
HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: ISSUES AND OPPORTUNITIES IN CORRECTIONAL HEALTH

HMA ROUNDUP: WASHINGTON CONTRACT AWARDS ANNOUNCED; GEORGIA CONSULTANT'S REPORT DUE THIS WEEK; PENNSYLVANIA CASELOADS CONTINUE TO DECLINE; NEW YORK GOVERNOR'S BUDGET RELEASED; INDIANA MMIS RFP

OTHER HEADLINES: KANSAS MEDICAID MANAGED CARE EXPANSION WEIGHED; COLORADO OREGON CONSIDER DELIVERY SYSTEM REFORMS; TENNESSEE SEEKS TO EXPAND HCBS WAIVER SLOTS

RFP CALENDAR: HAWAII CONTRACT AWARDS DUE FRIDAY; NEW HAMPSHIRE DELAYED

NOTICE: MACPAC PUBLIC MEETING, THURSDAY, JAN. 19, WASHINGTON, D.C.

JANUARY 18, 2012

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

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IN FOCUS: ISSUES AND OPPORTUNITIES IN CORRECTIONAL HEALTH

This week we are taking a break from our recent focus on Medicaid Managed Care procurements and dual-eligible care coordination integration projects, to review an emerging trend that is garnering attention among state officials. Specifically, we investigate the potential impact that the Affordable Care Act (ACA) will have on financing for correctional health systems. Correctional health programs are funded and administered by the states but generally have minimal overlap with Medicaid programs. Due to certain changes prescribed by the ACA however, opportunities are emerging to deliver certain services for incarcerated residents through the Medicaid program in a manner that would be eligible for federal matching funds. Moreover, with approximately 9 million individuals cycling through U.S. jails in a given year, and about 750,000 inmates released from prison, there is likely to be a meaningful number of newly eligible beneficiaries that transition between Medicaid and the correctional health system. Our analysis of the current and future opportunities that exist in the world of correctional health care was prepared by HMA Principal, Donna Strugar-Fritsch, of our Lansing, Michigan office. Donna is one of the nation's leading experts in the field of correctional health and is working with a number of states on the issues described below.

Background

Medicare, Medicaid, and many commercial insurance plans do not provide health care benefits to incarcerated persons. Federal Medicaid laws and regulations, however, allow coverage of inmate inpatient hospitalizations and skilled nursing home admissions if the inmate is enrolled in Medicaid. These provisions are confusing and widely misunderstood, but prisons, jails, and Medicaid agencies that work through its complexities can augment state or county budgets significantly with federal matching funds.

Medicaid laws and regulations clearly prohibit states from receiving federal Medicaid matching funds for services provided to incarcerated beneficiaries. However, in guidance provided to its regions in 1997, the Center for Medicare and Medicaid Services (CMS) clarified this important consideration: if an incarcerated person is admitted to a "medical institution" for more than 24 hours, that person, under Medicaid rules, is not considered to be incarcerated during the inpatient stay. Therefore, the state Medicaid program can cover the admission and receive federal matching funds for the covered services.

A "medical institution" may be a hospital or skilled nursing facility that is not owned or operated by a corrections organization. Inmates admitted to facilities on the grounds of a prison or jail, or off site but operated by a prison or jail, are not afforded Medicaid coverage. Inmates admitted to facilities that serve the general public are eligible for Medicaid coverage of those admissions. In 2010, CMS further clarified that Medicaid coverage is available when inmates are admitted to medical facility units that are reserved for inmates, even where locked and guarded by employees of corrections organizations.

Which Inmates?

Today, Medicaid eligibility is dependent on federal categorical definitions, individual state rules, and income and asset levels determined by each state. Generally, inmates

who are under age 21, age 65 or older, and/or are pregnant and meet state income tests are eligible for Medicaid. Other adults are typically eligible only if blind or disabled. As such, many inmates who are hospitalized do not qualify for Medicaid. This is often the reason that many corrections organizations have not pursued available Medicaid matching funds – the volume of reimbursable admissions is small.

However, the 2010 federal health care reform legislation significantly expands eligibility for Medicaid as of January 2014. If the reform provisions are implemented as intended, almost all persons under age 65 with incomes at or below 133 percent of the Federal Poverty Level will be eligible for Medicaid. As a result, virtually all inmates will be eligible for Medicaid (excluding undocumented immigrants), and their inpatient admissions will be eligible for federal matching funds. About 9 million individuals cycle through U.S. jails in a given year, and about 750,000 inmates are released from prison. These individuals will make up a substantial portion of the 16 million people covered by Medicaid expansions.

Federal Matching Funds: How Much is This Worth?

Federal Medicaid matching rates differ by state according to a statutory formula based on a state's average personal income compared to the national average. For 2012, federal Medicaid matching rates vary from a floor of 50 percent to a high of 74.18 percent. In 2014, however, federal matching rates for newly eligible Medicaid populations will be 100 percent. Those previously eligible under Medicaid's pre-health care reform eligibility categories will continue to be matched at the current lower statutory rate. Few states or counties can afford to pass up the full federal funding available in 2014 for newly eligible Medicaid enrollees.

Putting a Process in Place

Collecting available federal Medicaid matching funds for eligible inmate hospitalizations involves many challenges, including widespread misunderstanding of the issue, which can extend across prisons, jails, Medicaid agencies, and hospitals. As 2014 approaches, prisons, jails and Medicaid agencies are becoming increasingly interested in building a process to capture federal matching funds for inmate hospitalizations. Even the most significant challenges can be overcome with technical assistance and persistence.

Prison systems can face challenges in gaining the cooperation of Medicaid officials; dedicating corrections personnel to design, implement, and operate an on-going process to enroll eligible inmates in Medicaid; and addressing appropriate billing of individual hospitalizations. Hospitals that serve prison inmates may oppose the use of Medicaid coverage for inmates, especially where the prison currently pays higher rates than Medicaid. And because prisons can contract with numerous hospitals with differing locations, volume, contracts, and services, prisons may need to tailor approaches to specific hospitals.

Jails, by their nature, operate independently from one another. Some have successfully negotiated with local hospitals to enroll eligible inmates into Medicaid, and the Medicaid agency may not even be aware that this is occurring. In other instances, jails are overwhelmed by the complexity of this process, and there is no organized approach. Statewide associations representing counties or sheriffs may serve as a facilitator between

jails and Medicaid in a state, and can also represent jails in discussions with state department of corrections, to develop a unified approach with Medicaid.

Medicaid agencies face their own challenges. In many states, statutes or regulations prohibit enrolling inmates into Medicaid, and/or require that Medicaid eligibility be terminated at incarceration. These barriers must be removed, which may require legislative action and always take time. Also, many Medicaid systems cannot easily be modified to suspend rather than terminate Medicaid eligibility upon incarceration, to enroll inmates, or to limit claims payment to inpatient services. Most Medicaid agencies have reduced staffing, and all face significant new assignments to address the requirements under health care reform. Finding the resources to work with prisons and jails can be a struggle.

Other Medicaid Opportunities for Inmates

There is no move to expand Medicaid coverage of incarcerated beneficiaries – inpatient hospital and skilled nursing home admissions will be the only services that Medicaid will cover. However, there are important opportunities for improving continuity of care for inmates at release or parole, beginning in 2014. At that time, if the provisions of federal health care reform are implemented as intended, enrolling inmates in Medicaid at release or parole will be a simpler process. A web-based Health Benefit Exchange will operate in each state, through which individuals can enroll in Medicaid and other insurance plans using a simple, uniform application. Many eligibility determinations will occur in real time.

Inmates with mental illness, HIV/AIDS, hepatitis, and other chronic or serious conditions will have a continuous source of primary and specialty care and prescription drugs whether incarcerated or not. This affords a significant opportunity for continuity of care, so long as the prison or jail communicates with the inmate's community-based providers.

Expanding Medicaid coverage for inmates post-release also creates the opportunity for Medicaid agencies, state departments of corrections, jails, and community mental health organizations to develop uniform drug formularies that apply in all settings. This would create another major enhancement in continuity of care.

HMA MEDICAID ROUNDUP

Georgia

HMA Roundup - Mark Trail

The Medicaid redesign report, prepared by Navigant Consulting, is due to be released this week. It will be posted on the department's website. Please contact us for more information when it is released.

Indiana

HMA Roundup - Cathy Rudd

Last week, Indiana released an RFP (available [here](#)) for design, development and implementation (DDI) of all MMIS Core Services, with implementation taking place by June 30, 2015. The Core Services are: Core Systems and Services (claims processing, financials, DRG processing, claims code editing, EDI gateway, provider enrollment), Cost Avoidance (TPL) and Customer Relationship Management (CRM). Contracts will have an operational period of 4 years, with 2 one year options to renew for a total of 6 years.

Scoring criteria is provided below:

1. Adherence to Mandatory Requirements	Pass/Fail
2. Management Assessment/Quality (Business and Technical Proposal)	40 points
3. Cost (Cost Proposal)	15 points
4. Indiana Economic Impact	15 points
5. Buy Indiana	10 points
6. Minority (10) and Women Business (10) Subcontractor Commitment	20 points
Total	100 points

HP's current contract, which began in December 2007 and end in June 2014, is for almost \$217 million, but certain contract elements pertain to other programs that are not part of the MMIS RFP.

New York

HMA Roundup - Denise Soffel

Governor Cuomo on Tuesday presented a \$132.5 billion state budget that trimmed total spending for the second year in a row despite a 4 percent rise in outlays for education and Medicaid, the state's two largest expenditures. The budget, which must be enacted by April 1, still needs legislative approval.

Much of the hard work on cost-cutting actually took place last year. As part of last year's budget deal, the Governor limited the growth in Medicaid spending to 4 percent per year, or the rate of medical inflation. The Governor also decided to pass a two-year Medicaid budget, avoiding a contentious negotiation with the health care industry this year.

For the current fiscal year, Medicaid outlays will total \$54 billion. The 4 percent increase is significantly less than what had often been double-digit percentage increases in the past. The global cap on Medicaid, enacted in last year's budget, shifts responsibility for cost containment to the health care industry. However, Medicaid enrollment continues to climb, making these budget caps increasingly challenging.

New York is unusual in that counties and localities pay a significant share of Medicaid costs. Prior to the county share being capped in 2005, Medicaid costs in New York were split three ways, with the federal government paying 50 percent, and the state and the localities each paying 25 percent. As cost pressures on local governments grew, the increase in the county share was capped at 3 percent, but with last year's property tax cap of 2 percent, counties renewed their objection to the local Medicaid share. In response, Governor Cuomo promised to ease that strain as part of his larger effort to ease state mandates on municipal government. He is proposing that the state pay for cost increases currently born by localities, ultimately freezing local Medicaid spending by 2015.

Governor Cuomo's Executive Budget also includes legislation to establish a New York Health Benefit Exchange as a public benefit corporation that will serve as a centralized marketplace for the purchase and sale of health insurance, in accordance with the Federal health care reform law.

Pennsylvania

HMA Roundup - Izanne Leonard-Haak

Previously reported declines in Medicaid enrollment have continued through the end of calendar year 2011. State reports indicate that the decreases are driven almost entirely by the disenrollment of roughly 88,000 Medicaid children over the July 2011 to December 2011 period. December showed the most significant month-to-month enrollment drop at 4 percent.

	Total		Adults		Children	
	% Change		% Change		% Change	
	SFY Avg. Number	Over Prev. Year	SFY Avg. Number	Over Prev. Year	SFY Avg. Number	Over Prev. Year
SFY 09-10 Avg.	2,145,056	5.8%	1,058,912	5.9%	1,086,144	5.8%
SFY 10-11 Avg.	2,202,274	2.6%	1,067,773	0.8%	1,134,501	4.3%
	% Change		% Change		% Change	
	Monthly Number	Over Prev. Month	Monthly Number	Over Prev. Month	Monthly Number	Over Prev. Month
July 2011	2,243,850	-0.1%	1,084,245	-1.0%	1,159,605	0.8%
Aug.	2,246,170	0.1%	1,085,035	0.1%	1,161,135	0.1%
Sept.	2,223,418	-1.0%	1,080,249	-0.4%	1,143,169	-1.5%
Oct.	2,205,900	-0.8%	1,075,600	-0.4%	1,130,300	-1.1%
Nov.	2,196,953	-0.4%	1,079,225	0.3%	1,117,728	-1.1%
Dec.	2,181,399	-0.7%	1,108,335	2.7%	1,073,064	-4.0%

Source: ARMS72 Reports/DW(data warehouse) starting Oct. 2011.

Washington

HMA Roundup – Julie Johnston

The Washington Health Care Authority announced on Tuesday that the following five health plans were awarded 2012-13 Medicaid managed care contracts for more than 700,000 Medicaid and Basic Health beneficiaries:

- Amerigroup
- Coordinated Care Corporation (Centene)
- Molina Healthcare of Washington
- UnitedHealthcare Community Plan
- Community Health Plan of Washington.

Molina is the only incumbent national plan, currently holding nearly 50 percent of the market, while the local Community Health Plan of Washington serves another 33 percent. The RFP included roughly 115,000 non-dual aged, blind, and disabled Medicaid beneficiaries not previously enrolled in managed care plans. Back in September 2011, we estimated a market opportunity of roughly \$1.5 billion for the rebid of existing Healthy Options and Basic Health contracts. With 740,000 lives, this is roughly a blended PMPM of \$170. The Healthy Options Non-Dual ABD population expansion can be conservatively estimated at nearly \$830 million, with 115,000 covered lives and a PMPM of \$600. In total, we estimated the total value put to bid in this RFP at more than \$2.3 billion.

OTHER HEADLINES

Arkansas

- **Beebe proposes \$163M increase in Ark. budget**

Medicaid and public schools would receive the bulk of a \$163 million funding increase in a \$4.7 billion budget that Arkansas Gov. Mike Beebe presented on Tuesday, but lawmakers questioned his decision to not propose granting state employees a pay raise in the coming year. Beebe called for \$117 million in new money for the state's Human Services Department to pay for growth in Medicaid and wants \$56 million in additional funding for Arkansas' public schools for the coming year. Some of the increased funding is offset by reductions that the governor is proposing for other agencies, including \$15 million from a fund for merit-based pay raises. Many of the reductions come from one-time items from this year's budget that weren't continuing the following year. ([CBS News](#))

California

- **Lots To Do With Less Than Two Years To Go**

It is an eventful month for the California Health Benefit Exchange board. January 19, it releases its final solicitation for technology to help run the exchange. Proposals are due at the end of this month for the communication, outreach, assisters and health plan management components of the exchange. Meanwhile, Executive Director Peter Lee

said at January 17's board meeting, the exchange has continued to hire new personnel and is now negotiating for office space to lease in Sacramento to accommodate all of those new hires. The exchange board yesterday also scheduled an additional January board meeting for next week (January 26) to finalize comments on the essential health benefits listed in last month's CMS bulletin. Also next week, Lee said, the exchange staff plans to release the SHOP (Small-Employer Health Option Program) enrollment estimates on January 26. ([California Healthline](#))

- **Medical Transport Lawsuit Gets Federal Injunction**

A federal judge issued a preliminary injunction Wednesday to halt a 10% Medi-Cal provider reimbursement cut to medical transportation services. It was the third time the state has lost in court on this issue. State officials said the state will appeal. Preliminary injunction rulings at the end of December halted cuts in hospital and pharmacy services. Another lawsuit, brought by the California Medical Association and other providers, is still pending. Marat Sheynkman, executive director of the California Medical Transportation Association, which filed the suit that triggered Wednesday's ruling, said the 10% Medi-Cal reimbursement cut would have hit medical transport providers particularly hard. Sheynkman estimated that about half of the state's medical transportation providers would go out of business with a reduction like that. ([California Healthline](#))

Colorado

- **State Medicaid system may shift**

The state agency that manages Medicaid in Colorado described a philosophical shift in the program's delivery to lawmakers on Thursday. Sue Birch, executive director of the Department of Health Care Policy Finance, said the agency aims to replace the state's current fee-for-service approach to Medicaid with a more sustainable system geared toward healthy outcomes for recipients. Eliminating costs of hospital readmissions for infection and other avoidable medical events through front-end care is at the heart of the department's revamped plan for Medicaid payment to providers and treatment to qualified recipients. ([The Pueblo Chieftain](#))

- **Republican senator's bill would force state to seek Medicaid waiver, allow asset test**

Republican Senator Greg Brophy last Wednesday filed a bill that would require the Colorado Department of Health Care Policy and Financing to seek a federal waiver that would allow the state to set its own eligibility levels for Medicaid and other health programs such as CHP+, which insures poor children and pregnant women. Under the federal Affordable Care Act, eligibility cannot be decreased. Brophy's bill also would allow the state to reinstate asset tests for Medicaid recipients that have been eliminated. That's despite the research that said the asset tests cost more money than they save and despite the fact federal law also now bars adding asset tests. ([Denver Post](#))

Idaho

- **Medicaid eats up at least 17 percent of state budget and number could grow**

After a number of years of expending less on Medicaid as a share of the whole budget, Idaho is set to keep funds for the program at more than 17 percent of total state spending for the second straight year. Department of Health and Welfare officials are asking for \$44 million more in state funding next year, bringing the total allotment to \$481 million if approved. If lawmakers OK that amount, it would represent the greatest share dedicated to Medicaid in recent years. The \$481 million would represent 17.17 percent of the governor's proposed \$2.8 billion budget for 2013. If lawmakers provide a conservative estimate for state revenues, it's possible that percentage could jump even higher, though the \$44 million request isn't a sure thing. Medicaid is typically seen as a medical services safety net. More than 230,000 Idahoans utilize Medicaid services, with the majority of them being children. ([Idaho Reporter](#))

- **Idaho asks feds to extend deadline on creating a state-run health insurance exchange**

Gov. Butch Otter's chief of health and welfare sent a letter Nov. 3 to the U.S. Department of Health and Human Services asking for a one-year extension of the January 2014 deadline on creating a state-run health insurance exchange and online portal, where people and small businesses could buy insurance in a larger pool. Idaho also asked for details about a federal exchange — what Idaho will get if it doesn't build its own — but hasn't heard back from HHS. ([Idaho Statesman](#))

Kansas

- **Doctor and hospital groups endorse KanCare plan**

The heads of the Kansas Medical Society and the Kansas Hospital Association testified today in favor of Gov. Sam Brownback's plan to expand Medicaid managed care to include long-term services for the developmentally disabled, the elderly and the mentally ill. Those endorsements put the state's leading medical provider groups at odds with the state's 27 Community Developmental Disability Organizations (CDDOs). Those groups and their supporters have been the plan's most outspoken and organized opponents. About 400 people gathered Saturday at a church in west Wichita to voice concerns. Similar meetings have occurred or are planned in other parts of the state. But the chief spokesmen for the doctor and hospital groups said it was clear to their members that changes were needed in the Medicaid program and that the governor's plan offered potential for better coordination of care and improved health for Medicaid patients. Administration officials claim KanCare, the proposed plan, will be accomplished without major cuts in payments to medical providers, including doctors and hospitals. Thanks to better care coordination and elimination of unneeded services, they say, it will produce cost savings of about \$850 million over five years. ([Kansas Health Institute](#))

Louisiana

- **Rollout of new system rocky**

The first phase of the rollout of a new “Bayou Health” privatized system for providing health care to the state’s poor and uninsured is running into startup difficulties. Roughly 12 percent of eligible Medicaid recipients have enrolled with one of five private health plans scheduled to take over their care in February. Beginning Monday, the Jindal administration will start assigning the remaining quarter-million unsigned participants to one of the private companies. Also doctors, hospitals and other health-care providers have raised so many questions about how the new privatized program works that the state Department of Health and Hospitals, called DHH, started holding daily conference calls to try to clear the air. ([The Advocate](#))

Maine

- **LePage’s DHHS budget ignores debt owed state’s hospitals**

As lawmakers grapple with the governor’s proposal to close a more than \$120 million shortfall in the Department of Health and Human Services budget for the next six months, the funding gap could be twice as big. The state owes hospitals \$125 million through the remainder of this fiscal year, debt that has accumulated since 2009 as hospitals continue to serve Medicaid patients without being fully reimbursed by the state. The budget sets aside up to \$25 million in unappropriated funds that legislators could direct to cover the debt in the next fiscal year. ([Bangor Daily News](#))

Maryland

- **Expanding access to health care**

Gov. Martin O'Malley's administration is proposing to establish a number of health enterprise zones to address the glaring health disparities along racial and class lines that end lives prematurely and cost the state hundreds of millions of dollars a year in additional medical costs. This Baltimore Sun Op-Ed piece believes the proposal appears promising, if it is accompanied by adequate safeguards against fraud. ([Baltimore Sun](#))

Missouri

- **Nixon calls for cuts to Missouri budget**

Governor Nixon and legislative budget leaders have agreed to base next year's budget on projected growth of 3.9 percent, or about \$285 million. But that growth is insufficient to offset the end of federal stimulus money and a reduction in the rate the federal government pays for Medicaid. That's why Nixon had to find \$508 million in cuts. The biggest chunk of savings was \$191.7 million from Medicaid. The money would come from "efficiencies" such as increasing the use of generic drugs and maximizing federal matching funds for nursing home residents. ([STL Today](#))

- **Bankruptcy of former SynCare president sheds light on Medicaid debacle**

The president of SynCare, LCC - the Missouri Medicaid contractor ousted last year after a barrage of patient complaints - has filed for bankruptcy. ([STL Today](#))

Nebraska

- **Bill would stop state's Medicaid cuts**

An Omaha senator said Wednesday he would move to stop implementation of cuts to the Medicaid program announced last month by the state Department of Health and Human Services. Health care providers and advocates for those receiving Medicaid services that could be cut say they would be devastating for some of the Medicaid clients and their families. Nursing and home health services are among \$21 million in Medicaid cuts proposed by HHS. Proposed cuts in services and savings to Medicaid clients being considered would go into effect on or before July 1. They include:

- Limiting home health services to 240 hours per year, about 4.6 hours a week.
- Eliminating nursing services for clients who need more individual and continuous care than is available from a visiting nurse.
- Allowing personal assistance services only for those who meet nursing facility levels of care or participate in home and community-based service waivers.
- Eliminating oral nutritional supplements, not those used with feeding devices, such as formula and nutritional drinks such as Boost and Ensure.
- Limiting behavioral health therapy visits to 60 per year.

Sen. Jeremy Nordquist introduced a bill (LB952) to stop the cuts he said would "significantly weaken safety-net health services for Nebraska's most vulnerable populations." ([Journal Star](#))

Oregon

- **Business Plan for Oregon Health Plan's Transformation Begins Taking Shape**

The Oregon Health Policy Board is nearing completion of a business plan to overhaul the Oregon Health Plan, and intends to finalize that document at its meeting next Tuesday in time to deliver to the Legislature before its upcoming February session. But questions remain, particularly around how detailed the business plan should be, and whether it should include a lengthy set of requirements or flexible parameters for the coordinated care organizations (CCOs), the centerpiece of the transformation, which will integrate physical, mental and dental services for more than 600,000 people on the Oregon Health Plan. The dichotomous question of whether to be flexible or prescriptive has plagued the policy board since it began crafting the business plan. ([The Lund Report](#))

Tennessee

- **TennCare wants home-based care for more seniors**

A change that Tennessee made to its Medicaid program two years ago that helps families care for elderly and disabled relatives has proved so successful that the state is making it available to more people. TennCare wants to expand the number of slots. Between 11,000 and 15,000 TennCare beneficiaries could be receiving care outside of a nursing home after July 1 – significantly more than the currently approved range of 8,500 to 11,000. Families who sign up get coverage for wheelchair ramps, adult day

care, home visits from personal attendants and other assistance. The expansion of the program is expected to save the state money. Home-based care costs about \$19,000 a year on average compared with the \$55,000 yearly expense of a skilled nursing facility. ([The Tennessean](#))

United States

- **Supreme Court holds the fate of Medicaid**

Two cases before the Supreme Court have the potential to effectively do what Republican lawmakers have tried and failed: transform Medicaid into a block grant program for states with few enforceable federal rules about how they provide health coverage for the poor. Should the courts rule against the Obama administration and back the states' contention that Medicaid expansion under the health reform law is unconstitutional, it would severely limit Washington's ability to tell the states: If you want the federal Medicaid funds, you have to follow the federal Medicaid rules. The second Supreme Court case, arising from a dispute over California Medicaid payment rates to health care providers, could give states even more latitude to run their programs by limiting individuals' right to argue in court that a state Medicaid policy violates federal law. ([Politico](#))

- **States Ease Barriers To Medicaid, CHIP Enrollment, Survey Says**

Half the states last year made it easier for children and their parents to enroll in Medicaid by streamlining enrollment and using technology advances to verify citizenship requirements, according to a report released Wednesday. The survey by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured also found that eight states expanded eligibility rules so more children would qualify for Medicaid or the Children's Health Insurance Program, CHIP (KHN is an editorially-independent program of the foundation). Three of the states – Illinois, Texas and Vermont – began covering lawfully residing immigrant children without first having them wait five years. CHIP helps more than 5 million children from low-income families whose incomes make them ineligible for Medicaid. ([Kaiser Health News](#))

- **States face uphill climb in legal challenge over health law's Medicaid expansion**

The 26 states challenging President Obama's healthcare law are facing several thorny dilemmas as they try to convince the Supreme Court to throw out the law's Medicaid expansion. Both of the lower courts that heard the Medicaid challenge ruled against the states, even as those judges struck down the healthcare law's individual mandate. Legal experts on both sides of the debate over the mandate were surprised that the Supreme Court agreed to also hear the Medicaid piece of the states' lawsuit. ([The Hill](#))

PRIVATE COMPANY NEWS

- **Amerigroup Wins New Business in Washington State**

Amerigroup Washington will participate in the Healthy Options program and provide services for Temporary Assistance for Needy Families (TANF), TANF-related Children's Health Insurance Program (CHIP), and seniors and people with disabilities who are not also eligible for Medicare. Additionally, Amerigroup will participate in the state's Basic Health program, which currently provides subsidized health coverage for approximately 40,000 low-income adults. ([Amerigroup](#))

- **Centene Corporation Selected for Washington State Medicaid Contract**

Centene Corporation announced that its subsidiary, Coordinated Care Corporation, has been selected to contract with the Washington Health Care Authority (HCA) to serve Medicaid beneficiaries in the state. Approximately 840,000 beneficiaries are eligible to be served by the state's Healthy Options managed Medicaid and Basic Health programs. The Healthy Options program currently provides fully capitated, managed care services for approximately 700,000 Temporary Assistance for Needy Families (TANF) and TANF-related Children's Health Insurance Program (CHIP) clients. HCA intends to add about 100,000 Medicaid clients who are eligible for Supplemental Security Income (SSI) but who are not dually eligible for Medicare under the new contract at this time. Basic Health currently provides subsidized health care coverage for approximately 40,000 low-income adults. ([Centene Corporation](#))

- **Mentor Capital Acquires 50% of Brighter Day Health for \$5M**

Publicly traded Mentor Capital, a San Diego-based firm that acquires and invests in "leading-edge" cancer companies, has agreed to pay \$5 million for a 50 percent ownership stake in Houston-based Brighter Day Health, pending shareholder approval. Brighter Day provides face-to-face doctor interaction through secure computer video set-ups for health care delivery at nursing homes and other treatment facilities. ([PE Hub](#))

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 note that contract awards in New Hampshire have been delayed until March according to our sources. Additionally, we anticipate Hawaii will announce contract awards this Friday. Finally, Pennsylvania RFP responses are due today, January 18.

Date	State	Event	Beneficiaries
January 18, 2012	Pennsylvania	Proposals due	465,000
January 20, 2012	Hawaii	Contract awards	225,000
January 27, 2012	Virginia Behavioral	Proposals due	265,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
February 22, 2012	Kansas	Proposals due	313,000
February 27, 2012	Ohio	LOIs due	1,650,000
February 28, 2012	Nebraska	Contract awards	75,000
March	New Hampshire	Contract awards	130,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
March 19, 2012	Ohio	Proposals due	1,650,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 9, 2012	Ohio	Contract awards	1,650,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Georgia	RFP Released	1,500,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	100,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	100,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA RECENTLY PUBLISHED RESEARCH

Commonwealth Fund - Why Not the Best? Series: Eliminating Central Line Infections and Spreading Success at High-Performing Hospitals

Sharon Silow-Carroll, Managing Principal

Jennifer Edwards, Managing Principal

One of the most common types of health care-associated infections is the central line-associated bloodstream infection (CLABSI), which can result when a central venous catheter is not inserted or maintained properly. About 43,000 CLABSIs occurred in hospitals in 2009; nearly one of five infected patients died as a result. This report synthesizes lessons from four hospitals reporting that they did not experience any CLABSIs in their intensive care units in 2009. Lessons include: the importance of following evidence-based protocols to prevent infection; the need for dedicated teams to oversee all central line insertions; the value of participating in statewide, national, or regional CLABSI collaboratives or initiatives; and the necessity for close monitoring of infection rates, giving feedback to staff, and applying internal and external goals. The report also presents ways these hospitals are spreading prevention techniques to non-ICU units and strategies for preventing other health care-associated infections.

Read the case studies from the four hospitals:

- [Bronson Methodist Hospital](#) of Kalamazoo, Michigan;
- [Englewood Hospital and Medical Center](#) of Englewood, New Jersey;
- [Presbyterian Intercommunity Hospital](#) of Whittier, California; and
- [Southern Ohio Medical Center](#) of Portsmouth, Ohio.

Comparative performance data for these and other hospitals can be found on [WhyNotTheBest.org](#).

Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

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For the 11th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) present their budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. ([Link to report](#))