HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WE REVIEW THE WASHINGTON MEDICAID MANAGED CARE DRAFT RFP

HMA ROUNDUP: CALIFORNIA GOVERNOR'S REVISED BUDGET RELEASED MONDAY; TEXAS BUDGET AGREEMENT STALLS; MASSACHUSETTS PAYMENT REFORM DISCUSSIONS BEGIN

OTHER HEADLINES: CALIFORNIA DEBATES BASIC HEALTH PLAN; CONNECTICUT CONSIDERS PUBLIC OPTION; IDAHO RELEASES MENTAL HEALTH RFI; MAINE PASSES HEALTH INSURANCE REFORMS

HMA WELCOMES: JENNIFER KENT (SACRAMENTO), ROB BUCHANAN (BOSTON) AND GLENDA STEPCHINSKI (AUSTIN)

MEDICAID MANAGED CARE RFP CALENDAR

MAY 18, 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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Contents

IN FOCUS: WASHINGTON HMO JOINT PROCUREMENT DRAFT RFP

This week, our *In Focus* section looks at a draft RFP released last week by the Washington State Health Care Authority (HCA). The RFP seeks to reprocure the Healthy Options Program and Basic Health Program under joint contracts and add some enrollees eligible for Supplemental Security Income (SSI) to the Healthy Options Program. The decision to issue a joint procurement is part of a strategy to leverage the state's purchasing power and position state-contracted health plans to meet the demand from the Medicaid expansion and health reform implementation in 2014, according to a March 21, 2011 HCA informational meeting. It should be noted that the 18-month contract period ends December 31, 2013, with the Medicaid expansion occurring January 1, 2014.

Target Population

The Healthy Options program currently enrolls close to 700,000 Temporary Assistance to Needy Families (TANF) individuals and TANF-related Children's Health Insurance Program (CHIP) individuals. Total Medicaid enrollment in Washington as of June 2010 was 1.03 million. Also included in the joint procurement is the Basic Health Program, which offers low-cost subsidized managed care plans to approximately 40,000 low-income individuals who are not eligible for Medicaid or Medicare. There is currently a waiting list for Basic Health potential enrollees. Additionally, HCA intends to add SSI recipients who are not dual-eligible for Medicare to the Healthy Options procurement population, of which there are approximately 140,000 potential enrollees in the state. Total Medicaid managed care enrollment in the state will likely approach 900,000 beneficiaries upon implementation of the contract.

The March 21 informational presentation, available on the HCA Joint Procurement website, indicated potential inclusion of SSI recipients, the Children's Health Program, foster children, dual eligibles, and Disability Lifeline beneficiaries. It appears that, of this list, only SSI recipients were included in the draft RFP.

Timeline

HCA intends to release a final RFP on July 15, 2011, with a vendor conference to follow two weeks later. Awards will be announced in December, with enrollment set to begin in July 2012. A full tentative timeline is provided below.

Procurement Schedule	
July 15, 2011	Release RFP to Bidders
August 3, 2011	Bidder's Conference
September 12, 2011	Leter of Intent Due - Required
October 17, 2011	Proposal Due to HCA
December 19, 2011	HCA notifies apparently successful bidders (ASB)
February 1, 2012	Contract Execution
July 1, 2012	Begin serving enrollees under the Contract

As mentioned above, the contract term is designed to last 18 months, ending on December 31, 2013. There is language in the draft RFP that the contract can be extended, but the length of any possible extension is not specified. We believe the July 1, 2012, enrollment date is unlikely to change which we believe gives incumbents an advantage in securing contract awards. This and other procurements schedules will continue to be tracked in our Medicaid Managed Care RFP Calendar.

Evaluation Criteria

The HCA will establish an evaluation team to score each proposal. A failing score in any subsection of the proposal will eliminate a proposal from consideration. Low scores may require corrective actions on the part of the bidder to meet the stated requirements of the contract. However, HCA management will be guided, but not bound, by the scores presented by the evaluation team.

It should also be noted that in the auto-assignment methodology for bidders not entering a new service area, enrollees who do not select a plan will be assigned to one based on the followed criteria:

- 40% based on Rate scores
- 20% based on Quality Assurance and Performance Improvement (QAPI)
- 20% based on Access to Care and Provider Network scores
- 15% based on Care Coordination scores
- 5% based on all other scores combined

Prospective Vendors

As of April 2011 there were 693,456 beneficiaries enrolled in the Healthy Options program. Molina is the largest vendor in the state with just under 325,000 covered lives, or 47% market share. Certainly Molina may cede some membership if the state selects new plans to participate, though any losses could be offset by higher revenue enrollment gains among the newly covered SSI population. As noted above, we also highlight that the short timeframe for the RFP and the relatively short contract length may deter potential new entrants. Molina's large market share in the state has been built in part from the acquisition of members from exiting plans, including Aetna and Premera Blue Cross. It will be interesting to see if those plans' strategies have changed with respect to participation in the program going forward.

	Apr-11	% of Total
Molina Healthcare of Washington	324,768	46.8%
Community Health Plan of Washington	234,307	33.8%
Columbia United Providers	56,947	8.2%
Regence Blue Shield	38,730	5.6%
Group Health Cooperative	21,364	3.1%
King County Care Partners	6,967	1.0%
Asuris Northwest Health	3,825	0.6%
Kaiser Foundation Health Plan	595	0.1%
Various Tribal Organizations	5,953	0.9%
Total Washington	**693,456**	

Source: Washington State Department of Social and Health Services

Current RFP Activity

The table below provides our updated summary of current RFP activity. With the addition of Washington, we estimate that there are currently twelve RFPs in various stages of development or implementation. In aggregate, we estimate these contracts cover 6.4 million lives and total $24 billion of annualized premium. Importantly, Florida is not on this list since no RFP has been issued yet, but we estimate there are another 2.8 million lives and approximately $13 billion worth of spending in that state that are likely to be added to this list over the next 18 months.

	Populations covered	Status	Expansion enrollment	Enrollment re-bid	Members	Size ($M)	Plans
Texas	TANF, ABD	RFP	1,200,000	2,070,000	3,270,000	$12,800	
Washington	TANF, ABD	Draft RFP	700,000	180,000	880,000	$2,100	
Louisiana	TANF, ABD	RFP	875,000	0	875,000	$2,100	
California SPD	ABD	Member transition pending	380,000	0	380,000	$2,100	LA Care, Health Net, WellPpoint, Molina, others
Kentucky	TANF, ABD	RFP	295,000	165,000	460,000	$1,700	
Pennsylvania SW	TANF	Contract awards pending	0	300,000	300,000	$1,100	
Arizona (ALTCS)	LTC	Member transition underway	0	25,000	25,000	$1,100	Centene, UnitedHealth, Aetna, SCAN
Illinois	ABD	Member transition underway	35,000	0	35,000	$290	Centene, Aetna
West Virginia	ABD	Member transition pending	55,000	0	55,000	$290	WellPoint, Carelink, HP of the Upper Ohio Valley
South Carolina	TANF	Member transition underway	80,000	0	80,000	$200	Centene, UnitedHealth, BlueChoice, Select Health
California - Stanislaus	TANF	Member transition underway	0	50,000	50,000	$120	Health Plan of San Juaquin
Virginia	TANF	Member transition pending	30,000	0	30,000	$80	Amerigroup, WellPoint, Sentara, Coventry, VA Premier
Total			**3,650,000**	**2,790,000**	**6,440,000**	**$23,980**	

Source: HMA estimates

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Governor Brown's May Revised Budget was unveiled on Monday and proposes several significant points related to the Medi-Cal program.

- Budget reductions to-date have reduced the Medi-Cal Program by $1.518 billion in General Fund dollars across the current-year and 2011-12. These actions included mandatory copayments for services, provider payment reductions, "soft caps" for physician services, elimination of adult day health care services, cap on hearing aid expenditures, reduction to Medi-Cal eligibility administration and other related actions. 2011-12 Medi-Cal Program expenditures are projected to decline by about 10.8 percent due to the enacted reductions and the Governor's proposed May Revision adjustments.
- Effective January 1, 2012, all children in the Healthy Families Program (HFP) will be transitioned into the Medi-Cal Program, for an overall savings of $31.2 million General Fund in 2011-12. Trailer bill legislation is proposed for this transition, and a State Plan Amendment, subject to federal approval, is required. To the extent possible, transitioned children will be enrolled into Medi-Cal Managed Care delivery systems. The savings is based on a PMPM of about $100 in HFP and a cost per child in Medi-Cal FFS of about $70. A major challenge will be that Medi-Cal does not have a child PMPM rate. To achieve this savings there will need to be a new rate that assumes a flow of new enrollees into that plan who are lower cost and reduce the overall family PMPM by that amount.
- The Governor's May revision extends the existing hospital fee, for a savings of $320 million in General Fund dollars.
- In the 17 counties operating Medi-Cal Managed Care plans funded through intergovernmental transfers (IGT), the state will assess a 20% administrative fee on all IGTs, estimated to generate $32.4 million in general fund dollars. Counties will have the option to transfer funds to DHCS and receive federal match, which will be put towards higher capitation rates.
- Proposed funding of $170 million ($85 million in GF) for transition of adult day health care (AHDC) services have been reduced in the Governor's revised budget to $50 million ($25 million in GF).
- The May revised budget will lock Medi-Cal managed care enrollees into their plan for one year after a 60-day period.

In the news

- **Basic Health Program: Good or Bad for California?**

  The California Health Benefit Exchange board met earlier this week to discuss the possibility of setting up a Basic Health Program (BHP) as an alternative to one section of the exchange. The BHP is an alternative to the exchange's coverage for two sets of

Californians -- adults with incomes between 133% and 200% of the federal poverty level, and for legal immigrants with incomes below 133% of the poverty level. There are concerns that the BHP would undermine the success of the state exchange by shrinking the pool of potential enrollees. In case the state decides to pursue this new entity, SB 703 is the bill -- currently in the Senate Committee on Appropriations -- that would create a BHP in California. (California HealthLine)

Florida

HMA Roundup – Gary Crayton

On Tuesday, the Governor was presented with 31 appropriations bills. The Governor has until June 1, 2011, to act on these bills.

In the news

- **Hospitals: 12% Medicaid cut won't cause layoffs**

  Hospitals plan to absorb a 12 percent Medicaid reimbursement cut without reducing health care services or laying off nurses and caregivers. To reconcile a $4.6 billion revenue shortfall in the state budget, the Legislature agreed to reduce $510 million in Medicaid payments to hospitals. (Highlands Today)

- **Florida Pushing New Fees For Most Medicaid Recipients**

  Florida wants to impose the $10 monthly premium on all Medicaid enrollees – regardless of income -- who aren't in nursing homes. At least two-thirds of Medicaid recipients in Florida, and in the U.S. as a whole, have incomes less than 150 percent of the poverty level, according to the Kaiser Family Foundation. (Kaiser Health News)

- **Medicaid overhaul targets Florida's disabled and frail elderly patients for managed-care plans**

  In the Medicaid overhaul that the Legislature passed and Gov. Rick Scott is expected to sign, the elderly and disabled would be the first group required to enroll in managed care. If federal health officials approve the plan, in July 2012 the state will officially begin lining up HMOs and provider-service networks to take on the population beginning in October 2013. Other Medicaid patients — mostly healthy children and pregnant women — won't have to enter a managed care organization until 2014, although they can enroll sooner if they want. (St. Petersburg Times)

Georgia

HMA Roundup – Mark Trail

The Governor signed the interstate insurance purchase compact bill, allowing Georgia residents to purchase plans in out-of-state insurance providers, into law; however, this is viewed largely as a symbolic action at this point. If other states in the region push similar bills, this could be an area of interest.

The Governor is expected to take action in the next several weeks to establish the state health insurance exchange, likely to be handled through executive order.

Illinois

HMA Roundup – Jane Longo / Matt Powers

There is still uncertainty on the status of the Medicaid rate cuts. The latest word out of the Senate remains at a 3% cut, or half of the 6% cut proposed by the Governor Quinn. There has been some talk out of the House budget process of a cut closer to 1%. The House and Senate sessions both adjourn on May 31. Over the next week and a half, the final proposed Medicaid cuts will become clearer. There has continued to be vocal opposition in the press from the hospital community and other provider groups.

In the news

- **State shift in patient-care programs leaves Chicagoans without coverage**

  The Quinn administration next month is ending a statewide program touted for its savings for Medicaid patients with chronic diseases. It will be replaced with a larger, more expensive pilot program that covers the Chicago suburbs but excludes thousands of residents in the city and the rest of the state. Just a year ago, Julie Hamos, director of the state Department of Health and Family Services, was praising Your Health Care Plus, which has saved the state $569 million over four years, at a combined cost of about $126 million, according to state officials. The new program directly treats Medicaid patients with disabilities and diseases such as diabetes and asthma, unlike the prior program, which helped arrange for treatment. Though it covers about 40,000 patients in DuPage, Kane, Kankakee, Lake, Will and suburban Cook counties, Chicago residents are ineligible for enrollment in Integrated Care. As a result, thousands of Medicaid patients, among the most expensive to treat, will lose a key service that the state has lauded for keeping costs down. (Chicago Business)

- **A New Approach to Medicaid Management Information Systems**

  Illinois is looking to the state health information exchange, hosted by a commercial service provider, to house data repositories for different state programs. MMIS primarily involves claims processing, but he envisions a data warehouse supporting business services in a Lego-block kind of architecture. "We want to structure it so it can be built incrementally," Handler noted, admitting that there aren't vendors offering the type of services he's looking for — yet. But he is pushing the half-dozen vendors that traditionally service the MMIS space and perhaps some newcomers to think outside the box. (Public CIO)

Massachusetts

HMA Roundup – Tom Dehner

The first of five hearings on payment reform was held on Monday, in which Governor Patrick and several others made the case for swift action. However, there is a strong push from the House to delay until next year. It seems very likely that the Senate, although supporting the idea of tackling payment reform yet this year, will go along with the delay proposed by the House.

Texas

HMA Roundup – Dianne Longley

With respect to provider rates for the upcoming biennium, our understanding is that there is a tentative agreement in the conference committee that would cut hospital rates by 8% with no change to nursing home rates. Even with these cuts, however, there is still an estimated $4.8 billion shortfall in Medicaid funding (insufficient funds to cover the full biennium) which the legislature is suggesting it will address at the beginning of the next session in Jan. 2013. We note that while the House and Senate agreement on restored provider funding is notable, big differences remain in terms of the source of funds. As of Wednesday May 18th, the House has not considered legislation necessary to incorporate revenue increases, without which the state cannot fund the higher level of spending. Without an agreement on this issue, a special session may be necessary to finalize the budget.

OTHER HEADLINES

Connecticut

- **SustiNet backers, Malloy administration reach agreement**

  Leaders of the push to create a SustiNet state-run health plan have reached an agreement with the Malloy administration and Democratic legislative leaders, with a plan that includes examining but not committing the state to a public insurance option. Under this plan, the cabinet, known as the Governor's SustiNet Health Care Cabinet, would develop a business plan for implementing state and federal health reform and could look at other models for providing health care coverage. (CT Mirror)

Hawaii

- **Officials: Medicaid eligibility trimmed in Hawaii**

  Medicaid eligibility for low-income Hawaii residents will be reduced due to rising Medicaid costs, cutting about 4,500 people from the system, the state Department of Human Services announced Tuesday. In addition, benefits for healthy adults under 65 would be trimmed, with the new services imposing limits of 20 outpatient visits, 10 inpatient days and three outpatient surgical procedures a year. The Medicaid changes were expected to save the state about $75 million over the next two years as enrollment has risen to about 271,000 residents. (Forbes)

Idaho

- **RFI: Managed Care Delivery System for Medicaid-reimbursed Mental Health Services**

  The State of Idaho, Division of Medicaid, Office of Mental Health and Substance Abuse, P.O. Box 83720, Boise, Idaho, 83720-0036 has a requirement for information concerning the furnishing of a managed care delivery system for individuals seeking to obtain mental health services. We are interested in developing a managed care delivery system that will include adults as well as children. Information obtained may be used

to refine the requirements for a formal Request for Proposal (RFP) which may be released at a later date. Information obtained through this RFI will assist us in projecting a budget for acquiring the services, and also to help identify potential vendors who may be interested in providing a competitive proposal in the future. DUE DATE: June 13, 2011

Kentucky

- **Many questions, few answers as Kentucky Medicaid bid deadline nears**

  With the bidding deadline just two weeks away, insurance and hospital representatives, lawyers, patient advocates and others nearly filled a 250-seat auditorium Wednesday for their only chance to publicly question state officials about the request for proposals for some $5 billion in Kentucky Medicaid business. Health care companies represented Wednesday included Humana, Amerigroup, UnitedHealthcare, Wellcare Health Plans and AmeriHealth Mercy. AmeriHealth currently serves the Jefferson County region under contract to Passport, which – as the state's only Medicaid managed care entity – serves about 165,000 people in Jefferson and 15 surrounding counties under an $850 million-a-year contract with Medicaid. (Courier Journal)

Maine

- **Maine Senate enacts sweeping partisan health insurance reform**

  The state Senate gave final approval Monday to a health care reform bill that aims to spark more competition in Maine's insurance market but that critics contend could drive up costs, particularly in rural areas of the state. Beginning in 2014, individuals could shop around for policies in the other New England states with the exception of Vermont. The bill also would allow smaller businesses to pool together when purchasing insurance in order to get lower rates. The bill would not allow insurance companies to deny coverage based on pre-existing conditions. But the measure seeks to insulate insurance companies by creating a "high-risk pool" to cover Mainers who use more health services. (Bangor Daily News)

Nevada

- **Legislative panels adds $88M to Medicaid programs**

  Democrats on legislative money panels added back $88 million to Medicaid programs that assist Nevada's poor, elderly and disabled, saying some cuts in Republican Gov. Brian Sandoval's budget are too painful and would hurt health care and services for all. The committees also rejected shifting the cost of services for the aged, blind and disabled to counties, a move Sandoval said would have saved the state general fund $37 million over the biennium. (NECN.com)

New Mexico

- **State names firm to run Medicaid overhaul**

  The New Mexico Human Services Department announced Thursday morning that Alicia Smith & Associates of Washington, D.C., will be awarded the contract to overhaul Medicaid in the state. Contract negotiations are ongoing, and the HSD release

said the department hopes the deal will be completed by the end of May. (The New Mexico Independent)

North Carolina

- **Funding for disability services could be altered**

  Propelled by the state budget shortfall, a plan is being fast-tracked to significantly change the way behavioral health services are funded in North Carolina. The N.C. Department of Health and Human Services is looking to implement Medicaid waiver sites across the state. Under the change, state, federal and Medicaid money would be combined to pay for mental health, developmental disabilities and substance abuse services. Funding would be based on a per-person amount for a region's Medicaid population and be used for managed care programs. (Star News Online)

Ohio

- **Gov. John Kasich and nursing home lobby battle over proposed budget cuts**

  The nursing home industry and Governor Kasich are at odds over proposed cuts to nursing home reimbursements. Kasich's aim is to remake the entire Medicaid system, the most costly expenditure in the state's $55 billion budget proposal. He plans to do it largely by changing how the system operates. Too often, the governor said, nursing homes are the default for patients with no other options. He wants at-home care to eventually emerge as a viable choice. Medicaid serves about 2.1 million poor, elderly and disabled Ohioans. About 50,000 people live in nursing homes under Medicaid while another 30,000 are receiving assistance at-home. (Cleveland.com)

Vermont

- **Not everyone buying into Vermont's single-payer plan**

  Governor Shumlin is set to sign a single-payer health reform bill into law on May 26, while many advocates celebrate the process. However, there remains some opposition and concerns regarding costs in the program and how to control soaring health care costs. (Burlington Free Press)

Washington

- **Washington state preps for federal health care law**

  Gov. Chris Gregoire approved several proposals Wednesday to prepare the state for health care reform, even as Washington's attorney general challenges the law in court. The new bills include a plan to create a state health insurance exchange, making Washington the fourth in the nation to prepare such a system. Other parts of the bills Gregoire approved extend insurance coverage to dependents under the age of 26 and prevent insurance companies from using pre-existing conditions to deny coverage to people under the age of 19. Those measures bring the state into line with the federal health care law. (Seattle Times)

United States

- **State Medicaid directors want flexibility to trim rolls, control costs**

  The National Association of Medicaid Directors recently joined governors in urging federal officials to "find more workable interpretations" of federal rules that limit states' abilities to adjust eligibility requirements for both Medicaid and the Children's Health Insurance Program (CHIP). In a May 6 letter to Cindy Mann, deputy director of the Centers for Medicare and Medicaid Services, the association urged the agency to create a template that would provide "clarity" to states seeking waivers from what are known as maintenance of effort (MOE) requirements. (Kansas Health Institute)

- **House panel approves Medicaid flexibility bill**

  A House subcommittee voted Thursday to let states cut their Medicaid rolls despite unified Democratic opposition and amendments designed to highlight the bill's potential effect on children and the elderly. The bill would repeal "maintenance of effort" (MOE) provisions in the new healthcare law, which prevent states from reducing Medicaid eligibility before 2014. Republicans on the House Energy and Commerce health subcommittee touted the measure as a way to provide needed flexibility to the states as they face severe budget shortfalls. The Congressional Budget Office (CBO) estimated that children would make up roughly two-thirds of the people who would lose coverage if the MOE requirements are repealed. States could drop as many as 1.7 million beneficiaries from the Children's Health Insurance Program in 2016, CBO said. (The Hill)

- **HHS vows better coordination to help states keep Medicaid costs under control**

  The Obama administration announced Wednesday it plans to share Medicare information about prescription drug use and hospital visits with states to keep Medicaid costs under control and stave off Republican attempts to overhaul the program. The 9.2 million low-income seniors and people with disabilities who are eligible for both Medicare and Medicaid are responsible for about 40 percent of Medicaid spending — or $120 billion a year. The so-called Alignment Initiative announced Wednesday includes giving states faster access to Medicare data to support care coordination. HHS is also seeking public input on how to align care in six areas: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment and appeals. (The Hill)

PRIVATE COMPANY NEWS

- **WakeMed Makes $750M Bid for Rex Healthcare**

  WakeMed Health & Hospitals Thursday made a formal offer to buy Rex Healthcare from UNC Health Care System for $750 million, the Raleigh, NC-based health system said. (Health Leaders)

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 she 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, having 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 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