HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: REVIEWING THE $1 BILLION CMMI HEALTH CARE INNOVATION CHALLENGE

HMA ROUNDUP: WAIVERS APPROVED IN FLORIDA, MASSACHUSETTS; CALIFORNIA JUDGE ISSUES DRAFT ORDER HALTING CUTS

OTHER HEADLINES: MEDICAID CUTS THREATEN RURAL HOSPITALS IN ARIZONA, NURSING HOMES IN NEW JERSEY; COLORADO MOVES AHEAD ON EXCHANGE; PENNSYLVANIA MEDICAID ENROLLMENT DROP SCRUTINIZED; WISCONSIN REPORT HIGHLIGHTS GROWTH IN MEDICAID CONTRACTOR SPENDING; STATES NATIONWIDE CATCHING UP ON "MEANINGFUL USE" OF ELECTRONIC HEALTH RECORDS

DECEMBER 21, 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: CMMI HEALTH CARE INNOVATION CHALLENGE

This week, our *In Focus* section reviews the Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Challenge. The CMMI Innovation Challenge initiative will award a total of $1 billion in funding through contracts of $1 million to $30 million to applicants who propose to rapidly implement new models of health care service delivery and payment improvements that meet the "triple aim" of: (1) improved health status for a population, (2) higher quality of the patient experience, and (3) lower costs. These models will organize the care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) enrollees. CMMI has stated that awards will go to interventions that show "capability to improve care" within the first six months of the award, and create sustainable savings to Medicare, Medicaid, or CHIP within two to three years.

CMMI hosted a series of four webinars on the Innovation Challenge, beginning November 17, 2011, with the most recent on Monday, December 19, 2011. The webinar materials and audio broadcasts are available at CMMI's website (link to webinar materials). Webinars included:

1. An Overview of the CMMI Innovation Challenge – November 17, 2011
2. Designing Effective Project Proposals – December 6, 2011
3. Achieving Lower Costs through Improvement – December 13, 2011
4. Measuring Success – December 19, 2011

Interested applicants were required to submit a letter of intent (LOI) on Monday, December 19, 2011. Applicants must have submitted a LOI to be eligible for awards. While CMMI has indicated that this is an open invitation to applicants to submit new and innovative ideas, the award criteria are rigorous (new models must be "shovel ready") and the process is on an aggressive timeline, with final proposals due on January 27, 2012 and the first round of awards set to be announced on March 30, 2012. CMMI indicated that more than 4,000 potential applicants have submitted LOIs.

We note that due to the competitive nature of these applications, proposals are not likely to be made public until after the submission deadline. Health Management Associates is assisting more than a dozen applicants in the Innovation Challenge process and we look forward to bringing you further details about individual proposals and award grantees as they become publicly available. Below we review the overall aims and structure of the CMMI Innovation Challenge, as well as the application requirements and scoring criteria.

The "Triple Aim" and Key Model Features

Through the webinars and application materials, CMMI placed a strong emphasis on the "triple aim" of (1) improved health status for a population, (2) higher quality of the patient experience, and (3) lower costs. Applicants who meet these three goals are the cornerstones of the broader objectives of the Innovation Challenge, which include:

- "Engage a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field and that produce better care, bet-

ter health, and reduced cost through improvement for identified target populations."

- "Identify new models of workforce development and deployment and related training and education that support new models either directly or through new infrastructure activities."
- "Support innovators who can rapidly deploy care improvement models (within six months of award) through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with other public and private sector partners."

Proposals were encouraged to clearly frame the narrative of the innovation project with a target population identified, a clear listing of what will be accomplished by what data, interim process measures, and aims that are "S.M.A.R.T." (specific, measurable, aspirational, realistic, and timed).

We expect CMMI to award funding to applicants who are, first and foremost, operationally ready and capable of rapidly deploying a model of health care delivery. Application materials indicate that preference will be given to projects that implement their care improvement activities faster than six months. As noted above, workforce development will also factor into award decisions. CMMI indicates that workforce development can include the retooling or redistribution of existing health professionals.

Total Cost of Care and Model Sustainability

The financial portion of the proposal requires applicants to compute the total cost of care, or all payments by health care purchasers (Medicare, Medicaid) to health care providers. For a specific category of service.—the unit cost or price multiplied by the total units receiving service (volume) equals a total cost of care for that category. For example, for inpatient services, in a unit of time (a month), the average cost of inpatient care multiplied by the number of admissions equals the total cost for inpatient care. This total cost can be divided by the number of beneficiaries to get the per beneficiary per month (PBPM) cost for inpatient care. The same analysis is expected to be performed for professional fees, pharmacy costs and all other categories of care, which can be summed to a total PBPM.

Arriving at these estimates in the CMMI application will require finding unit costs of care and volumes of care. The volume or units of service will depend on the population targeted in the application. Obtaining both these figures will allow the grantee to estimate total costs for a category of service. CMMI indicates that the process that grantees should use in approaching the financial section follows:

- Define the population- both current population served and proposed expansion population
- Determine the basket of services to be provided in the grant—whatever the target population should use
- Determine how many units of service the targeted population uses currently for the array of services chosen
- Determine the unit costs or price of each services

- Calculate the total cost for each category of service
- Add up all the categories to get a total cost of care for the targeted population.

CMMI has acknowledged that it will be a challenge to obtain data to arrive at the total costs of care (both prices and volume) in many cases. The December 13, 2011 webinar presentation indicated that it may be difficult to acquire precise data for these estimates, and that thoughtful, data-driven estimates based on publicly available data will be viewed as favorably as those with actual data figures. The implication here is that the larger the planned innovation and the more services targeted, the more complex will be the data challenges in developing reasonable estimates, and CMMI does not wish to discourage applicants for lack of data.

Proposal financial modeling and sustainability will be assessed based on credible short-term and long-term savings, with a strong return on investment over the three year award cycle. In terms of sustainability, applicants are encouraged by CMMI to identify how savings will be maintained after the grant period ends, as well as identify new partners and funding sources if necessary.

Timeline and Evaluation Process

As noted above, LOIs to CMMI were due on Monday, December 19, 2011. Applications are due less than six weeks later, on January 27, 2012. This is an aggressive timeline and may be an attempt by CMMI to rule out proposals that do not meet the goal of rapid deployment. Awards will be announced on March 30, 2012. If there is additional funding remaining in the $1 billion award pool, CMMI will initiate another procurement cycle. We estimate LOIs for this second cycle would be due sometime in May 2012.

Timeline Summary	Date
Letters of Intent Due	December 19, 2011
Applications Due	January 27, 2012
Awards Announced	March 30, 2012

Below we summarize CMMI's indicated selection criteria and scoring for proposals. At a high level, however, to be considered a proposal must meet the "triple aim" of better health, better care, and lower costs.

Selection Criteria		Points
Model Design	How innovative is the approach to a population?	**30**
Organizational Capacity	What track record does the applicant have? How realistic is the proposal?	**25**
Workforce Transformation	What is the impact on workforce usage or change?	**15**
Sustainability/Financing	Is there a path to sustainability? An ability of the plan to decrease health system costs?	**20**
Evaluation	Is there a plan for self-evaluation and continuous improvement?	**10**
Total		**100**

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

A federal district court judge has issued a draft injunction preventing the state from implementing a 10 percent provider rate cut under the Medi-Cal program. As we have previously reported, the provider community has sued the state and federal CMS for approval of the provider rate cut. The 9th Circuit court previously upheld the providers right to sue over proposed rate cuts. Assuming the district court judge issues a final ruling to stay the 10 percent cut, the fight would likely be taken up by the 9th Circuit. However, if the 9th Circuit were to defer on ruling, the state would need Congress to enact a change in federal law to implement the proposed rate cut.

In the news

- **California's pre-existing health condition plan getting new funds**

  California will receive $118 million in federal funds to bolster its 2012 coverage of adults with pre-existing medical conditions. The state-run, federally funded Pre-Existing Condition Insurance Plan, or PCIP, was created last year to insure the uninsurable – those who because of their medical conditions have been denied coverage by insurers or who have had to pay prohibitive insurance premiums to ensure they were covered. The plan acts as a bridge to 2014, when the federal health care overhaul will begin barring carriers from declining or tacking higher rates onto coverage for pre-existing conditions. With the new funding, the federal contribution to the state program rose to $347 million. Officials at the state's Managed Risk Medical Insurance Board, which operates PCIP, said the cash infusion was needed both to expand the program and to keep pace with the cost of subscriber claims. Enrollment in the California plan – among the nation's largest – stood at 5,972 members as of the end of November. (Sacramento Bee)

- **Mental Health Services Heading to DHCS**

  The state is taking a big step toward integrating care by shifting Medi-Cal mental health benefits away from the Department of Mental Health and into the Department of Health Care Services by July 1 of next year. The idea is to incorporate mental health care and substance abuse treatment into people's overall health care, so that it's not a segmented benefit. DHCS Director, Toby Douglas said that the transition plan is in place now and that his department has been working with stakeholders to clear all of the possible hurdles for the July move. (California Healthline)

Florida

HMA Roundup – Gary Crayton

On December 15, 2011, CMS approved the 3-year waiver extension request the Agency for Health Care Administration (AHCA) submitted on June 30, 2010. The waiver extension period for Florida's Section 1115 Waiver is December 16, 2011 through June 30, 2014. The waiver applies only to the five county pilot program, but was a key step for the state in pursuing a statewide Medicaid reform effort beginning in 2014. The negotiation process with CMS has been ongoing for the past 18 months, with several temporary extensions granted, as reported in previous weekly roundups. One of the key changes in the approved waiver is the imposition of an 85 percent MLR requirement. The new agreement also ends a cap on maximum annual benefits and it calls on the state to put in place restrictions that ensures that hospitals and other providers that receive low income pool money are not receiving payments in excess of the services they receive. Additionally, the state must spend $50 million of the low income pool money that helps improve the health and care of Medicaid patients. The following are links to the federal approval documents for the 3-Year waiver extension request.

- CMS Approval Letter, 12/15/11
- CMS's Waiver Authorities and Special Terms and Conditions, 12/15/11

In the news

- **Health insurance coverage continues to drop in Florida**

  Enrollment in commercial health insurance is continuing to decline in Florida. An annual market report adopted Tuesday by the Florida Health Care Insurance Advisory Board shows enrollment dropped by 4.3 percent during 2010. It fell from 4.5 million people in 2006 to 3.7 million last year. The report says that's probably a reflection of Florida's persistent economic woes. Another troubling aspect is enrollment under the federal Health Insurance Portability and Accountability Act increased by 30 percent last year. That coverage is offered to individuals who have no other health care options often because they lost previous coverage through no fault of their own. It was taken by 100,790 people last year. (Orlando Sentinel)

Illinois

HMA Roundup – Jane Longo / Matt Powers

In a public Medicaid Advisory Committee meeting held on Friday, December 16, 2011, the Department of Health and Family Services (HFS) reiterated that they are finalizing the Phase I RFP for the Care Coordination Innovations Project, and that the RFP will be released sometime in January 2012. As a reminder, the Care Coordination Innovations Project directly relates to a state law mandating that at least 50 percent of Medicaid beneficiaries be enrolled in a care coordination entity by 2015. The Phase I RFP seeks to procure non-commercial managed care organizations as managed care coordination networks (MCCNs) or care coordination entities (CCEs) to manage care for the highest 10 percent of Medicaid users – namely the disabled and other high cost adult Medicaid

population. A Phase II RFP is expected in the six months following to procure managed care organizations.

Massachusetts

HMA Roundup – Tom Dehner

On Tuesday, CMS approved the state's Medicaid waiver that authorizes funding for the health care overhaul implemented in 2006. The previous waiver expired in June and had been temporarily extended while state and federal officials negotiated provisions of the new waiver. Included in the waiver is $120 million in new funding to transform payments to safety-net hospitals, moving toward a payment structure under which hospitals receive a set budget to treat Medicaid patients.

OTHER HEADLINES

Arizona

- **Medicaid squeeze could squeeze some rural hospitals to death**

  Across the state, rural are facing "significant and irreversible harm," as the Medicaid-dependent facilities see already thin margins squeezed by AHCCCS cuts to reimbursement rates and by swelling numbers of Medicaid and uninsured patients. In 2011, six of 14 state-designated "critical access hospitals" in Arizona – rural hospitals in isolated medical service areas – operated at deficits, and four of them are at risk of closure, according to hospital administrators. Those officials now fear that the number of troubled hospitals could climb to as many as nine after the state cut reimbursement rates – twice so far in 2011 – and imposed new restrictions on AHCCCS enrollment, which is expected to force about 100,000 Arizonans off the rolls this year. (AZ Capitol Times)

- **Arizona Supreme Court to consider AHCCCS case**

  The Arizona Supreme Court on Monday agreed to consider a challenge to state Medicaid cuts. The court put the matter on its Feb. 15 agenda and will decide then whether to take the case and hear oral arguments. Three public-interest law groups challenged an enrollment freeze for childless adults in the state's Medicaid program, the Arizona Health Care Cost Containment System. A lower-court judge and an Arizona appeals-court panel upheld the cuts. Gov. Jan Brewer and state lawmakers enacted the freeze as part of $500 million in AHCCCS reductions to help balance the current-year budget. (AZ Central)

Colorado

- **State lawmakers move ahead on health insurance exchange**

  Colorado lawmakers moved forward Thursday with an $18 million federal grant application to set up an insurance marketplace required under the new health care law. Lawmakers voted 9-1 to apply for the grant on an issue that divides Democrats who advocate for the new health care law and Republicans who want to see it repealed. A

bipartisan group of lawmakers overseeing the implementation of the insurance exchange were gridlocked in September on a grant application that at the time would be for $22 million. Republican Rep. Bob Gardner disagreed with the previous grant proposal but said he favored this one because it gives Colorado more flexibility over how to implement the exchanges and it's a grant for less money. (Daily Camera)

New Jersey

- **Medicaid cuts stun N.J. nursing homes**

  New Jersey officials had decided in July to move to a reimbursement system that would allow homes that care for the patients with greater medical needs to be paid at a higher daily Medicaid reimbursement rate. But officials recognized that some of the facilities that care for healthier patients would be subject to an abrupt drop in revenue if the new rates weren't phased in more slowly. So the new reimbursement rules contained a provision that prevented any one nursing home's rates from going up or down by more than $10 a day. But before that new rate system could go into place, the budget signed by Governor Christie called for a $75 million reduction in Medicaid spending on long-term care, which was supposed to be spread across all facilities in the form of a 3 percent cut. Because some facilities were already going to lose more than the amount called for in the new rate system, the state instead cut rates to those that hadn't already experienced a loss. (North Jersey)

Pennsylvania

- **Fox Chase to merge with Temple University Health System**

  Fox Chase Cancer Center will become part of the Temple University Health System, officials announced Thursday. The combination, which is expected to close next summer, will join two prominent Philadelphia health-care institutions, both of which have faced fiscal difficulties lately. Temple, based in North Philadelphia, will get a nationally recognized research partner that could help it compete with other academic medical centers in the region. Fox Chase, which will keep its name, will get a bigger referral base for patients, room to expand at Temple's Jeanes Hospital next door, and a chance to save money as health-care reform further squeezes the dollars available for clinical care and research. (Philadelphia Inquirer)

- **Pennsylvania's drop in Medicaid rolls stirs controversy**

  Since August, the Corbett administration has cut off more than 150,000 people - including 43,000 children - from medical assistance in a drive to save costs. That purge far exceeds what any other state has tried, health policy experts say, and officials may be walking a fine line between rooting out waste and erecting barriers to care for the poor and disabled. When most states were experiencing flat or rising Medicaid enrollment from the economic downturn, stepped-up eligibility reviews in Pennsylvania began producing a decline over the summer. The pace of cuts picked up in November, with 90,000 cases, or 4 percent, dropped in a single month. In New Jersey, enrollment increased by 391 the same month. The Department of Public Welfare in Harrisburg says most of the people cut were dead, had moved out of state, or were found to be ineligible, but it could provide no breakdown. Advocacy groups, clients, and representatives for caseworkers paint a different picture. Pressure to quickly review a backlog of files

and close cases overwhelmed the system, they say, as reams of paperwork were lost and computer programs automatically ended benefits when patients' responses had not been entered by preset deadlines. (Philadelphia Inquirer)

- **Heading the Right Way**

  Pennsylvania's unemployment rate fell two-tenths of a percentage point in November, the State Department of Labor and Industry said Thursday. The 7.9 percent for November was also six-tenths of a percentage point down from November 2010. There are 31,000 more employed people than there were in November 2010 and 12,000 more than October.

Tennessee

- **TennCare Managed Care Organizations continue to improve**

  The results of the 2011 HEDIS/CAHPS Report, an analysis of audited results from TennCare Managed Care Organizations (MCOs) have been released, and Tennessee has exceeded the 2010 national Medicaid average in child health in areas such as childhood immunization status, lead screening, testing for pharyngitis, use of appropriate medications for asthma and access to primary care physicians. Women's health also showed improvement, particularly in prenatal care and screening for breast cancer, cervical cancer and Chlamydia. TennCare saw improvement in behavioral health as well, especially in the areas of follow-up visits. In 2006, Tennessee became the first state to require National Committee on Quality Assurance certification across its Medicaid managed care network. NCQA is an independent, nonprofit organization that assesses and scores managed care organization performance. (Sparta Expositor)

Virginia

- **Virginia budget would deny Medicaid inflation**

  Virginia Gov. Bob McDonnell's $85 billion budget does away with Medicaid and public-school increases for inflation and eliminates public broadcasting support. It also increases the state's cushion against potential federal cuts and fattens the rainy day fund, the Republican governor said Monday. The spending plan contains no tax increases and includes McDonnell's previously announced wishes to spend an additional $2.2 billion on state employee and teacher pensions, provide $100 million a year for higher education and divert more sales tax revenues to transportation. (UPI.com)

Wisconsin

- **Medicaid contractor spending increases**

  As Wisconsin's health programs for the poor have ballooned in recent years, the state has relied increasingly on private contractors to administer the programs, completed fewer investigations into potential fraud and not taken full advantage of cheaper ways of delivering health care, a new audit has found. The report released Tuesday by the Legislative Audit Bureau found that as of June, there were at least three times as many contract workers working on Medicaid health programs as there were state workers. Over the past four years, payments to private vendors for Medicaid nearly have doubled and in some cases increased beyond the spending limits written into the state's budget, the audit found. The audit raises questions about whether, given the growth

in the health programs, the state Department of Health Services is able to oversee both its contractors and the overall Medicaid programs. It also found that the state could do more to shift to lower-cost models such as health maintenance organizations, or HMOs, that charge a capped rate for patients. (Journal Sentinel Online)

- **Low Medicare, Medicaid rates shift costs to insurers, study finds**

  An estimated $851 million is added to the cost of commercial health insurance to make up for the lower fees that Medicare and Medicaid pay hospitals in southeastern Wisconsin, according to a study released last week. The study, commissioned by the Greater Milwaukee Business Foundation on Health, supports the long-standing position of the hospital industry that the government health programs don't cover their share of costs and that the shortfall is passed on to employers and individuals through higher prices for commercial health plans. The study released last week estimated that the cost of charity care and bad debts at hospitals in southeastern Wisconsin added $365 million to the cost of commercial health insurance last year. (Journal Sentinel Online)

United States

- **Medicare Penalties For Readmissions Could Be A Tough Hit On Hospitals Serving The Poor**

  Medicare is preparing to penalize hospitals with frequent potentially avoidable readmissions, which by one estimate cost the government $12 billion a year. Medicare's aim is to prod hospitals to make sure patients get the care they need after discharge. But this new policy is likely to disproportionately affect hospitals that treat the most low-income patients, according to a Kaiser Health News analysis of data from CMS. Hospitals with the highest proportion of poor Medicare patients were nearly three times as likely as others to have substantially high readmission rates for heart failure, the analysis found. At these hospitals, low-income people comprised a greater share of the patients than they did at 80 percent of hospitals. Many of those hospitals already operate on tight margins and fear the new penalties could make it even harder for them to properly care for impoverished patients. (Kaiser Health News)

- **Supreme Court sets week's worth of arguments over Obama's health care plan for late March**

  The Supreme Court announced Monday that it will use an unprecedented week's worth of argument time in late March to decide the constitutionality of President Barack Obama's historic health care overhaul before the 2012 presidential elections. he high court scheduled arguments for March 26th, 27th and 28th over the Patient Protection and Affordable Care Act. With the March dates set, it means a final decision on the massive health care overhaul will likely come before Independence Day. (Washington Post)

- **State Medicaid Programs Catch Up On Meaningful Use**

  Most state Medicaid programs have finally launched programs to provide health IT incentives to physicians and hospitals, one year after they were authorized to do so. As recently as October, more than half of states had not paid any incentives to hospitals or eligible professionals for Meaningful Use of electronic health records (EHRs). Seventeen states had initiated their programs but not paid anything out yet, and 11 states were still in the planning stage. According to CMS, "Forty-one of 50 states have launched their Medicaid EHR Incentive Program in 2011. ... And of those 41 states, we expect at least 38 to be making payments in 2011. Currently active states have issued nearly $1 billion in incentives, with huge leaps in the most recent two to three months. Once California and New York fully ramp up their incentive programs (both will initiate payments to hospitals this month), the curve will go up even more dramatically. The majority of the remaining states are aiming for January-March for a program launch, and we expect all states to be launched and making payments by July 2012." (Information Week)

- **Concern growing over deadlines for health-care exchanges**

  With many states unwilling or unable to get insurance exchanges operational by the health-care law's deadline of Jan. 1, 2014, pressure is growing on the federal government to do the job for them. But health-care experts are starting to ask whether the fallback federal exchange called for in the 2010 law will be operational by the deadline in states that will not have their exchanges ready. Although federal officials are saying very little about their progress, they have signed contracts worth more than $150 million with several private contractors who are working on creating the federal exchange. Last month, Oregon's top insurance regulator, Teresa Miller, was hired by HHS to oversee development of health-insurance exchanges. (Washington Post)

- **HHS Gives States Flexibility On Health Law's 'Essential Benefits'**

  States will be given wide latitude to decide what "essential benefits" insurers must offer in their health policies come 2014, the Obama administration said Friday in a move that pushes off final federal rules on the topic until an unspecified date. Essential benefits, which must be offered by insurers in most policies sold to individuals and small businesses, are one of the key flash points in the federal health law. Patient advocates have called for a broad national standard covering a wide range of treatments, while business groups have said affordability must be a top consideration, even if it means a more limited package. The long-awaited guidance gives states four choices for designing a benchmark insurance package. Regulators can base their package on the benefits offered by: one of the three largest state employee health plans (by enrollment); one of the three largest federal employee health plan options; the largest HMO plan offered in the state or one of the three largest small-group plans in the state. (Kaiser Health News)

PRIVATE COMPANY NEWS

- **Molina's Medicaid Claims Processing System Receives Full Federal Certification in Maine**

  Maine's Department of Health and Human Services and Molina Healthcare, Inc., announced that the State's Medicaid Management Information System received full federal certification from the federal Centers for Medicare and Medicaid Services (CMS). The Maine Integrated Health Management Solution (MIHMS) was designed and implemented by Molina Healthcare's wholly owned subsidiary, Molina Medicaid Solutions. As a result of certification, the Maine Integrated Health Management Solution system has been found to meet the standards of CMS for a certified claims management system. This will allow Maine to claim 75 percent reimbursement for ongoing operations retroactive to September 1, 2010 - the date that the system began processing claims. (Molina Press Release)

- **CareSource hiring 60 navigators**

  CareSource is about to embark on a big statewide experiment: deploying 60 people to help frequent Medicaid users navigate Ohio's fragmented health care system. The Dayton-based nonprofit, which now covers about 10 percent of all insured Ohioans and through November had 2011 revenues of $2.5 billion, is betting that those "patient navigators" will be a cost-effective way to improve outcomes for its most high-risk members. Those improvements would be due in large part to eliminating barriers to access, communication and trust that individuals encounter or perceive in the health care industry. (Dayton Daily News)

- **Cressey & Co.** has acquired a majority stake in **InnerChange**, a residential treatment provider offering therapeutic services and academics to young women with behavioral, emotional and substance abuse problems. No financial terms were disclosed.

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 New Hampshire proposals are due Friday.

Date	State	Event	Beneficiaries
January, 2012	California (Central Valley)	Evaluation (delayed)	N/A
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	130,000
January 17, 2011	Hawaii	Contract awards	225,000
January 17, 2012	Washington	Contract awards	800,000
January 18, 2011	Pennsylvania	Proposals due	465,000
January 31, 2012	Kansas	Proposals due	313,000
January 31, 2012	Ohio	RFP Released	1,650,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
February 28, 2012	Nebraska	Contract awards	75,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
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 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
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 that reported 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 participation 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 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

Vernon K. Smith, Managing Principal
Eileen Ellis, Managing Principal
Kathleen Gifford, Principal

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)