
HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: WE PROVIDE A SUMMARY OF HEALTHCARE RELATED BUDGET ACTIVITY TO DATE IN NINE STATES INCLUDING FLORIDA AND TEXAS

HMA ROUNDUP: FLORIDA MANAGED CARE BILL SET FOR DEBATE PRIOR TO END OF LEGISLATIVE SESSION ON FRIDAY; CMS EXPRESSES PREFERENCE FOR MINIMUM MLR IN FLORIDA; ILLINOIS PAYMENT REFORM DISCUSSIONS PROGRESS;

OTHER HEADLINES: CMS PROPOSED RULE WOULD REQUIRE THAT STATES EVALUATE ACCESS TO CARE BEFORE MAKING PROVIDER RATE CHANGES; REPUBLICANS SEEK TO ELIMINATE MAINTENANCE OF EFFORT REQUIREMENT; NEW JERSEY TO MOVE 200,000 BENEFICIARIES TO MANAGED CARE,

MEDICAID MANAGED CARE RFP CALENDAR

MAY 4, 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: STATE BUDGET PROGRESS & HEALTH CARE UPDATES

This week, our *In Focus* section takes a look at the status of the legislative budget process in several key states that HMA follows closely. States have wrestled with budget crises, lagging revenue, and shortfalls for the last several years, but this cycle has shown far more significant cuts in spending than in previous years. One reason for this is the expiration of American Recovery and Reinvestment Act (ARRA) funding for Medicaid. Additionally, many states have new governors in office, elected on platforms of budget overhaul and controlling growth in state expenditures. We focus particularly on budgetary impacts to Medicaid programs, Medicaid managed care, and hospital and other provider reimbursements. The states we look at are California, Florida, Georgia, Illinois, Michigan, New York, New Jersey, Ohio and Texas. In each state summary, we provide an overview of the budget process to date, summarize the key points, highlight any significant sticking points, and lay out the next steps and key upcoming milestones in the budget process.

It is worth noting that CMS is considering changes to its process for approving rate changes. A proposed rule issued last Friday (discussed in the “other headlines” section below) would require that states conduct an “access review” every year in order to determine whether or not proposed rate changes would adversely impact beneficiary access to care. Going forward, this may act as a constraint on states’ ability to reduce provider rates as a budget balancing mechanism. The first access reviews would not be required until the beginning of the first calendar year 12 months following the enactment of the final rule. As such, to the extent that the rule is enacted we don’t expect it to impact the current rate cycle.

California

The legislature has filled close to half of a \$26 billion budget gap, with another \$15 billion yet to be resolved. Included in the first round of budget cuts was a 10% Medi-Cal provider rate cut. This rate cut, while passed, is pending federal approval. Without federal approval, the state will have to come up with additional budget savings. Governor Brown is expected to release a revised budget on May 18, 2011. Part of the Governor’s proposal was to put a temporary income tax increase to a vote through a special ballot initiative. This plan appears to have stalled, at least for the moment. The legislature has focused on non-budgetary issues in the meantime, waiting for the revised budget to be released two weeks from today.

Florida

Florida’s House and Senate broke through several weeks of budget impasse in the past 48 hours, appearing to have reached an agreement that would allow for a budget vote on Friday, May 6, 2011, the final day of session. One of the major points of contention was whether to cut provider rates 7% or 10%. The final agreement is on a provider cut of 12%. While this looks worse on paper, the agreement maintains funding for the Medical-

ly Needy and MEDS-AD programs. The Senate budget proposal had eliminated funding for both programs and could have pushed the negative financial impact to hospitals over \$1 billion. As it stands, the 12% cut should equate to \$510 million in reduced payments to hospitals. Certain hospitals may be able to mitigate the impact of the cut if the county is willing to put up the state share of the cost.

Georgia

In mid-April, Governor Deal signed a resolved budget passed by the House and Senate after conference committee negotiations during the second week of April. The key budget provisions impacting the state's healthcare programs are:

- Reducing Medicaid reimbursement by 0.5% for all providers except hospitals, skilled nursing facilities, and home and community based services (\$5 million savings).
- Removing the payment floor for outpatient services from Medicaid managed care organizations (\$5 million savings).
- Realizing the benefit from the drug rebate equalization provision of the federal healthcare reform bill that increases Medicaid managed care rebates (\$14.5 million savings).
- Authorizing \$10 million in bond funds to design and implement a new Medicaid eligibility system. Increasing funds for the Express Lane Eligibility Project, which will simplify the enrollment process (\$1.3 million cost).

Three noteworthy items were proposed but not passed:

- Including the 2.25% premium tax within the existing administrative percentage for care management organization (CMO) capitation rate range development.
- Implementing a minimum Medical Loss Ratio (MLR) requirement of 87% for Medicaid CMOs.
- Transitioning Medicaid eligibility from 6 month reviews to 12 month reviews while still requiring clients to report changes in their status that occur prior to the scheduled review.

Illinois

As part of a plan to close an \$8 billion budget gap, Illinois legislators have proposed a 6% across-the-board cut in Medicaid provider rates. The legislature has been at odds over earlier attempts to pass a partial budget. While it has recently appeared unlikely that the budget would be resolved by the May 31 deadline, there has been optimistic talk lately from state agencies that the House and Senate would avoid an extended session in which a super-majority is required to pass anything. Regardless of timing, there has been no indication that the 6% Medicaid rate cut will not be included in a final budget resolution.

Michigan

Since returning from a legislative break, both the House and Senate have responded to Governor Snyder's Executive Recommendation with budget proposals that closely mirror his outlined cuts.

The Senate bill (S.B. 172) was passed by the full Senate on April 26, 2011 and included Medicaid-related provisions that totaled an additional \$60 million in general fund savings over Governor Snyder's recommendation.

The House bill (H.B. 4269) has been reported out of the appropriations subcommittee and awaits action in the full House Appropriations Committee. H.B. 4269 included Medicaid-related provisions that totaled an additional \$25.5 million in general fund savings over Governor Snyder's recommendation.

Items included in both bills that mirror the Governor's cuts include:

- Integrated Medicare and Medicaid funds for dual eligibles (\$10 million in general fund savings)
- Include behavioral health drugs in preferred drug list (PDL) (\$6.3 million in general fund savings)
- Additional savings through eliminating adult home help assistance, strengthened Medicaid estate recovery legislation, and required data match between auto insurers and Medicaid (\$17 million in general fund savings Governor and Senate, \$18 million in general fund savings House)

Items that differed between the chambers:

- The Governor and House bills include a 40% reduction of the Medicaid graduate medical education (GME) program funding (\$22.8 million in general fund savings). The Senate bill includes full elimination of the Medicaid graduate medical education (GME) program (\$57 million in general fund savings)
- All three bills include elimination of "small hospital" disproportionate share hospital (DSH) pool (\$2.5 million in general fund savings), however, the House bill allocates \$11.3 million in DSH payments from an existing state-wide \$45 million DSH pool to facilities previously receiving small hospital DSH pool payments
- The House expanded savings attributed to Medicaid revenue maximization efforts (\$3.6 million in general fund savings)

The Governor has previously indicated a desire to have a signed budget bill by the end of May. This budget process may move swiftly over the next several weeks.

New Jersey

Governor Christie's administration has projected a \$1.3 billion deficit in the state's Medicaid program. While a budget is not likely to be resolved until sometime in June, the administration has already taken preemptive action, transitioning nearly 200,000 Medi-

caid enrollees, many with developmental and mental disabilities, into managed care programs beginning in June, a move that is expected to save \$41 million.

New Jersey is also developing a comprehensive Medicaid waiver. According to a presentation prepared by the state, the waiver is estimated to save \$300 million in its FY 2012 budget through a series of changes including competitively bidding its HMO contracts. Other changes include the following:

- Close NJ FamilyCare to new parents
- Implement Medical Home Model and Pilot Accountable Care Organizations for High-Utilizers
- Increase or impose cost-sharing (premiums/targeted copays)
- Pilot payment reform models consistent with the Affordable Care Act
- Manage/Integrate Behavioral Health for adults through HMO and Administrative Service Organization
- Expand Home and Community Based Services and Supports for people with developmental disabilities consistent with the Affordable Care Act.

A copy of the presentation is available upon request.

New York

The New York State Legislature finalized its budget on March 31, 2011, closing a \$10 billion budget deficit through significant spending reductions. Among Governor Cuomo's executive budget proposals included in the final New York budget were the following:

- Two percent reduction in all provider payments (with some exemptions), resulting in "no less than" \$345 million in savings.
- Permanent elimination of annual inflation factors.
- Required mandatory enrollment in Medicaid managed long term care for persons twenty-one years or older residing in the community in need of home and community-based long term care services.
- Pharmacy benefits "carved in" to the Medicaid managed care benefit package.
- Establishment of Behavioral Health Organizations to provide Medicaid behavioral health care services under a capitated payment arrangement.

Ohio

The House subcommittee bill, approved by the House finance committee on the evening of Tuesday, May 3, 2011, made few changes to the executive budget proposal from Governor Kasich's Office of Health Transformation. The full House is expected to vote on the bill Thursday, May 5, 2011. The bill will then go to the Senate. Governor Kasich is expected to sign a final two-year budget bill by July 1, 2011.

For more detail on the specific actions proposed in the Executive Budget, please see our Weekly Roundup dated March 23, 2011 in which provide a detailed analysis of the state's health transformation plans. That report is available upon request. Key changes proposed by the governor are summarized below.

- A series of changes to hospital payment methodologies that are estimated to increase total inpatient spending by 0.6 percent, though spending on a per member per month (PMPM) basis will decline 1.8 percent. Total outpatient spending is forecasted to decline 4.5 percent, or 6.7 percent on a PMPM basis. (Table 2)
- A series of changes to nursing facility payment methodologies that in aggregate would reduce nursing facility rates by 7.3% in FY 2012.
- An actuarial review of MCO capitation rates resulted in several recommendations included in the proposal:
 - Medical cost inflation calculations will use the lower boundary of the inflation trend.
 - Administrative components of the capitation rate are reduced to reflect reductions in administrative requirements put in place by the Ohio Medicaid program.
 - Administration components of the capitation rate are also reduced to reflect actual managed care plan experience and national trends.
 - Increased managed care enrollment allows administrative costs to be spread more efficiently across more lives.
- The Executive Budget Proposal carves the pharmacy benefit back into the managed care program effective October 1, 2011.

Texas

The Texas legislature has not completed deliberations on its FY 2012/2013 biennial budget. The House has adopted its bill which includes 10% across the board rate reductions for all providers in Medicaid and CHIP. The Senate has not yet voted on the bill that was approved by the Senate Finance Committee (SFC). The SFC bill includes the following rate changes:

- **Physicians, dentists, and professionals:** No additional cut. 2% cut that went into effect FY 2010/11 remains in place.
- **Hospitals:** 6-8% rate cut on top of 2% reduction that went into effect FY 2010/11.
 - Children's hospitals exempted from inpatient cut but not outpatient
- **Durable Medical Equipment, Labs:** 10.5% rate cut on top of 2% reduction that went into effect FY 2010/11.
- **Nursing homes:** No additional cut. 3% cut that went into effect FY 2010/11 remains in place.
- **ICF/MR:** 2% rate cut on top of 3% reduction that went into effect FY 2010/11.

- **HCS Waiver:** 1% rate cut on top of 2% reduction that went into effect FY 2010/11.

Importantly, even with these proposed cuts the budget will still have significant shortfalls. Under the House bill, the remaining shortfall would be \$4.2 billion while under the Senate bill, it would be \$3.4 billion. As such, even with the significant rate cuts proposed, the state will still have to appropriate more money or make further cuts prior to the end of the current budget cycle (July 2013). Supplemental funds can be approved once the next legislative session begins in January 2013.¹

In terms of timing, we currently expect the budget bill to go to conference committee next week. It is possible that a special session will be required to finalize the budget.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup - Gary Crayton

In addition to the budget deal apparently reached on Tuesday, we are watching the status of the Senate managed care bill. A hearing on the bill scheduled for Saturday was cancelled, but there is still time for the Senate to pass something before Friday. The House would need to amend the bill and send it back to the Senate by the end of the day on Friday, May 6, 2011. There is no 72 hour requirement for the bill to be printed as is the case with the budget bill.

On April 28, CMS sent a letter to Florida Agency for Healthcare Administration (AHCA) secretary Elizabeth Dudek in which CMS informed the state that CMS would not be able to extend the state's current managed care waiver until the state enacts legislation and presents a detailed implementation plan. This ruling was expected and CMS appears open to working with the state once the legislature finalizes its plans. In the letter, CMS outlines a series of elements that it expects the state to consider in developing its waiver program including network adequacy requirements and continuity of care provisions. Among the items listed are a limit on the number of managed care plans (Florida is currently an "all comers" state) and a requirement that all Medicaid managed care organizations meet a minimum medical loss ratio (MLR) requirement. As a reminder, the Florida Senate's healthcare reform bill included a 90% minimum MLR while the House version employed an experience rebate methodology similar to what is utilized in Texas. The CMS letter appears to be indicating its preference for a minimum MLR, although it doesn't specify at what level. A copy of the letter is available upon request.

In the news

- **Legislation seeks to curb Medicaid 'gaming'**

As Florida struggles to reduce state spending, the debate over who qualifies for costly Medicaid long-term care assistance has reached a high pitch. Two bills before the Flor-

¹ "House vs. Senate Finance Committee budgets: How they compare on Medicaid and selected HHS issues, and with 2003 cuts" Center for Budget and Policy Priorities, Anne Dunkelberg, May 3, 2011

ida Legislature - House Bill 1289 and Senate Bill 1356 - would make it more difficult to transfer wealth before applying for Medicaid. ([Palm Beach Post](#))

- **Feds: Fla. can't expand Medicaid pilot statewide**

Federal health officials told Florida lawmakers Thursday they can't privatize Medicaid statewide for now, saying they need to see specific details of how the state plans to change the program, which provide health insurance to mostly low-income residents. ([Bloomberg Business Week](#))

Georgia

HMA Roundup – Mark Trail

The interstate health insurance compact legislation recently signed into law, while largely symbolic at this time, signifies a push to develop health care reform solutions outside of the federal ACA implementation. If additional states in the region pass similar legislation, Georgia would be in a position to offer health plans across state lines. A similar bill passed the legislature in Arizona but was vetoed by Governor Brewer.

The Medicaid MCO redesign RFP (seeking a consultant to evaluate the Georgia program) is expected to be released soon. As a reminder, Georgia DCH is seeking a consultant to evaluate the state's current Medicaid managed care program and make recommendations regarding potential improvements for the next contract. The RFP will be posted to the following website.

<http://ssl.doas.state.ga.us/PRSapp/PublicBidDisplay>

Illinois

HMA Roundup – Jane Longo / Matt Powers

Last Friday, April 29, 2011, the Illinois Department of Health and Family Services (DHFS) held a public forum on a hospital Medicaid payment reform initiative. The Illinois Hospital Association issued a statement of cooperation with the State on redesigning the hospital payment structure, currently dominated by supplemental payments, rather than volume-driven Medicaid payments. One particular point of interest is how much influence CMS will exert on Medicaid payment policies when the ACA Medicaid expansion is in place beginning in 2014 and the Federal government pays 100% of all expenditures for newly-eligible Medicaid enrollees. Navigant Consulting is working with DHFS in transitioning to a new inpatient and outpatient Medicaid payment system. Presentations from the forum are available here: <http://hfs.illinois.gov/hospitalratereform/>

In the news

- **Rally Against Medicaid Cuts Comes to Buffalo Grove**

The Health Care Council of Illinois (HCCI), a leading voice for the nursing home community in Illinois, led a rally in Buffalo Grove, opposing Gov. Pat Quinn's proposed 6 percent cuts in Medicaid funding. Nursing home advocates claim the cut could eliminate \$140 million in funding. ([Buffalo Grove Patch](#))

Indiana

HMA Roundup - Cathy Rudd

A new hospital bed tax is included in the budget that would be used to fund an increase in base hospital Medicaid rates. (This proposal is in contrast with the use of hospital taxes in many other states to fund add-on payments rather than base rates.) It is unclear if the tax is to be assessed on all bed days, including Medicare and commercial, but we expect there to be hospitals that lose out in the new tax structure. Waivers are expected to be submitted by October 1, 2011, with taxes retroactive to July 1, 2011.

There are no proposed Medicaid rate cuts, however, the rate cuts implemented last year have been extended.

Included in the Healthy Indiana Plan (HIP) bill was an amendment that the state is not to implement any provisions of the Affordable Care Act.

OTHER HEADLINES

Arkansas

- **Beebe gets federal nod to pursue Medicaid changes**

Gov. Mike Beebe's spokesman Matt DeCamp said that federal officials have given Arkansas "conditional permission to proceed" with proposed changes to its Medicaid program. Beebe wants to change Medicaid's "fee-for-service" model and move to a more holistic approach, including medical homes, to managing health care through the entire system. He contends that changing the system could corral costs and produce better health outcomes. The Governor has warned that the state could be facing an \$87 million budget shortfall by FY 2013 if changes are not made. ([The City Wire](#))

Arizona

- **Brewer vetoes out-of-state insurance bill**

Gov. Jan Brewer on Thursday vetoed a bill that would have waived many of Arizona's health-insurance mandates and allowed insurance companies from other states to write policies in Arizona. Senate Bill 1593, passed in the last week of the legislative session, mobilized the groups and individuals who have benefited from Arizona's insurance mandates, ranging from parents of children with autism to diabetics.

([Arizona Republic](#))

- **Feds give okay to AZ plan to freeze Medicaid enrollments**

Arizona got federal approval Friday to freeze enrollment for a program that helps people whose incomes are low because of their huge medical bills. That's about 5,700 Arizonans who are part of the so-called "spend-down population." This could signal additional, and much larger, enrollment freezes in the coming months. ([KOLD.com](#))

Connecticut

- **Judge orders four nursing homes closed**

A Superior Court judge has ordered the closure of four financially-troubled nursing homes that together have 472 beds and employ 575 people. The four homes had a net

loss of almost \$6.5 million in 2009. The homes, which were previously owned by the troubled Haven Health Care chain and more recently managed by Genesis Eldercare Network Services, went into receivership in January. ([CT Mirror](#))

Minnesota

- **Dayton to HMOs: Put in your bid**

In a strategy that could save taxpayers millions of dollars and harness the power of market forces, Gov. Mark Dayton has begun rolling out a plan that forces HMOs to bid competitively for \$3 billion in annual state business providing health care to low-income families. The four biggest insurers -- Medica, UCare, HealthPartners, and Blue Cross and Blue Shield of Minnesota -- are reacting cautiously. ([Star Tribune](#))

New Jersey

- **N.J. plans to seek federal approval to reduce parent eligibility for FamilyCare health insurance**

New Jersey plans to seek federal approval to reduce the number of parents eligible for a popular health insurance program aimed at poor working families, officials of the Department of Human Services said today. The decision to close the FamilyCare program to parents with a household income above the federal poverty level — about \$18,530 annually for a family of three — is part of Gov. Chris Christie's plan to save \$300 million by overhauling Medicaid, the officials said. ([NJ.com](#))

- **N.J. alerts 200K Medicaid recipients of requirement to enroll in HMO**

Not content to wait for the state budget to pass in late June, the Department of Human Services is alerting about 200,000 Medicaid recipients — many with developmental or mental disabilities — that they will be required to enroll in an HMO. Gov. Chris Christie's administration anticipates the move will save about \$41 million over the budget year that begins July 1. ([NJ.com](#))

Vermont

- **Vermont lawmakers reach agreement on health care**

Major health reform legislation working its way through the Vermont Legislature has won final approval in the Senate, with the House expected to follow suit. It's expected to be at least next week, if not the week after, before Gov. Peter Shumlin signs the bill into law. ([Boston Globe](#))

Texas

- **Institutions for Disabled Unlikely to See Major Cuts**

With less than a month left in the legislative session, it appears unlikely the state will close 13 state-supported institutions for the disabled. Even with a \$15 billion to \$25 billion budget shortfall and a series of blunt recommendations from the Legislative Budget Board, lawmakers say there isn't the political capital to move the ball far.

([Texas Tribune](#))

- **Lawmakers chafe as push continues to privatize prison health care**

Efforts by private companies to get a piece of Texas' nearly \$1 billion prisoner health care system are quietly continuing behind the scenes as company representatives make

sales pitches to lawmakers and seek changes in state law to authorize privatization. ([The Statesman](#))

- **Children’s Hospitals See Peril in Proposed Budgets**

Despite some efforts to ease the blow to pediatric health care providers, Texas’ proposed budget cuts will most likely have a disproportionate effect on children’s hospitals. The financial implications will not mean halting operations, or necessarily curbing care, advocates for the hospitals say. Instead, the result will be cutting back on expansions needed to serve a growing population and on efforts to recruit and retain the best specialists and faculty. ([New York Times](#))

- **Senate Approves Medicaid Savings Bill**

The Senate unanimously approved Sen. Jane Nelson’s bill to find extensive cost savings in Texas’ Medicaid program, the primary health care provider for children, the disabled and the very poor. The measure expands Medicaid managed care into South Texas, where it has long been carved out – expected to save the state \$290 million over the biennium. It pulls prescription drug sales into the managed care program and requires most Medicaid patients to use medicines on a state preferred drug list, at a projected savings of \$51 million a biennium. And it ensures people with disabilities receiving attendant care services at home are using a Medicaid contractor, saving an estimated \$28 million a biennium. ([Texas Tribune](#))

United States

- **Rule Would Discourage States’ Cutting Medicaid Payments to Providers**

In a new effort to increase access to health care for poor people, the Obama administration is proposing a rule that would make it much more difficult for states to cut Medicaid payments to doctors and hospitals. The rule could also put pressure on some states to increase Medicaid payment rates, which are typically lower than what Medicare and commercial insurance pay. [Link to proposed rule\(PDF\)](#). ([New York Times](#))

- **GOP unveils Medicaid flexibility bill**

Congressional Republicans’ bill to let states cut their Medicaid rolls would save the federal government nearly \$3 billion over the next five years, according to a preliminary estimate from the Congressional Budget Office (CBO). According to preliminary CBO estimates, the bill would save \$2.8 billion over the first five years and \$2.1 billion over 10 years. ([The Hill](#))

- **States turn to work-arounds on health insurance exchanges**

State governments across the country are exploring work-arounds to get health exchanges up and running after Republican legislators and tea party protests have blocked state laws to implement this piece of health care reform. At least half of the states in which exchange legislation has failed are now considering all options, such as expanding existing agencies and using executive orders, which would allow them to establish the health reform centerpiece without the support of their legislatures.

([Politico](#))

PRIVATE COMPANY NEWS

- **Steward completes deal for hospitals**

Steward Health Care System, the Boston holding company formed last year by the private equity firm that bought Caritas Christi Health Care, said yesterday that it has completed its \$21 million acquisition of two for-profit community hospitals: Merrimack Valley Hospital in Haverhill and Nashoba Valley Medical Center in Ayer. The deals bring to eight the number of Eastern Massachusetts hospitals in the Steward chain. In addition to the two just acquired, it owns the six Catholic hospitals in the Caritas Christi group, including St. Elizabeth's Medical Center and Carney Hospital in Boston. ([Boston Globe](#))

- **Managed Health Care Associates Inc.**, a portfolio company of **Diamond Castle Holdings**, has acquired **Tidewater Group Purchasing** from **Omnicare Inc.** (NYSE: OCR). No financial terms were disclosed. Tidewater is a Milford, Ohio-based provider of group contract pricing solutions for the senior care market. www.mhainc.com

- **Hellman & Friedman** is putting **Sheridan Healthcare** on the block, according to Reuters. It hopes to secure around \$1 billion for the Sunrise, Florida-based doctor and nurse staffing company. www.sheridanhealthcare.com

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. We will be updating this list as new information becomes available, though we note that RFP timelines often slip without any formal announcement.

Date	State	Event	Beneficiaries
May 1, 2011	Illinois ABD	Implementation	40,000
May 9, 2011	Arizona LTC	Contract awards	25,000
May 11, 2011	Kentucky	Vendor conference	460,000
May 23, 2011	Texas	Proposals due	3,200,000
May 25, 2011	Kentucky	Proposals due	460,000
June 1, 2011	California ABD	Implementation	380,000
June 24, 2011	Louisiana	Proposals due	892,000
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey	Implementation	200,000
July 25, 2011	Louisiana	Contract awards	892,000
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
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

HMA RECENTLY PUBLISHED RESEARCH

Sustaining State Health Information Exchange: A State Toolkit

National Governors Association Center for Best Practices

By M. Renee Bostick, Gary Crayton, Eliot Fishman, Elaine Peters and Vernon Smith

Financing and sustainability are one of the key challenges in developing a statewide health information exchange. Workable business models for HIE have been elusive in the past and states are struggling to figure out how to assure the future of health information exchange in the midst of an unprecedented state budget crisis. This report discusses some of the challenges states are facing surrounding sustainability and methods states and HIEs can use to develop support for their financial needs ([Link to Report](#)).

Reducing Hospital Readmissions--Lessons from Top-Performing Hospitals

The Commonwealth Fund – Why Not the Best?

Principals Sharon Silow-Carroll and Jennifer N. Edwards, and Senior Consultant Aimee Lashbrook have contributed a series of readmission reports to the Commonwealth Fund's *Why Not the Best?* series.

Significant variability in 30-day readmission rates across U.S. hospitals suggests that some are more successful than others at providing safe, high-quality inpatient care and promoting smooth transitions to follow-up care. This report offers a synthesis of findings from four case studies of hospitals with exceptionally low readmission rates—McKay-Dee Hospital in Ogden, Utah; Memorial Hermann Memorial City Medical Center in Houston, Texas; Mercy Medical Center in Cedar Rapids, Iowa; and St. John's Regional Health Center in Springfield, Missouri. Hospitals' environments contribute to their capacity to reduce readmissions. The four hospitals studied are influenced by the policy environment, their local health care markets, their membership in integrated systems that offer a continuum of care, and the priorities set by their leaders. ([Link to Report](#))

CLASS Technical Assistance Briefs – Spring 2011

The SCAN Foundation

HMA Principals Susan Tucker and Marshall Kelly contributed a series of briefs to the SCAN Foundations CLASS Technical Assistance Briefs series, released earlier this month.

1. Elements of a Functional Assessment for Medicaid Personal Care Services

By: Marshall E. Kelly and Susan M. Tucker

This brief discusses the results of the identification and analysis of the assessment instruments and data elements states use for determining medical conditions, activities of daily living and cognitive functional ability within Medicaid-funded personal care services programs. It identifies the elements states use for an assessment of a person's physical and cognitive limitations and need and compares these elements to the requirements of the CLASS Plan. ([Link to Report](#))

2. Determining Need for Medicaid Personal Care Services

By: Susan M. Tucker and Marshall E. Kelly

This brief focuses on the ranking and scoring criteria and mechanisms that state Medicaid programs use to determine functional need and the level of services provided for Medicaid-funded personal care services programs. Because CLASS requires a determination of need and must identify a benefit level for which regulations must be promulgated, this information can be very useful for the development of the CLASS Plan. ([Link to Report](#))

3. Functional Assessment Processes for Medicaid Personal Care Services

By: Susan M. Tucker and Marshall E. Kelly

This brief focuses on components of states' Medicaid functional assessment processes with an eye toward how these processes could potentially inform the development of regulations for CLASS. We explore how states handle the assessment process and determine who performs the assessment and where it is performed. Each of these components is important to the design of CLASS so that those determined eligible can receive appropriate benefits. ([Link to Report](#))

HMA SPEAKING ENGAGEMENTS

CBHA: Reading Some of the Tea Leaves for Healthcare Reform's Directions

Matt Powers, Principal

May 9, 2011

Oak Brook, IL

Thomson Reuters 2011 Healthcare Advantage Conference: *What's Next for Medicaid: Unprecedented Challenges of Health Reform, Budget Stress and Political Uncertainty*

Vernon Smith, Principal

May 10, 2011

Salt Lake City, Utah

Medicaid Pharmacy Administrators Conference, South East Region: *"Medicaid and Health Reform in an Era of Economic and Political Uncertainty."*

Vernon Smith, Principal

Charlottesville, VA

May 17, 2011

Medicaid Managed Care Congress

Vernon Smith, Principal

May 18-20, 2011

Baltimore, Maryland

National Commission on Correctional Health Care's "Updates in Correctional Health Care": *Medicaid Payment for Inpatient Hospitalizations: Now and 2014*

Donna Strugar-Fritsch, Principal

May 23, 2011

Phoenix, Arizona

AcademyHealth's Annual Research Meeting 2011: *Topics in System and Payment Reform*

Dr. Jennifer Edwards, Chair

June 12-14, 2011

Seattle, Washington