HMA

HEALTH MANAGEMENT ASSOCIATES

# *HMA Investment Services Weekly Roundup*
# *Trends in State Health Policy*

**IN FOCUS: FLORIDA MEDICAID MANAGED CARE BILL CLEARS LEGISLATURE**

**HMA ROUNDUP: ILLINOIS SENATE PROPOSES 3% PROVIDER RATE CUT; TEXAS HOUSE AND SENATE BUDGET BILLS MOVE TO CONFERENCE COMMITTEE; CALIFORNIA BUDGET AWAITS GOVERNOR'S MAY REVISE DUE NEXT WEEK; GEORGIA CONSULTING CONTRACT INDICATES MANAGED CARE RFP DUE JULY 2012**

**OTHER HEADLINES: ARIZONA AWARDS LTCS CONTRACTS TO AETNA, CENTENE, UNITED; BLUE CROSS BLUE SHIELD OF FLORIDA EXPRESSES DESIRE TO BID ON MEDICAID BUSINESS; KENTUCKY MANAGED CARE RFP VENDOR CONFERENCE HELD TODAY; HHS ANNOUNCES MEDICAID COST SAVINGS INITIATIVE, TOOLS FOR STATES**

**PRIVATE COMPANY NEWS: WAUD CAPITAL PARTNERS ACQUIRES REVENUE CYCLE SOLUTIONS, INC.; H.I.G. CAPITAL COMPLETES NOVAMED ACQUISITION; STEWARD ACQUIRES PAIR OF ESSENT HEALTHCARE HOSPITALS**

**MEDICAID MANAGED CARE RFP CALENDAR**

**MAY 11, 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: Florida Medicaid Managed Care Bill Clears Legislature

This week, our In Focus section walks through the details of the health care reform bill that cleared the Florida legislature last week. The bills (HB 7107 and 7109) will expand mandatory managed care enrollment to all Medicaid enrollees, excluding the developmentally disabled population and a few other small eligibility populations. We originally provided a summary of the Senate bill in our February 23, 2011 weekly *In Focus* section. A House bill was released shortly after that included certain differences that came to be significant sticking points in the process of reaching an agreement between the two bills. While the agreement did not pass until last Friday, May 6, the last day of session, there was strong support all along from Governor Scott. The passed bill now awaits the Governor's signature, which is expected shortly. In our summary below, we highlight the key sticking points between the House and Senate bills, summarize the provisions of the passed bill, and lay out a timeline for key milestones in the implementation process.

### *Key Sticking Points Resolved*

- The House proposed dividing the state into seven (7) regions, while the Senate proposed 19 regions. The final bill divides the state into 11 regions. While not as advantageous as the House version, we believe the compromise favors the managed care organizations, as fewer regions allow for greater negotiating leverage in hospital contracting and limit the potential reach of the provider service networks (PSNs).
- The Senate proposed a minimum medical loss ratio (MLR) of 90% for all plans, while the House proposed an experience rebate threshold. Under the final bill, plans will retain 100% of income up to and including 5%, 50% of income between 5% and 10%, and will refund to the state any income above 10%. Again, we believe this resolution clearly favors the managed care organizations as the experience rebate methodology, at least as it has been employed in Texas, tends to result in a more stable rate environment and allows for investment in expanded capabilities and administrative services.
- The House bill excluded the developmentally disabled (DD) population from mandatory MCO enrollment. This exclusion remains in the final bill. Additionally, several smaller eligibility populations are also excluded.

### *Summarized Agreement Bill*

#### Medicaid Managed Medical Assistance Program

Below we identify the key characteristics of the final bill as it pertains to the medical assistance program.

- Florida will use an invitation to negotiate (ITN) process with a target date of no later than January 1, 2013 to select plans, and full implementation targeted to oc-

cur by October 1, 2014. Based on the timeline, we would expect an ITN to be issued in early 2012.

- Contracts will be for a duration of five (5) years, and selection will be based on quality and performance standards. The bill places a preference on plans that can deliver the following services:
  - Programs for recognizing patient-centered medical homes
  - State-based plans with the entity's principal office in Florida, and not a subsidiary or joint venture with plans located in other states. This provision appears to position WellCare favorably, although also is favorable for Blue Cross Blue Shield of Florida, who just recently expressed interest in entering the Medicaid market.
  - Specific disease management programs
- The state will be divided into 11 regions with a minimum of two (2) plans per region and a maximum of 10. There must be one provider service network (PSN) per region.
- Any plan awarded a contract in Region 1 or Region 2 will be awarded a contract in any other region in which they submitted a bid.
- The Agency for Health Care Administration (AHCA) will apply for any state plan amendments, waivers, or extended or expanded current waivers by August 1, 2011. During the waiver application process, AHCA will seek public and stakeholder comments.

## Long-Term Care (LTC) Managed Care Program

Below we identify the key characteristics of the final bill as it pertains to the long-term care managed care program.

- The program includes Medicaid enrollees 65 and older, as well as those individuals with a disability, meeting a level of care for LTC services, ages 18 and older.
- Dually eligible recipients receiving services from Medicare Advantage plan participating in managed LTC program shall be automatically enrolled in that plan.
- The ITN process for the LTC managed care program is separate from, but identical to, that of the managed medical assistance program.
- AHCA will begin implementation by July 1, 2012, with a targeted full implementation in all regions of October 1, 2013. Based on this timeline, we expect the ITN process to initiate in the 4th quarter of 2011.

## Additional Provisions

- As noted above, under the achieved savings rebate, which replaced the Senate proposal of a 90% MLR, plans will retain 100% of income up to and including 5%, 50% of income between 5% and 10%, and will refund to the state any income above 10%. Any prepaid plans incurring a loss in the first contract year may apply that loss as an offset to income in the second contract year.

- In the first contract year, AHCA is required to guarantee aggregate savings of at least 5% through negotiated capitation rates or FFS payments. In current HMO regions, savings are based on rates paid in the previous year. In non-HMO regions, savings are based on Medicaid rates paid in the previous year.
- The passed bill includes the following penalties for plans for withdrawal and enrollment reductions:
    - PSNs must pay a per-enrollee penalty not to exceed three (3) months payment and continue to provide 90 days of services to the enrollee.
    - Prepaid plans must pay a penalty equal to 25% of the minimum surplus requirement.
    - Plans must provide AHCA with 180 days notice before withdrawing from a region.
    - If a plan withdraws from a region before the end of the contract term, AHCA will terminate all contracts with the plan in other regions.

## *Market Opportunity*

In order to assess the market opportunity for Medicaid managed care plans in Florida, we begin by describing the current enrollment distribution by delivery system type. As the table below indicates, there are currently 2.9 million Floridians enrolled in the Medicaid program. Of that total, 39% are in a Medicaid HMO, 21% are in the MediPass (PCCM) program and 33% are in fee for service. As of August 2010, there were a little over 50,000 developmentally disabled (DD) Medicaid enrollees who will be excluded from the managed care expansion.

**Florida Medicaid Enrollment by Delivery System**

| Feb-11 | Enrollees | % of total |
|---|---|---|
| Medicaid HMO | 1,120,566 | 38.8% |
| Provider Service Networks/ACOs | 196,190 | 6.8% |
| MediPass (PCCM) | 613,987 | 21.3% |
| Nursing Home Diversion | 19,145 | 0.7% |
| Fee for Service | 936,805 | 32.5% |
| **Total** | **2,886,693** | |

*Source: Florida Agency for Healthcare Administration*

The total Medicaid Services budget appropriation for FY 2011-12 is $21.2 billion, of which managed care is $3.2 billion. HMA estimates that the total size of the market opportunity for managed care plans would increase to $12 to $14 billion upon full implementation. We note that the bill requires that the whole program be rebid, including the current contracts.

## HMA Medicaid Roundup

### California

#### HMA Roundup – Stan Rosenstein

Attention has turned to the Governor's revised budget, expected to be released mid next week. We will be keeping a watch in the coming weeks for the budget process to resume.

#### In the news

- **Round One Goes to Services for Developmental Disabilities**

  California facilities for residents with developmental disabilities have been squeezed by state budget cuts -- including a Medi-Cal freeze on some reimbursement rates. But just because California is low on cash, that doesn't give the state the right to freeze those rates, U.S. District Court judge Christina Snyder said. She issued a preliminary injunction on Friday that halted some budget-cutting measures that don't follow the law. (California Health Line)

- **California Dispatch: State Reviews Medicaid Cuts with HHS**

  From Politico.com: The state's Health and Human Services department is currently having talks with its federal counterpart about whether Gov. Jerry Brown's proposed 10 percent cut to MediCal is in compliance with Medicaid and MOE requirements. And while the state is not asking for MOE relief, it's unclear what exactly California will do if the state's proposal does not get approved. "When we met with leaders at CMS in Washington, we made it clear that we have not joined the states asking for maintenance of effort relief," California HHS Secretary Diana Dooley told Politico. "But if we can't meet our budget targets with their cooperation, we will have to go back into considerations and look at what we can do to make reductions. We have to bring this program into budget."

### Georgia

#### HMA Roundup – Mark Trail

The Georgia Department of Community Health (DCH) is seeking proposals from one qualified Consulting firm to provide solution planning and strategic options for managing the financing and care of Georgia's Medicaid and Children Health Insurance Program (CHIP) populations. In the RFP, the state indicates an intention to release the managed care RFP in July 2012. (Link to procurement website)

#### In the news

- **2010 better than expected for Grady Hospital**

  Grady Memorial Hospital did better financially last year than officials initially expected with an overall loss of $208,000, though it's now wrestling with a new spate of financial troubles. The hospital's federal and local county funding to help pay for the poor and uninsured fell by roughly $20 million this year. It provided around $220 mil-

lion in indigent care in 2010. Hospital executives are discussing ways to make up the rest of the funding gap without making dramatic program cuts, such as reducing the average length of stay for patients and managing overtime more closely. Grady's budget is roughly $870 million. The hospital is also in the middle of conducting a nationwide search for a new top executive following the resignation of CEO Michael Young, whose last day is June 15. (Atlanta Journal Constitution)

## Illinois

### HMA Roundup – Jane Longo / Matt Powers

The Illinois Medicaid Advisory Committee (MAC) met last Friday, May 6. A few key takeaways from the meeting are highlighted below:

- The Integrated Care Program, which mandates MCO enrollment for the aged, blind and disabled (ABD) population in suburban Chicago, launched this month.
- The Illinois Senate is looking at ways to only implement a 3% Medicaid provider cut instead of the Governor's proposed 6% cut. The House last week was potentially looking at a cut greater than 6%.
- The legislature is likely to move HB1577. It would establish a legislative study committee on health insurance exchange options to report back on September 30, 2011. Substantive legislation to establish the health insurance exchange would be approved during the October Veto Session.
- Discussion of Care Coordination guidelines were presented at the previous MAC meeting. Changes were proposed to the state's primary care case management (PCCM) program to allow PCCMs to meet the 2015 requirement that 50% of Medicaid enrollees are enrolled in care management programs. While these changes were not immediately approved, they will be taken up by a care coordination subcommittee in the coming months. There were some doubts as to the future of the PCCM program in Illinois. However, the Director reiterated her intent to continue the program.

## Massachusetts

### HMA Roundup – Tom Dehner

The initial hearing on the Governor's payment reform legislation before the Committee on Health Care Financing is next Monday, May 16 at 10:00 a.m. in Gardner Auditorium at the State House. The Committee has announced additional hearings around the state. Hearings will be held on Monday, May 23 at 11:00 a.m. at UMASS Medical School in Worcester, and on Monday, June 6 at 11:00 a.m. at Salem State University, in Salem. The Committee is also working on scheduling a hearing in southern Massachusetts at the end of June and a hearing a week or two later in the western region of the state.

### In the news

- **Mass. House leader urges caution on health bill**

Massachusetts lawmakers plan to take a slower and more cautious approach to changing the health care payment system as part of an effort to rein in medical costs, the majority leader of the House told a gathering of doctors at the Statehouse on Monday. The governor has proposed a cost-containment bill that seeks to move Massachusetts away from the traditional fee-for-service approach to paying for health care and toward a global payment system in which costs are more reflective of patient outcomes. (Boston Globe)

## Ohio

### HMA Roundup – Alicia Smith

Although Ohio was not awarded a Center for Medicare and Medicaid Innovation (CMMI) grant for duals, there are still plans to develop an integrated care delivery system (ICDS) for duals, the severely and persistently mentally ill, and home and community based waiver enrollees who have a skilled nursing facility (SNF) level of care. Models of implementation could still include managed care, health homes, accountable care organizations (ACOs) and other integrated care models. Discussions with CMS are reportedly taking place to seek support on the concept and discuss how best to execute.

In the news

- **Ohio Legislation Will Use Hospital Franchise Fee to Avoid Medicaid Payment Cuts**

  The Ohio House has included a hospital franchise fee in its budget bill (Sub. HB 153) to generate funds for the state's Medicaid program, thereby avoiding cuts to inpatient and outpatient reimbursement rates, according to a statement from the Ohio Hospital Association. The OHA, however, voiced its disappointment the House did not remove a non-contracting mandate for hospitals and Medicaid managed care providers. The OHA says the non-contracting mandate "removes any incentive for [Medicaid managed care plans] to participate in meaningful negotiation with hospitals," according to the statement. (Link to OHA statement) (Becker Hospital Review)

- **Battle begins over nursing-home cuts**

  The nursing home industry has launched a campaign against Governor Kasich's proposed cuts to nursing home services. The governor's budget plan would expand home care for Medicaid-eligible Ohioans and reduce spending on nursing homes by $427 million over the next two years, with much of the savings achieved by cutting the rate paid to nursing homes. The House passed the budget last week, sending it to the Senate and sparking the latest on-air salvo from the influential Ohio Health Care Association, which has argued that the cuts will force nursing homes to slash thousands of jobs and affect care. (Columbus Dispatch)

## Texas

### HMA Roundup – Dianne Longley

The House and Senate budget bills are finalized and set to go to conference committee this week. The Senate bill officially includes an 8% Medicaid inpatient reimbursement cut. This, combined with a 2% cut from the previous year, brings the cumulative inpa-

tient hospital cut to 10%. Children's hospitals are exempt from the 8% cut. We believe the conference committee process will keep the reimbursement cut within the 8% proposed by the Senate and the 10% proposed by the House.

## Other Headlines

### Arizona

- AHCCCS has awarded managed care program contracts to provide long term care services to Arizonans enrolled in the Arizona Long Term Care System (ALTCS). Contracts were awarded to Aetna, Centene, and United. The contracts begin October 1, 2011, and are in place for a five year period. Please see the link below for more information. (Link to ALTCS Award Announcement)

### Florida

- **Blue Cross to enter Medicaid program**

  Blue Cross and Blue Shield of Florida plans to enter the Medicaid program and compete in what likely will become a statewide managed-care system. Blue Cross, the state's largest health insurer, has stayed out of Medicaid in the past. But its new stance comes as Florida lawmakers seek to enroll almost all Medicaid beneficiaries in managed-care plans - and as last year's federal health law prepares to funnel more people into the system. Though it has stayed out of Medicaid, Blue Cross has long been an influential player in state legislative and political circles. For instance, it has a contract to administer part of the state's employee health-insurance program and also is well-known for its clout when lobbying on insurance issues. (News Service of Florida)

### Hawaii

- **State's new Medicaid plan is aimed at improving care**

  State officials unveiled yesterday a new way of providing and coordinating health care for Medicaid patients, particularly the chronically ill, starting in January. Called "medical home model," the program integrates primary health care, behavioral care and social services for Medicaid recipients, said Department of Human Services Director Patricia McManaman. (Star Advertiser)

### Maine

- **Fast-tracked health insurance bill clears House in party-line vote**

  In a party-line vote last Thursday, House Republicans gave initial approval to a package of sweeping changes in Maine's health insurance laws, overriding minority Democrats' objections that lawmakers had not had time to read the contents of the bill or consider the implications of their vote. (Bangor Daily News)

### South Carolina

- **State pushes to privatize services: Proposed change to Mental Health Dept. raises concerns**

The S.C. Department of Mental Health is considering privatizing care for about 200 mentally ill patients who have committed crimes and 120 sexual predators. The decision alarms Mental Health employees, who worry they could lose access to state benefits just as they near retirement, and some mental health advocates who worry patients will not receive the same quality of care that they get now. But others say private firms can improve patient care, noting most states already have privatized such care. (Post and Courier)

### West Virginia

- **W.Va. hospitals wrote off more than $700 million in 2009, group says**

West Virginia hospitals spent more than $721 million on charity care and bad debt in 2009 -- more than double the cost in non-reimbursed care from a decade ago, according to a report by the West Virginia Hospital Association. (Saturday Gazette Mail)

### Wyoming

- **Wyoming to study Medicaid cost savings**

State lawmakers hoping to avoid skyrocketing Medicaid costs are set to explore a slew of options -- ranging from major reforms to finding new grant opportunities -- to strengthen the entitlement program. The rising Medicaid costs and how the federal health-care reform act will affect the program are the top subjects for a legislative interim meeting Monday and Tuesday in Evanston. (Wyoming Tribune Eagle)

### United States

- **HHS offers new tools to help states lower Medicaid costs, provide better care**

The U.S. Department of Health and Human Services (HHS) announced on May 11, 2011 a series of initiatives to work with states to save money and better coordinate care for the 9 million Americans enrolled in both Medicare and Medicaid. The new initiatives include better access to Medicare data and better coordination of health care between Medicare and Medicaid. The initiatives will be led by the new Federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office), which was created by the Affordable Care Act to help make the two programs work together more effectively to improve patient care and lower costs. (Link to news release)

## Private Company News

- **Waud Capital Partners acquires Revenue Cycle Solutions of Westchester, IL**

Waud Capital Partners (WCP) announced that it has joined with veteran healthcare executives Mike Jacoutot and Mary Ann McLaughlin to acquire Revenue Cycle Solutions, Inc. (RCS). RCS will serve as the platform investment in WCP's effort to build a best-in-class patient account resolution company serving hospitals, hospital-based physician groups and other healthcare facilities nationwide. Established in 2002 and headquartered in suburban Chicago, RCS partners with over 100 hospitals across the country and provides a wide range of account resolution services including early-out self-pay, third-party insurance and aged receivables recovery.

- **H.I.G. Capital** has completed its take-private acquisition of **NovaMed Inc.**, an operator of ambulatory surgery centers in partnership with physicians. The deal was valued at approximately $214 million, including assumption or repayment of $105 million of indebtedness. NovaMed stockholders received $13.25 per share. www.novamed.com

- **Essent Healthcare** has sold a pair of Massachusetts hospitals to **Steward Healthcare System LLC of Boston.** Essent is a portfolio company of **Vestar Capital Partners**. The PE firm invested in the hospital system through its fourth fund. More here…

## 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 | Ilinois ABD | Implementation | 40,000 |
| 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 Welcomes…

**Jennifer Kent** joins us as a new Principal in the Sacramento office. Jennifer has served in California state government for nearly seven years and comes to HMA from California's Department of Health Care Services where she has most recently served as the Associate Director responsible for implementing state and national health reform initiatives for Medi-Cal. Jennifer has also coordinated stakeholder involvement, and issues of other affected state departments, in the implementation of California's comprehensive 1115 waiver, and provided policy and strategic advice on fiscal and budgetary matters. Prior to this assignment, Jennifer served as the Deputy Legislative Secretary in the Office of the Governor. In this post, Jennifer was Governor Schwarzenegger's lead policy and strategic advisor on California's Health Exchange legislation and served as the legislative lead

for all matters pertaining to health, human services, managed care, revenue and taxation, health-related boards, veteran affairs, and alcohol regulation. Before joining the Office of the Governor, Jennifer served in both the California Health and Human Services Agency and the California Department of Health Services. Jennifer earned her Bachelor of Arts degree at Saint Mary's College of California and her Master's in Public Administration degree at the University of Southern California.

**Rob Buchanan** joins us as a Senior Consultant in the Boston office. Rob has spent the last four years at Partners Healthcare System in the Office of Clinical Affairs, first as the Manager of Hospital Quality and Pay for Performance, and most recently as the Program Director of Performance Incentives. In these roles, Rob has administered a $36 million portfolio of hospital quality financial incentives in commercial payer contracts, developed expert analyses on performance measurement and quality benchmarking, and designed and implemented data reporting processes and performance dashboards. Prior to his experience at Partners Healthcare System, Rob was Budget Director for Acute, Ambulatory, and Behavioral Health Care in the Massachusetts Office of Medicaid. During this time, he managed key financial components of the Commonwealth's 2006 health care reform effort, including federal reimbursement maximization strategies and health care reform payment methodologies, and the negotiation and resolution of strategic finance issues with CMS, Massachusetts' safety-net hospitals, and managed care organizations. Rob earned his Bachelor of Arts degree at the University of Wisconsin – Madison, and his Master in Public Policy degree at Harvard University.

**Glenda Stepchinski** will join HMA on June 1 as a Senior Consultant in the Austin office. For nearly 20 years, Glenda has served the State of Texas Medicaid program through her roles with the state's fiscal agents, first with EDS, and since 2003 with ACS. Most recently, Glenda has been ACS' Medical Affairs Officer for the Texas Medicaid and Healthcare Partnership contract where she has led over 200 medical and non-medical professionals in policy areas including Long-Term Care, Home and Community-Based Services, Children with Special Healthcare Needs, Fee-For-Service, and Primary Care Case Management. Prior to this assignment, Glenda served as the Prior Authorization and Primary Care Case Management Director, managing the prior authorization departments, directing and implementing new programs and system enhancements, and acting as the liaison with State customers. Glenda also has experience in medical and case management, utilization review, policy development and analysis, budget development and management, operational and strategic planning, and development of fiscal agent proposals. Glenda is a Registered Nurse, and earned her Bachelor of Science in Nursing degree at the University of Texas Health Science Center.

## HMA Recently Published Research

### Lessons from High- and Low-Performing States for Raising Overall Health System Performance

*The Commonwealth Fund*

Principal Sharon Silow-Carroll and former Senior Consultant Greg Moody (now Director of the Governor's Office of Health Transformation in Ohio) provided the following brief to The Commonwealth Fund, published May 5, 2011.

The authors of this brief interviewed stakeholders in states with high-ranking and low-ranking health system performance, according to The Commonwealth Fund's State Scorecard on Health System Performance. Findings suggest there are market, political, and cultural characteristics that can help or hinder health system improvement. High-performing states are more likely to have: a history of continuous reform and government leadership; a culture of collaboration among stakeholders; transparency of price and quality information; and a congruent set of policies that focus on system improvement. Regardless of starting point, state policymakers and proponents for health system improvement can work to align incentives to change provider, health plan, purchaser, and consumer behavior; frame health in terms of economic development to gain public and political support; engage purchasers and payers to drive value and quality improvement; bring stakeholders together to develop goals and build trust; and take advantage of federal funding, incentives, and reform opportunities. (Link to Brief)

### 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 Foundation's Community Living Assistance Services and Supports (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

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

Vernon Smith, Principal

May 17, 2011

Charlottesville, VA

### 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, Principal

June 12-14, 2011

Seattle, Washington