HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: A REVIEW OF SERVICES REQUIRED TO OPERATE A HEALTH INSURANCE EXCHANGE AND THE VENDORS THAT PROVIDE THEM

HMA ROUNDUP: FLORIDA BUDGET CONFERENCE COMMITTEE CONVENES TODAY; ILLINOIS STAKEHOLDER MEETINGS ON PAYMENT REFORM FRIDAY; TEXAS MCO RFP VENDOR CONFERENCE ATTENDEES

OTHER HEADLINES MAINE, FLORIDA CONSIDER MANDATORY DRUG TESTS FOR MEDICAID ENROLLEES; FALLON CLINIC IN TALKS TO JOIN ATRIUS HEALTH IN MASSACHUSETTS; LOUISIANA MCO RFP VENDOR CONFERENCE ATTENDEES; VERMONT'S HEALTH OVERHAUL ADVANCES IN SENATE; WEST VIRGINIA WAITS FOR CMS APPROVAL ON MEDICAID BRAIN INJURY WAIVER

MEDICAID MANAGED CARE RFP CALENDAR

APRIL 27, 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: THE BUSINESS OF EXCHANGES

This week, our *In Focus* section looks at the functions of a Health Insurance Exchange and identifies some of the companies with which states may choose to contract for aspects of its development and operation. With FY 2012 legislative sessions entering their stretch runs, many states are making both legislative and administrative progress toward the creation and implementation of Exchanges. As of Wednesday, April 26th, California, Maryland, and West Virginia have enacted exchange laws since the federal requirement was enacted last year. They join Massachusetts, Utah and Washington State which already had similar laws in place. Another 6 states appear to be making significant progress toward Exchange creation (Colorado, Connecticut, Montana, New York, North Dakota and Oregon) while many others are using the Exchange planning grants funded by the federal government to conduct planning sessions. We expect this activity to accelerate as we enter the second half of 2011 and into 2012. Accordingly, we have asked our HMA colleague Tom Dehner, who is spearheading much of our firm's activity around Exchange planning, to describe the functions that states will be required to perform through their Exchanges and the vendors that are likely to bid on those projects.

The Business of Exchanges

The ACA establishes two types of insurance Exchanges in each state, one for the individual market (American Health Benefit Exchanges) and one for the small-group market (Small Business Health Options Program or SHOP Exchanges). States can combine the two types into a single organizational entity, and generally have wide discretion to design organizational and management structures that define a state Exchange. As of April 2011, many states are heavily involved in initial Exchange planning, funded by Exchange planning grants distributed to 48 states and DC in September 2010. HHS has released guidance on ongoing funding for states establishing Exchanges, and federal grants will continue either for additional planning support (known as Level 1 grants) or for actually funding the establishment of an Exchange (known as Level 2 grants). Those grants will provide states with resources to begin Exchange development, and vendor contracting, in earnest.

At a high level, significant state policy decisions will be required to establish business operational plans for Exchanges. For example, who will govern the Exchange? How many individuals will purchase insurance on the Exchange? How will the state approach its role to certify plans for the Exchange – as a passive marketplace for all licensed insurers or with the more active intention of selecting a limited number of low-cost or high-quality plans? These are only the most obvious examples of the kind of policy decisions states will confront as Exchange structures are established.

Moreover, Exchanges will be a source of both descriptive and evaluative information. For example, Exchanges are required to rate qualified Exchange plans based on relative quality and cost and provide those ratings in some form to consumers shopping for insurance. States are also required to obtain justifications of premium increases from participating health plans, and Exchanges are empowered to remove from the Exchange health

plans that propose unreasonable rate increases. In summary, Exchanges combine operational and administrative functions with strategic policy-related functions. As such, assessing how state Exchanges plan to define and separate those functions is important to understanding how an Exchange will ultimately operate, and how that will translate into business opportunities.

Exchange Functions

In terms of business operations the functions that Exchanges will perform are fairly clear. According to guidance provided by the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO) on February 11, Exchanges will be required to fulfill the following functions.

Minimum Functions of an Exchange

- Certification, recertification, and decertification of qualified health plans
- Call center
- Exchange website
- Premium tax credit and cost-sharing reduction calculator
- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

Source: U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight

In light of the accelerated timeframes required for states to comply with the ACA requirements, as well as states' historical preference for partnering with the private sector to conduct similar services, we believe that Exchanges in many states will elect to purchase key capabilities from the private sector rather than develop them internally. This report focuses on these operational requirements of Exchanges, and reviews the kind of potential business partners Exchanges may need to satisfy those requirements.

Expected Timelines

Exchanges will be operational in all states on January 1, 2014. Contracted development work to start up an Exchange will begin soon –likely in late 2011 or early 2012. Vendors providing ongoing operational services to Exchanges should expect work to be bid starting in the spring or summer of 2013.

Start-up funding for Exchanges will come from federal grants, under which state grantees will be expected to competitively bid any contract over $100,000. Depending on the state and its chosen organizational structure, state Exchanges may not be subject to all of the same procurement rules as a typical state agency, though we think that most states will award large contracts using some form of public competitive bidding process.

Potential Partners

Consulting Services. Without question states will be utilizing consulting firms throughout the Exchange planning process. Consulting services will remain an important business need for Exchanges even after the initial planning and implementation process, with the need likely to continue in particular for actuarial services and information technology (IT) consulting services. States have and will continue to utilize both smaller local firms and larger national or global consulting firms. Health Management Associates is proud to have been selected as the primary contractor for exchange planning services in four states thus far.

Website Development. A customer-friendly web portal is a central element of the ACA and will be a high priority item for Exchange officials. Through the web portal, consumers can shop for and enroll in health insurance, and apply for subsidized insurance. It is unlikely that this element of Exchange operations will stand alone. Rather, Exchanges will seek to integrate the development of a web portal with related work for Exchanges.

Eligibility System Support. Exchanges need to have IT systems that will be capable of performing a wide range of business functions. One of the most challenging for states will be the need for Exchanges to design or purchase systems that can determine eligibility for Exchange-based subsidies. IT systems needs to be constructed to receive application information from online (the web portal) and paper (the traditional written application) sources, to interface with and access federal sources of information, such as IRS income data, and to interact with existing state systems that perform Medicaid and CHIP eligibility.

At the same time, state Medicaid agencies need to update eligibility systems to take account of expanded Medicaid standards and other new ACA requirements. In many states, dated legacy systems are in place that will require full-scale redesign or significant changes, so IT firms that specialize in developing or updating health program eligibility systems will be needed by states. To encourage ACA-based improvements, Medicaid eligibility system development and enhancements now receive an enhanced (90%) match from the federal government. That creates a significant incentive for states to address Medicaid IT needs. The ACA also authorizes Exchanges to purchase services from state Medicaid agencies. That means IT firms will try to bundle Medicaid enhancements with new functionality that Exchanges can utilize for non-Medicaid functions. Although approaches to achieving eligibility integration will differ by state, these operational requirements will require relationships between Exchanges and Medicaid agencies to which vendors will need to adapt.

Health Plan Enrollment and Premium Billing Support. **A** central function for Exchanges is to support the enrollment of individuals into health plans. There are technology and customer service/call center dimensions to this business need, which we anticipate states

will want to fill with one vendor, not two. In states with Medicaid managed care programs, state often contract with vendors to provide neutral enrollment broker services and a range of other customer services. Enrollment brokers include Maximus and Policy Studies, Inc. Also providing some of these services are the companies that provide Medicaid fiscal agent services, such as HP Enterprise Services (formerly EDS), ACS (a Xerox Company), and Molina Information Systems (formerly Unysis). The current Medicaid enrollment broker market players are well-positioned to adapt their offerings to Exchanges.

Similarly, a range of private and non-profit companies provide insurance purchasing support and should expect to play a significant role in Exchange implementation. Health insurance intermediaries, also known as TPAs or third party administrators, provide administrative services, including enrollment, premium billing and collection, mid-year changes in enrollment, COBRA administration, and other administrative services. This is a well-developed market in the non-group and small group markets where the Exchange will operate, so TPA companies that provide premium billing and other administrative support to health plans should have some functionality that can be adopted to support Exchanges.

In Massachusetts, the Connector contracts with a "sub-Connector" to help administer the unsubsidized Commonwealth Choice program and provide Customer Service and administrative support for that program. That contract was awarded to an existing intermediary in the state, the Small Business Service Bureau (SBSB), which already supported small business purchasers in the Massachusetts market by providing intermediary-type services and which has an associated brokerage arm, the Small Business Insurance Agency. In Utah, the state contracts with HealthEquity, which performs administrative and financial functions for the Health Exchange. HealthEquity performs premium billing and other administrative functions and remits payments to carriers and brokers.

It is worth noting that Exchanges are not obligated to provide premium billing services to customers. In fact, the ACA contemplates leaving that function for carriers themselves, although Exchanges must play an administrative role. However, Exchanges are likely to see the function as a value-added offering, and as noted above there will be plenty of companies willing to sell the function as one of a suite of Exchange services.

Finally, Exchanges are expected to activate a sophisticated web portal, operate their own IT systems, integrate seamlessly with existing state-based systems, and provide enrollment and customer service supports. The range of services in play will drive states to look for and vendors to provide combined or end-to-end solutions. For example, large technology software/hardware or integration firms, including Accenture, Dell (which in 2010 acquired Perot Systems), Deloitte, Microsoft and others will position themselves as "one-stop-shops" for states that need to integrate disparate technology systems with a front-end Exchange website that accepts Medicaid and Exchange tax credit applications. Some states will favor solutions that combine necessary functionality with back-end customer services supports – the kind of work both Medicaid enrollment brokers and third-party administrators do today. Those businesses may seek to develop, acquire, or partner with companies that can offer web development or eligibility determination capacities.

The table below lists some of the potential vendors for each of the services that states may consider outsourcing as they design, implement and operate their health insurance exchanges. This is by no means an exhaustive list but is meant to illustrate the types of organizations that are likely to bid on the different elements of Exchange work.

Policy Consulting Services	Actuarial Consulting Services	Website Development
Health Management Associates	Mercer	Likely procured in conjunction
Lewin Group	Milliman	with other services
Public Consulting Group (PCG)	Wakely	

Eligibility	Enrollment/Premium Billing Support	"All-in-one" Solutions
Deloitte Consulting	Maximus	Accenture
Maximus	Policy Studies Inc. (PSI)	Dell (Perot Systems)
Policy Studies Inc. (PSI)	ACS (Xerox)	Deloitte Consulting
	HP Enterprise Services	Microsoft
	Molina Medicaid Solutions	

States to Watch

Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a consortium of New England states led by Massachusetts were awarded a total of $241 million in Exchange "Early Innovator" grant funds in February 2011. (Oklahoma has since returned its $54 million grant award.) The grants are intended by The US Department of Health and Human Services (HHS) to support the development of models for Exchange IT systems that can be shared or adapted to other states. These states deserve close scrutiny, because vendors who succeed in capturing that business developing Exchange IT systems will have both relevant experience for other Exchanges and a quicker-to-market product to offer.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

Deliberations over the $15 billion state budget gap have slowed as legislators await Governor Brown's revised budget due out May 18, 2011. As a reminder, provider rate cuts have been passed and are pending federal decision. Meanwhile, the Governor's plan to extend current tax increases through a ballot initiative appears to have stalled for the moment.

In the news

- **Aged, Blind, Disabled Moving Into Managed Medi-Cal**
  Last month, state officials began informing more than 380,000 aged, blind and disabled Californians receiving subsidized health coverage that they need to choose a managed Medi-Cal plan in the coming months. Mandatory managed care for Seniors and Persons with Disabilities (SPDs) is part of a sweeping Medicaid waiver negotiated last

year between California and CMS. The waiver will bring about $10 billion in federal funds over the next five years. (California Health Line)

Florida

HMA Roundup – Gary Crayton

The House and Senate returned to session this week. As of Monday, there was little optimism on a budget agreement, particularly on the issue of allocation. However, on Tuesday, the House and Senate announced an allocation agreement for the FY 2011-2012 budget. A budget conference committee is set to convene today, April 27, 2011, to reconcile the House and Senate bills. The bills must be resolved by early next week if the budget is to be passed by next Friday's deadline – bills must be printed 72 hours before a vote in Florida. The managed care bill will be handled by a separate committee.

In the news

- **House gives Gov. Rick Scott a legislative victory**
  A measure that would force welfare recipients to be drug-tested before receiving benefits -- a key campaign issue for Gov. Rick Scott -- passed the House by a vote of 78 to 38 Tuesday. (Florida Current)

- **House bill would slow sale of public hospitals**
  With the hospital industry divided on the issue, a House committee on Thursday approved a bill that would require judges to sign off on deals that would shift control of public hospitals to private companies. The Judiciary Committee voted 10-8 to approve HB 619, which one supporter said would stop "sweetheart" deals to lease or sell public hospitals. (Health News Florida)

Georgia

HMA Roundup – Mark Trail

The Governor signed a bill that would allow Georgia to work with other states to offer health insurance plans across state lines. Georgia joins Arizona and Wyoming as the only states that have passed legislation of this nature. The Oklahoma and Montana legislatures are considering similar bills.

Elsewhere, Medicaid managed care rate negotiations will begin in late May or early June, and are expected to be completed by July or August.

In the news

- **Deal signs health compact bill into law**
  Governor Deal signed House Bill 461, which allows states to work together on health care through a legal compact -- a measure that could make it possible for them to avoid implementation of the federal health care law. But, since any compact requires congressional approval, many see Georgia's move as largely symbolic. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The proposed 6%, across-the-board provider rate cut in Medicaid is still on the table, and while the hospital community has yet to speak out aggressively against it, their summary of the budget cuts unveiled some points of discomfort.

Last week, a deal on changes to outlier payments to hospitals fell apart due to opposition from some segments the provider community. The deal between the Department of Healthcare and Family Services (HFS) and the provider community would have offset payment threshold changes with some other enhanced payments. This deal falling apart could signal future conflicts between HFS and providers on payment reform.

There is a HFS meeting set for this Friday, April 29, 2011 at 1:00 PM CDT, to discuss the department's initiative to restructure and modernize the hospital reimbursement system. Meetings will be held in Chicago and Springfield.

Texas

HMA Roundup – Dianne Longley

The Senate budget subcommittee's proposed provider rate cuts are significantly lower than the House proposal, with the Senate finance committee voting to use additional rainy day funds to close budget gaps. The Senate as a whole has not voted on this proposal. The position of the Senate on provider rates should become clear this week, with a goal of sending a bill to the House by May 1, 2011.

The Texas Health and Human Services Commission (HHSC) has denied a vendor request to extend the deadline for RFP submission by Medicaid managed care organizations, with all proposals due May 23, 2011. We believe the short timeframe for responding to the RFP favors incumbent plans.

Attending the vendor conference on April 18, 2011 were the following companies:

Health Plans
Aetna
Amerigroup
Bravo/Health Spring
BCBS of Texas
Community First Health Plans
Community Health Choice
CompCare
Cook Children's Health Plan
Driscoll Children's Health Plan
El Paso First Health Plans
FirstCare
Molina Healthcare
Parkland Community
Scott & White Health Plan
Sendero Health Plan
Seton Health Plans
Superior Health
Texas Children's Health Plan
United Healthcare
Universal Health Care
Valley Baptist Health Plan
WellCare
WellPoint

Consultants
Caddo Associates
Dennis Edmonds & Associates
Dynamic Consulting Services
Health Management Associates
Oak Hill Technology
Public Policy Solutions

Other
Independent Living Systems
MultiPlan
Beacon Health Strategies
Perrone RX
Progeny Health
RGV Preferred Health Care
Texas Association for Home Care and Hospice
Texas Council of Community Centers
Texas Hospital Association

OTHER HEADLINES

Louisiana

- **Medicaid managed care bidder's conference**
  Louisiana held a series of bidders conferences last week related to its Coordinated Care Network (CCN) RFP. In attendance at the conference for pre-paid health plans were the following companies:

Health Plans
Aetna
Amerigroup
AmeriHealth Mercy/LaCARE
BCBS of Louisiana
Centene/Louisiana Healthcare Connections
Coventry
Meridian Health Plan
United Healthcare
WellCare
WellPoint

Consultants/lawyers
Ben Beardon Consulting
HAPCO International
LMA Consultants
MTM
Sourthern Strategy Group
Public Policy Solutions
Taggert Morton

Providers/Other
Independent Living Systems
Acadian Ambulance Service
American Academy of Pediatrics
Automated Health Systems
Children's Hospital
Community Health Solutions of America
Health Choice
Lab Corp
Louisiana Academy of Family Physicians
Louisiana Independent Physicians Association
LSU Health
McKesson Health Solutions
The Physician Alliance Corporation
Valence Health
Walgreens
Westside Rural Health Services
Woman's Hospital

Source: Louisiana Department of Health and Hospitals

Additionally, in its presentation to the pre-paid health plan bidder's conference, the state disclosed an enrollment breakdown of its mandatory eligibility groups. As the table below indicates, over 80% of the mandatory population is under the age of 19.

Enrollment by Eligibility Group	
Mandatory CCN Enrollees	**847,138**
Medicaid Children <19	559,111
% of Total	*66%*
CHIP Children	127,071
% of Total	*15%*
Parents	84,714
% of Total	*10%*
ABD	76,242
% of Total	*9%*

Source: Louisiana Department of Health and Hospitals

Maine

- **Bills would mandate drug testing for MaineCare enrollees**
  Lawmakers Monday introduced two proposals that would impose mandatory — and possibly unconstitutional — drug testing on Maine residents who are enrolled in MaineCare, the state's Medicaid program for low-income and disabled residents. (Bangor Daily News)

Massachusetts

- **Fallon, Atrius talking of partnership**
  Fallon Clinic is in discussions with Atrius Health, the state's largest private medical practice, to form an affiliation that the organizations say would improve patient care

and control costs. Newton-based Atrius Health, is an affiliation of Dedham Medical Associates, Granite Medical, Harvard Vanguard Medical Associates, Southboro Medical Group and South Shore Medical Center. Those groups, in total, have 844 physicians and about 717,000 patients, with Harvard Vanguard the largest. (Worcester Telegram)

Montana

- **Schweitzer eyes cutting Medicaid rates to providers by as much as 6%**
  The Schweitzer administration is preparing to cut Medicaid payments to hospitals, nursing homes, group homes and other providers of medical and disability services to the poor by as much as 6 percent, according to provider-group representatives and other sources. The administration has told some providers that it plans to file rules the first week of May to cut the Medicaid rates by 5 percent or 6 percent. (Billings Gazette)

New York

- **Cuts to Medicaid may drive dentists away**
  On May 1, the state plans to cut reimbursements to dentists in the Medicaid program, the public health plan for low-income and disabled New Yorkers. The $60 million cut largely affects upstate dentists and patients. Currently, only 20 percent of dentists take Medicaid patients, according to the New York State Dental Association. Dr. Michael Wilson said more will drop out when reimbursement rates are reduced. (Times Union)

North Dakota

- **Gripes aside, ND GOP approves $1M for health benefit exchanges**
  Despite opposition from republicans, North Dakota's Senate voted 31-15 on Monday to approve the $1 million in planning money for a health benefit exchange in the state. The House approved it last week and the bill now goes to the governor. (INFORUM.com)

Oregon

- **State OKs grant for insurance exchange**
  The Legislature's chief budget writers said Tuesday that Oregon will accept a $48 million federal grant enabling it to develop software technology for the electronic marketplace known as a health-insurance exchange. (Statesman Journal)

South Carolina

- **Senate leader: SC can't sustain Medicaid spending**
  Senate President Pro Tem Glenn McConnell said Tuesday that Medicaid spending in the state is unsustainable. McConnell's remarks came as the Senate opened debate on a $5.8 billion spending plan that includes more than $1 billion in spending on caring for the state's elderly, disabled and poor. (Beaumont Enterprise)

Vermont

- **Vermont Senate advances health care bill**
  The state Senate gave preliminary approval Monday to health care legislation that is a key part of Gov. Peter Shumlin's agenda. The Senate legislation won initial approval on a 21-8 vote and is due for final action Tuesday. It calls for setting up a health care marketplace, called an exchange, in keeping with federal health care legislation. It also sets up a board that would review and approve designs for a publicly financed pro-

gram available to all residents. Differences between the House and Senate versions of the legislation would be worked out in a conference committee, and then the bill would go to the governor for his signature. (Bloomberg Business Week)

West Virginia

- **W.Va. seeks federal permission to start Medicaid-funded brain injury program**
  West Virginia is seeking a federal Medicaid waiver to offer a program that would help people with traumatic brain injuries remain in their homes. Department of Health and Human Resources spokesman John Law says the program will begin when the federal Centers for Medicare and Medicaid Services approves the waiver. The Legislature has appropriated $800,000 for the program. (Charleston Daily Mail)

United States

- **Insurers Clash With Health Providers As States Expand Medicaid Managed Care**
  Lobbying battles over Medicaid Managed Care expansions are being fought across the country as more than a dozen governors try to contain the cost of Medicaid, the state-federal program for the poor and disabled, by requiring more people to go into managed care plans. With billions of dollars at stake, insurance companies, hospitals and doctors are fighting over money and control. (Kaiser Health News)

- A new advocacy group that will advocate for simplified enrollment procedures for government-supported health programs, Enroll America, announced that it will soon launch. It is funded by organizations including the Pharmaceutical Research and Manufacturers of America (PhRMA), America's Health Insurance Plans (AHIP), the American Hospital Association (AHA), and Kaiser Permanente. Membership of the group is broader than these funders and includes advocacy organizations. The group is planned as a temporary alliance that will end a year or two after the major coverage expansion under the ACA takes place in 2014.

PRIVATE COMPANY NEWS

- **Veteran Health Care Executive Bradley Fluegel Joins Health Evolution Partners as Executive in Residence**
  Health Evolution Partners, a manager of healthcare investment funds, announced today that Bradley M. Fluegel has joined the firm as Executive in Residence. Mr. Fluegel is a seasoned executive with deep experience in strategy, product planning, operations, corporate development and public affairs. He will work with HEP's Growth Fund and Spectrum Fund to identify promising new investment opportunities and to help portfolio companies become market leaders. (Sun Herald)

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 9, 2011	Arizona LTC	Contract awards	25,000
May 11, 2011	Kentucky	Vendor conference	460,000
May 23, 2011	Texas	Proposals due	3,300,000
May 25, 2011	Kentucky	Proposals due	460,000
June 1, 2011	California ABD	Implementation	380,000
June 24, 2011	Louisiana	Proposals due	875,000
July 1, 2011	Kentucky	Implementation	460,000
July 25, 2011	Louisiana	Contract awards	875,000
August 31, 2011	Texas	Contract awards	3,300,000
October 1, 2011	Arizona LTC	Implementation	25,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	875,000
March 1, 2012	Texas	Implementation	3,300,000

HMA Recently Published Research

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 condi-

tions, 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

The American Society on Aging's 2011 Aging in America Conference:

Understanding and Implementing the CLASS Act: A Breakthrough in Long-Term Services and Support

The Impact of the Economic Downturn on Long-Term Services and Supports

Susan Tucker, Principal

April 28-29, 2011

San Francisco, California

National Association of State Budget Officers: *Budget Strategies & State Fiscal Conditions*

Mark Trail, Principal

April 30, 2011

Ft. Lauderdale, Florida

National Council of Behavioral Healthcare Annual Conference - Primary and Behavioral Health Care Integration Leadership Summit: ***Key Considerations in Designing the Health Home SPA***

Alicia Smith, Senior Consultant

May 1, 2011

San Diego, California

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