managed care plan bids in early to mid-2012.

As noted above, states must meet certain standards and conditions established by CMS for either of the two payment model designs. While the CMS letter states that these will be forthcoming to interested states, and will vary depending on the payment model pursued, the following points will be included in memorandum of understanding between a state and CMS:

- Integrated care management across primary, acute, behavioral health and long-term care;
- Enrollment targets and outreach initiatives;
- Estimated savings, certifiable by CMS Office of the Actuary;
- Integrated beneficiary level claims data to inform program management and evaluation;
- Adequate access to medical and support networks, quality measurement and oversight infrastructure; and
- Public notice and meaningful stakeholder/consumer engagement.

Improving Nursing Facility Care Quality

The Center for Medicare and Medicaid Innovation, in collaboration with the Medicare-Medicaid Coordination Office, will establish a new demonstration focused on reducing preventable inpatient hospitalizations among residents of nursing facilities. This initiative supports the Administration's Partnership for Patients goal of reducing hospital readmission rates by 20% by the end of 2013.

CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 150 nursing homes Interventions could include using nurse practitioners in nursing facilities, supporting transitions between hospitals and nursing facilities, and implementing best practices to reduce the likelihood of the most common causes for unnecessary hospitalizations.

The intervention will be targeted to nursing facilities with high hospitalization rates and a high concentration of dual eligible residents.

CMS Technical Resource Center

The Centers for Medicare & Medicaid Services announced it is establishing a resource center to assist States in delivering coordinated health care to high-need, high-cost beneficiaries. This resource will provide technical assistance to States at all levels of readiness to better serve beneficiaries, improve quality and reduce costs.

The resource center will assist the CMS Medicare-Medicaid Coordination Office and the Center for Medicaid, CHIP and Survey & Certification as they work with States to more effectively promote innovative approaches to delivering coordinated health care to beneficiaries including those with chronic conditions and/or eligibility for both the Medicare and Medicaid programs.

The focus will be to provide technical assistance to States in promoting seamless coordinated care and reducing costs to achieve positive individual and population outcomes. The Resource Center will provide technical assistance to States at all levels of readiness.

Examples of the types of assistance that will be provided by the Resource Center include:

- Conducting needs assessment and gap analysis to identify opportunities for improvement in States' existing healthcare delivery systems;
- Providing technical assistance in areas including program design, stakeholder engagement, data, and health information technology;
- Facilitating sharing of best practices across States; and
- Developing resources to support States' efforts to coordinate primary, acute, behavioral health, and long-term supports and services for high-need, high-cost individuals, including Medicare-Medicaid enrollees.

Specific resources will be available to States interested in participating in the newly announced demonstration to test financial models to support care coordination for Medicare-Medicaid enrollees, States considering the health home option under Medicaid, and the fifteen States participating in the State Demonstrations to Integrate Care for Dual Eligible Beneficiaries design contract.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

The Basic Health Plan bill passed out of assembly health committee, but still faces a significant hurdle in the assembly appropriations committee. The bill would create a plan with an essential benefits package for individuals with incomes above Medicaid eligibility, but still below 200% of poverty. The plan would also cover low-income legal immigrants excluded from Medicaid coverage. We believe the committee will take up the bill

in August. Additionally, the legislature has to move the hospital fee and MCO premium tax though the House and Senate.

In the news

- **Adult day health care still endangered, despite new funding**

  Money set aside in California's newly approved budget for the Adult Day Health Care program provides little to no assurance that the program will continue to exist. The existing program will still be eliminated later this summer, and a new program that is supposed to replace it faces an uncertain fate. After resisting at first, Gov. Jerry Brown has approved the amount the Legislature set aside to create the new program. But the final budget language does not include plans to use the funds for that purpose. Instead, the budget summary states that the $85 million was allocated to provide funding to transition current program recipients into alternative services. (HealthyCal.org)

- **Assembly Committee Approves Basic Health Bill**

  This week, the Assembly Committee on Health approved a bill to establish low-cost health coverage for as many as 800,000 low-income Californians. For a program that could pull a substantial number of expected participants out of the California Health Benefit Exchange, there has been surprisingly little resistance to it. The Basic Health Program would establish an alternative to the exchange's coverage for two sets of Californians -- adults with income between 133% and 200% of the federal poverty level, and for legal immigrants with income below 133% of the poverty level. (California Health Line)

Florida

HMA Roundup – Gary Crayton / Elaine Peters

The Florida Commission on Review of Taxpayer Funded Hospital is considering "whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health-care access for the poor." Created by an executive order by Gov. Scott, the Commission will submit a report with findings and recommendations to the Governor and Legislature by January 1, 2012. The study will inform decision making on the continued taxpayer funding of public hospitals, or if private hospitals can effectively care for low-income Medicaid and uninsured populations. The Commission has already met twice and will have its third meeting on July 20, 2011.

Georgia

HMA Roundup – Mark Trail

The state is expected to announce a notice of intent to award the Medicaid design consultant contract yet this week. Additionally, the non-emergency medical transportation (NEMT) bid is still under evaluation, with a notice of intent expected in the next two weeks. Last, we expect the state to issue an RFP for the redesign of the state's eligibility system in early Fall.

On the issue of Medicaid rates, the state is still working with its actuaries to set rates after an adjustment to enrollment numbers.

The Governor's Exchange Committee met for the second time on Tuesday, July 12. The meeting included presentations on other state health insurance exchange models. The next Committee meeting is set for August 16, 2011.

In the news

- **State exchange panel considering options**

  A Georgia committee Tuesday discussed the pros and cons of building a health exchange, a day after new rules from the federal government loosened the deadlines that states face on creating these online insurance marketplaces. State officials, meanwhile, said they are analyzing the federal exchange rules that were released Monday. The committee is expected to present a report to the governor in September on whether Georgia should create its own exchange or leave the task to the federal government. If the decision is for the state to craft its own, then the committee would work on proposing a structure. At the Georgia meeting Tuesday, committee members discussed the benefits and risks of an insurance exchange. (Georgia Health News)

- **State in a bind on Medicaid funding**

  Facing the addition of hundreds of thousands of new enrollees to Georgia's Medicaid system, the state is re-examining the program — searching for more cost-effective ways to provide care. Medicaid is already facing a $180 million shortfall this fiscal year; meanwhile, officials say the 600,000-plus people expected to join its rolls under the federal health care overhaul starting in 2014 could cost the state an additional $2.1 billion by the end of this decade. Medicaid and PeachCare for Kids currently provide health care to roughly 1.7 million low-income Georgians. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The suburban Chicago managed care rollout continues with enrollment up to roughly 12,000 enrollees, split evenly between the two offered plans, Aetna Better Health and IlliniCare (Centene). Enrollment is expected to reach 38,000.

The Medicaid Advisory Committee's (MAC) subcommittee on the state's patient centered care model (PCCM) meets next Tuesday, July 19. The focus of the subcommittee is on the state's PCCM program's role in the state Medicaid reform requirement that 50% of Medicaid enrollees be in a care coordination program. Look for a report next week on the MAC subcommittee meeting.

In the news

- **Quinn-Backed Budget Means 5-Month Delay in Illinois Medicaid Payments**

  Illinois Gov. Pat Quinn's recently signed state budget, which includes $276 million in Medicaid cuts to hospitals, would mean a five-month delay in payments, according to an Illinois Statehouse News report. Though Illinois lawmakers proposed a 2012 budget that would have delayed Medicaid payments by 110 days, Gov. Quinn's order to cut

Medicaid spending would push back payments to 162 days, according to the news report. A spokeswoman for Gov. Quinn said Illinois safety net hospitals would be protected, though she did not disclose how much sooner those facilities would be paid. Danny Chun, spokesman for the Illinois Hospital Association, said the IHA prefers a longer payment cycle over the alternative, which was cutting Illinois' already low reimbursement rates even more, according to the news report. (Becker's Hospital Review)

- **Hospitals: State's delay in Medicaid payments will hurt**

  Hospitals already waiting for Medicaid payments will have to wait a little longer under an order signed this week by Gov. Pat Quinn that will reduce the payments by $276 million. Quinn's cuts will push Medicaid bills out into the next fiscal year, thereby extending the payment cycle to 162 days. Advocate Health Care voiced concerns that the extended payment cycles could lead to access impediments for Medicaid beneficiaries. (Northwest Herald)

Indiana

HMA Roundup – Cathy Rudd

The state held a public session on a RFI to rebid the state's pharmacy benefit management (PBM) contract. The state held individual meetings with the following vendors: HP, ACS, Goold, Magellan, EnvisionRxOptions. The RFP will likely be released this Fall. Services expected to be included are : pharmacy claims processing, pharmacy audit services, pharmacy prior authorization, PDL, preferred diabetic monitor rebate, drug utilization review, drug rebate, diabetic test strip rebate.

The incumbent PBM, ACS, does not perform pharmacy claims processing or auditing, currently handled by other vendors. The current contract had an initial term from April 2007-June 30, 2010 for $16M. It was extended for a 3 year term through June 30, 2013. At roughly $5M per year for each of the 3 extension years. Given that ACS is not processing claims or doing audits, we expect the contract awarded through the procurement will be higher. However, the State is not specifying an amount at this point.

In the news

- **Judge blocks Indiana from cutting Medicaid Rx fees**

  A federal judge has temporarily blocked Indiana from cutting the fees it pays pharmacists for dispensing Medicaid prescriptions by 38 percent. Judge Tanya Walton Pratt of the U.S. District Court in Indianapolis ruled that the Indiana Family and Social Services Administration acted in a "premature" fashion when it cut the dispensing fee from $4.90 to $3 on July 1 before the reduction was approved by the U.S. Department of Health and Human Resources. The judge also wrote that the reduction would cause many pharmacies to "continue to hemorrhage dollars" and affect their ability to continue providing Medicaid services. (Indy Star)

United States

HMA Roundup – Lillian Spuria

The big news out of the federal government this week was the anticipated release of the first set of federal rules on state health insurance exchanges. One of the key initial take-away points is that HHS appears to have eased on a strict deadline of state readiness and may grant approval to states that do not fully meet guidelines for exchange readiness, but are close to ready and will be expected to fully meet guidelines by implementation date. Much more discussion and analysis is expected of the rule in the coming weeks.

In the news

- **'Flexibility' may help states meet key part of health-care law**
- Faced with the possibility that many states may not be ready to meet a crucial requirement of the federal health-care law passed last year, the Obama administration has proposed rules redefining what "ready" means. The regulations proposed Monday address that issue by trading the club of federal intervention for the carrot of increased "flexibility." States that are not quite on track but at least appear likely to have their exchanges operational by 2014 could get "conditional approval" of their plans; states that have only some of the pieces in place would be able to create partnerships that draw on the federal versions of, for instance, IT systems; and states that initially cede full control to the federal government could still establish exchanges down the line. (Washington Post)
- **Report: Systems designed to catch billions of dollars in Medicare, Medicaid fraud inadequate**

  The federal government's systems for analyzing Medicare and Medicaid data for possible fraud are inadequate and underused, making it more difficult to detect the billions of dollars in fraudulent claims paid out each year, according to a report released Tuesday. The Government Accountability Office report said the systems don't even include Medicaid data. Furthermore, 639 analysts were supposed to have been trained to use the system — yet only 41 have been so far, it said. (Washington Post)
- **July 9, 2011 letter - Medicaid reductions**

  The National Governors Association wrote to President Obama and Congressional leaders urging them not to cut Medicaid funding to states or transition Medicaid costs to states though a blended matching rate or similar proposal. The full letter is available here: (National Governors Association)
- **First Study of Its Kind Shows Benefits of Providing Medical Insurance to Poor**

  When poor people are given medical insurance, they not only find regular doctors and see doctors more often but they also feel better, are less depressed and are better able to maintain financial stability, according to a new, large-scale study that provides the first rigorously controlled assessment of the impact of Medicaid. While the findings may seem obvious, health economists and policy makers have long questioned whether it would make any difference to provide health insurance to poor people. (New York Times)

OTHER HEADLINES

Idaho

- **Medicaid recipients sue Idaho in federal court**

  Two men with developmental disabilities and their guardians are suing the state over changes to Medicaid's residential habilitation program, saying Idaho is violating their right to freely choose providers. Since certified family homes became a part of Idaho's Medicaid program in the mid-1990s, the people running the certified family home providers were able to pick from a few dozen residential habilitation agencies. But earlier this year, the Idaho Department of Health and Welfare decided to contract with just one agency in an effort to save money. Starting next month, Community Partnerships of Idaho will be the only residential habilitation program coordinator that certified family homes can use under the Medicaid program. (Idaho Statesman)

Louisiana

- **Pick for La.'s Medicaid work protested**

  A company with ties to the state's health secretary low-balled the cost it gave for handling the state's Medicaid claims processing work, a competitor alleged in a protest of the contract award. ACS State Healthcare, one of the competitors, claims in recently filed documents that CNSI stated it would perform certain required work, then failed to budget personnel and dollars to do the jobs the contract required. State officials have said repeatedly that CNSI's low price tipped the scales toward the Maryland company winning the contract. CNSI submitted a $184.9 million cost over the 10-year contract period. ACS came in second on price at $238 million while Hewlett Packard ES was the highest cost at $394 million. (The Advocate)

Kansas

- **Kansas seeks ideas for Medicaid reform in Dodge City**

  If Kansas doesn't reform its Medicaid program, the state could face a $900 million budget deficit by 2016. Officials are seeking ideas for improving the quality of care under Medicaid while reining in costs, which have doubled in the past 10 years and are expected to reach $2.8 billion in fiscal year 2011, according to the Kansas Health Institute. The state will be responsible for covering about $1.1 billion of the cost. (Dodge Globe)

- **Kan. governor says cut in Medicaid rates possible**

  Gov. Sam Brownback wouldn't rule out cutting payments to Kansas health care providers under the state's Medicaid program, and he defended his administration's recent decision to close nine social services offices, including a site in one of the state's largest communities. Brownback said he's waiting to see what proposals emerge from public meetings this summer on overhauling the Medicaid program, which covers medical services for the poor, disabled and elderly. He also said his goal remains cutting administrative costs without denying services to the more than 300,000 Kansans currently covered by the program. (Forbes)

Kentucky

- **Most Ky. Medicaid recipients will choose a company to manage their care**

  Private companies will manage care for the vast majority of Kentucky's 815,000 recipients of Medicaid, the health insurance program for the poor and disabled that has been a financial nightmare for the state, Gov. Steve Beshear announced Thursday. Starting in October, Medicaid recipients in much of the state will choose among three companies that will compete to manage their care. A massive education program must start immediately, advocates said after the announcement. The three new contracts were awarded to:

  1) CoventryCares of Kentucky, a division of Coventry Health and Life Insurance Co., a subsidiary of Coventry Health Care Inc. Coventry companies provide Medicaid managed-care services in eight states: Florida, Maryland, Michigan, Missouri, Nebraska, Pennsylvania, Virginia and West Virginia.

  2) Kentucky Spirit Health Plan, a subsidiary of Missouri-based Centene Corp., which has 27 years' experience managing Medicaid plans. It provides services in 12 other states: Arkansas, Arizona, Florida, Georgia, Illinois, Indiana, Maryland, Mississippi, Ohio, South Carolina, Texas and Wisconsin.

  3) WellCare of Kentucky, a part of WellCare Health Insurance of Illinois, which serves 2.2 million members in seven states: Florida, Georgia, Hawaii, Illinois, Mississippi, New York and Ohio.

  An annual contract with Passport, which had been Kentucky's only managed care provider, has been renewed. (Kentucky.com)

Massachusetts

- **Hospitals in Mass. feel fiscal squeeze**

  Massachusetts hospitals are buckling under growing financial strains, with 16 - nearly a quarter of them - losing money last year, according to a new state report. Thirteen hospitals in the state also suffered losses in 2009, but the deficits at many of them widened in 2010, the report from the state Division of Health Care Finance and Policy showed. Thirty others managed only modest profits last year. (Boston Globe)

Michigan

- **Mich. consumers likely to see effect of health claims fee, but state would gain Medicaid funds**

  Michigan residents with health insurance could get hit this fall with a premium increase tied to a new assessment on health insurance claims. The assessment is intended to raise $400 million the state can use to draw $800 million in federal funds for Medicaid, two-thirds of which is paid for by the federal government. Not passing the assessment could tear a $1.2 billion hole in the Medicaid budget, which provides health care for nearly 2 million low-income Michigan residents, most of them children, seniors, pregnant women or people with disabilities. The 1 percent fee is likely to be felt by consumers. Blue Cross Blue Shield of Michigan estimates the fee would cost its cus-

tomers more than $100 million annually. The legislation passed the Senate but must still pass the House. (The Republic)

New York

- **Medicaid Contract Bleeds New York**

Over the past decade, the state has paid a Virginia-based IT company nearly $1 billion to set up and operate a Medicaid billing and processing system hobbled by delays, cost overruns and programming flaws. Gov. Cuomo's administration now says they're rethinking the entire plan and conducting a broader review of the state's billing system. That's left the status of the contract in limbo—and payments to CSC flowing indefinitely. The administration says the Medicaid program's move toward managed care and away from fee-for-service means that managed-care companies will assume more responsibility over the review of payment claims. Officials say the state may not need the same kind of billing and data system it had originally sought. Cuomo officials say they intend to complete their review by the end of the summer. (Wall Street Journal)

Utah

- **Utah wants to use ACOs to control Medicaid spending**

Utah is asking federal officials for permission to change its Medicaid program so that it pays physicians and hospitals based on outcomes and quality. But the state's major physician organization said the proposal is just managed care under a new name. The measure was adopted by the Utah Legislature in March and signed by Utah Gov. Gary Herbert on March 23. It would implement accountable care organizations and pay them risk-adjusted, capitated, per-member, per-month rates to provide care and medical homes to Medicaid enrollees. ACOs could be formed by organizations that can manage risk, distribute payments for all covered services and meet certain quality standards. The Utah Dept. of Health, the state's Medicaid agency, submitted the waiver request on July 1, said spokeswoman Kolbi Young. If the Centers for Medicare & Medicaid Services approves the waiver as submitted, it would take effect in Utah's four most populated counties -- where 80% of the state's Medicaid enrollees live -- by July 1, 2012. Utah's Medicaid program has about 240,000 enrollees. (American Medical News)

Vermont

- **RFP: Vermont Demonstration to Integrate Care for Dual Eligible Individuals**

CMS is providing funding and technical assistance to states to develop person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports, and other services for dual eligible individuals. The goal is to identify and validate delivery system and payment coordination models that can be tested and replicated in other states. The State to seeks assistance from contractors in developing a demonstration design proposal including data analysis, actuarial analysis, policy research, policy development, legal analysis, and overall program design. Successful bidders will be invited to negotiate contracts with the State. Responses due July 25, 2011.

Washington

- **Medicaid first payor to join Wash. HIE**

  The Washington State Medicaid program is the first healthcare payor to sign up for a statewide health information exchange (HIE), the state's Healthcare Authority announced. The system—the OneHealthPort Health Information Exchange—was funded primarily through a cooperative agreement between the Olympia, Wash.-based Healthcare Authority and the National Coordinator for Health IT and supported by private contributions from Seattle-based IT management company OneHealthPort and the Washington Healthcare Forum. (CMIO)

HMA WELCOMES…

Melissa Corrado, Senior Consultant

Melissa Corrado will join HMA as a Senior Consultant in our New York office on Monday, July 11, 2011. Melissa comes to us from the Primary Care Development Corporation (PCDC) where she has served most recently as the Director of Performance Improvement. In this position, Melissa was a key member of PCDC's leadership team, and played a significant role in the development of new projects and product lines, including the Primary Care Medical Home toolkit, the creation of PCDC's health information technology service line (EMR adoption services and the creation of Health Information Exchange infrastructure), the Care Model Process Leader Training for the Health Resources and Services Administration (HRSA), and the development of a patient safety initiative for primary care providers. Prior to her time at PCDC, Melissa was the Director of Planning and Program Development for the AMDeC Foundation, a consortium of 39 of New York State's medical schools and teaching hospitals established to promote collaboration in New York State's biomedical research enterprise and to grow the state's biotechnology sector. Melissa started her career as a Research Assistant at the Greater New York Hospital Association.

Melissa earned her Master of Business Administration in Health Care Administration at the City University of New York, and her Bachelor of Science degree in Public Health at Rutgers College.

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
July 15, 2011	Washington	RFP Released	880,000
July 19, 2011	Massachusetts Behavioral	Proposals due	386,000
July 25, 2011	Louisiana	Contract awards	892,000
July 30, 2011	Kentucky RBM	Contract awards	N/A
August 1, 2011	New Jersey LTC	Implementation	200,000
August 3, 2011	Washington	Bidder's conference	880,000
August 15, 2011	Kentucky RBM	Implementation	N/A
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 17, 2011	Washington	Proposals due	880,000
December 19, 2011	Washington	Proposals due	880,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 1, 2012	New York LTC	Implementation	120,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

Health Reform: "DNA Profile"

National Update from Health Management Associates

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

Accountable Care in the Safety Net

National Update from Health Management Associates

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

California Exchange: "As Ambitious As You Can Be"

National Update from Health Management Associates

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

UPCOMING HMA APPEARANCES

The Health Industry Forum: "The Evolution of State Health Insurance Exchanges"

Jennifer Kent, featured speaker

July 13, 2011

Washington, D.C.

Michigan Association of Health Plans' 2011 Summer Conference: "The Case for Integration: Mental Health and Substance Abuse Services and Primary Care"

Alicia Smith, featured speaker

July 16, 2011

Boyne Falls, Michigan

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

Mark Trail, featured speaker

August 2, 2011

Charleston, West Virginia