HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: STATE DUAL ELIGIBLE INTEGRATION LETTERS OF INTENT

HMA ROUNDUP: ILLINOIS SEEKS WAIVER TO EXPAND MEDICAID ELIGIBILITY; CALIFORNIA JUDGE STRIKES DOWN PROVIDER RATE CUTS; INDIANA TO ISSUE MMIS RFP; NEW YORK DELAYS HEALTH HOME IMPLEMENTATION; CALIFORNIA GOVERNOR'S PROPOSED BUDGET TO BE RELEASED NEXT WEEK

OTHER HEADLINES: TWENTY-THREE STATES AWARDED CHIP ENROLLMENT BONUSES; COVENTRY COMPLETES CHILDREN'S HEALTH MERCY ACQUISITION; ALASKA, PENNSYLVANIA MOVE FORWARD ON HEALTH INSURANCE EXCHANGE, WISCONSIN HALTS PLANNING

RFP CALENDAR: OHIO MEDICAID MANAGED CARE RFP EXPECTED THIS MONTH

HMA WELCOMES: GINA ECKERT (INDIANAPOLIS) AND AMY SHIN (CALIFORNIA)

JANUARY 4, 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: STATE DUAL ELIGIBLE INTEGRATION LETTERS OF INTENT

This week, our *In Focus* section reviews the state-submitted letters of intent (LOIs) in response to CMS guidance on financial models for integration of care for dual eligible individuals enrolled in both Medicaid and Medicare. In a letter to state Medicaid directors, issued Friday, July 8, 2011, CMS offered two financial models that the federal government is highly interested in implementing in cooperation with state Medicaid agencies. These payment and financing models are intended to promote better care and align incentives for improving care, as well as lower costs to States and the federal government.

For more details on the State Medicaid Directors (SMD) letter, please refer to our July 13, 2011 *In Focus* section available on our website at this link. Summaries of the two models are provided below.

Under the **Capitated Model**, states, CMS, and health plans will enter into a three-way contract, under which managed care plans will receive a blended capitated rate for the full continuum of benefits provided across both Medicare and Medicaid. Blended rates will be set to target aggregate savings to both states and the federal government. CMS indicated that managed care plans will be required to meet established quality thresholds. Health plan contracts will be awarded through a joint procurement by states and CMS, and the SMD letter indicates a preference toward plans that have demonstrated the capacity to provide Medicaid and Medicare services to plan enrollees.

Under the **Managed FFS Model**, CMS will establish a retrospective performance payment system, under which states will receive performance payments based on Medicare savings net of federal Medicaid costs. This model requires upfront investment in care coordination, with savings determinations made by the CMS Office of the Actuary.

Overview of State LOI Responses

A total of 38 states responded to CMS with a LOI to pursue one or both financial models for dual integration. Fourteen states are pursuing a capitated model, with nine states pursuing a managed FFS model. Ten states indicated an interest in both models, while five remaining states did not specify which model they intended to pursue.

	Letter of Intent Submitted	Capitated Only	Fee-for Service Only	Interest in Both Models	Not Specified
Alabama	No				
Alaska	Yes		X		
Arizona	Yes	X			
Arkansas	No				
California	Yes			X	
Colorado	Yes		X		
Connecticut	Yes		X		
Delaware	Yes	X			
District of Columbia	Yes				X

	Letter of Intent Submitted	Capitated Only	Fee-for Service Only	Interest in Both Models	Not Specified
Florida	Yes				X
Georgia	No				
Hawaii	Yes	X			
Idaho	Yes	X			
Illinois	Yes			X	
Indiana	Yes	X			
Iowa	Yes		X		
Kansas	Yes				X
Kentucky	Yes	X			
Louisiana	No				
Maine	Yes		X		
Maryland	Yes				X
Massachusetts	Yes	X			
Michigan	Yes	X			
Minnesota	Yes			X	
Mississippi	No				
Missouri	Yes		X		
Montana	Yes		X		
Nebraska	No				
Nevada	Yes		X		
New Hampshire	No				
New Jersey	No				
New Mexico	Yes	X			
New York	Yes			X	
North Carolina	Yes		X		
North Dakota	No				
Ohio	Yes				X
Oklahoma	Yes			X	
Oregon	Yes	X			
Pennsylvania	Yes			X	
Rhode Island	Yes			X	
South Carolina	Yes			X	
South Dakota	No				
Tennessee	Yes	X			
Texas	Yes	X			
Utah	No				
Vermont	Yes	X			
Virginia	Yes	X			
Washington	Yes			X	
West Virginia	No				

	Letter of Intent Submitted	Capitated Only	Fee-for Service Only	Interest in Both Models	Not Specified
Wisconsin	**Yes**			**X**	
Wyoming	**No**				
Totals	***38 Yes / 13 No***	***14***	***9***	***10***	***5***

For those states pursuing the capitated model, a key upcoming issue will be the process for plan selection. Twelve states have indicated a preference for developing three-way federal-state-MCO contracts with their existing contracted Medicaid plans where those plans also offer (or are pursuing) Medicare Advantage Special Needs Plans (SNPs). Seven states have expressed their intent to conduct a separate procurement to contract with a distinct set of plans. As noted above, the SMD letter contemplates a separate procurement in which CMS will play a role in both RFP design and plan selection. However, a number of states indicated their preference for building from existing programs that cover dual and non-dual ABD populations, without conducting a separate RFP. While the process and requirements for plan selection have not been defined at this time (and may vary by state), we believe that the standards that the states and CMS will use in evaluating and approving plans for participation will be rigorous and that both Medicare and Medicaid experience (particularly with population groups that utilize long term care services) will be a critical evaluation criteria.

For more information on the approaches described in the states' LOI's, please don't hesitate to contact me at 212.575.5929 or gnersessian@healthmanagement.com.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

As we anticipated in our December 22, 2011 Roundup notes, a federal district court judge has issued final rulings preventing the state from implementing a 10 percent provider rate cut for pharmacies and hospital based nursing facilities under the Medi-Cal program. The provider community, including pharmacists, physicians and hospital operated nursing homes, sued the state and CMS regarding the approval of the provider rate cut. At this time both the pharmacists and hospital operated nursing home cuts have been struck down by the district court judge, while the physician suit (filed by the California Medical Association) is expected to also be stayed once it has worked its way through the system. In striking down the cuts, Judge Christina Snyder relied upon the 9th Circuit Court's decision that provider rate studies had to be cost-based and rejected CMS's approval of California's state plan amendments. Judge Snyder ruled that "the State's fiscal crisis does not outweigh the serious irreparable injury plaintiffs would suffer" if the cuts were made permanent. Moreover, she noted that a "monitoring plan" that the state submitted to CMS that is meant to evaluate the impact of the payment reduction

on beneficiaries' access to services "at best presents a potential remedy after an access or quality problem has been detected."

Assuming the state appeals the decision, the fight would likely be taken up by the 9th Circuit. However, if the 9th Circuit were to uphold the decision, the state and CMS would either need to take these cases to the U.S. Supreme Court or ask Congress to enact a change in federal law to implement the proposed rate cut. Since the 9th Circuit decision requiring a cost-based rate is not an issue that the U.S. Supreme Court agreed to hear and these cases are filed against both the state and CMS, it is not clear what impact the pending U.S. Supreme Court decision on whether providers have standing to sue the state on rate issues will have on these cases.

Also of note, Governor Brown's proposed budget will be released on January 10th 2012. According to legislative analysts, the budget shortfall is projected to be in excess of $13 billion for FY 2013.

In the news

- **Judge stops Medi-Cal budget cuts; state plans appeals**

  Attorneys for California's Medi-Cal program are gearing up to appeal two court rulings issued last week that strike down a 10 percent cut to some medical service providers for low-income Californians. A U.S. District Court judge in Los Angeles ruled in favor of pharmacies and hospital-based nursing facilities that sought to fend off the rate cut. In both cases, the judge ruled that the gravity of the state's fiscal crisis is not greater than the harm that might come to patients who are denied medical care. A separate lawsuit by the California Medical Association, which represents about 30,000 physicians, is pending and also seeks to strike down the rate cut. A hearing on the case is expected later this month. (California Watch)

- **Case-by-Case, California Examines Adult Day Care**

  Adult day health care centers in California came close to elimination after lawmakers in the Golden State voted to cut all Medicaid funding for the centers in order to save about $85 million. Advocacy groups quickly sued to stop the cuts in federal court, arguing that the centers, which offer services such as health care, physical therapy, mental health treatment, shared meals and exercise, help keep some 35,000 frail seniors and disabled people out of costly nursing homes. The groups reached a last minute legal settlement with the state that is meant to keep a scaled-down program in place for those who need it the most. Under the settlement, the state will continue to pay for the services through its Medicaid program but only for those who have severe illnesses, disabilities or dementia. To determine who will qualify under the tighter eligibility rules, two hundred state nurses have fanned out to centers around California to review patient records. The state has guaranteed services to more than 9,000 Californians. The remaining 26,000 will be evaluated face-to-face by the nurses. (Kaiser Health News)

- **California adds patients to health insurance rolls**

  Despite a slow start, California's push to extend health coverage to those with preexisting medical conditions — a three-year stopgap effort until federal healthcare reform fully kicks in — has enrolled more than 6,000 patients. California now ranks second

only to Pennsylvania with the highest number of enrollees in the temporary federally funded insurance plan. The interim coverage helps people with cancer, heart disease and other long-term disorders pay for doctor visits, hospital stays and medications. (Los Angeles Times)

Georgia

HMA Roundup – Mark Trail

The Georgia legislature will open the 2012 session next week, with Governor Nathan Deal's revised FY 2012 budget likely to be issued the following week. It is expected that the Governor's budget will restore funding to the Medicaid program that was stripped last year in order to fund the state employees' health benefits program. In addition, the decision to delay one month of managed care capitation payments into FY 2013 will likely be reversed according to a set of budget priorities the Governor had identified.

Illinois

HMA Roundup – Jane Longo / Matt Powers

Cook County Health and Hospitals System (CCHHS) is in the process of applying for a federal waiver from CMS to provide early expanded Medicaid coverage to uninsured adults prior to the nationwide Medicaid expansion 2014. Cook County is proposing to create a coordinated care network that will assign beneficiaries to primary care physicians. Cook County currently provides more than $500 million in annual uncompensated care to the uninsured population in the Chicago area. When interviewed this week, Dr. Ramanathan Raju, the CCHHS CEO, said approval of the waiver could be granted as early as July 2012.

In the news

- State budget preview projects dismal picture

  Gov. Pat Quinn on Tuesday issued an outline of his likely budget for the next fiscal year. It won't be pretty. Most state operations should expect a 9 percent reduction in the next budget, Quinn warned, and "further and larger reductions are needed to stabilize Medicaid costs." The governor also said he still wants the General Assembly to approve his plan to pay off old state bills by borrowing up to $7 billion. The information is contained in an economic and fiscal policy report that must be filed annually by Quinn's budget office under recently enacted laws designed to improve the state's budgeting process. The report is not the detailed budget proposal that Quinn will present to lawmakers in March. However, it does give an outline of what to expect when Quinn makes his budget presentation. (Olney Daily Mail)

Indiana

HMA Roundup – Cathy Rudd

On December 20, 2011 the Indiana Family and Social Services Administration (FSSA) published a notice indicating that an RFP for MMIS system development and implementation is under development and expected to be released in January 2012. The current MMIS vendor in Indiana is Hewlett Packard.

In the news

- **Daniels asks permission to keep Healthy Indiana Plan**

  Gov. Mitch Daniels asked federal health officials Wednesday for permission to continue operating the Healthy Indiana Plan after 2012. Federal approval of the state's consumer-directed health insurance program for some 50,000 low-income Hoosiers expires next December. Under the Affordable Care Act, current HIP participants and nearly one in four Hoosiers will be eligible for an expanded Medicaid program set to begin in 2013. In a letter, Daniels told Health and Human Services Secretary Kathleen Sebelius that HIP costs less than Medicaid and Hoosiers should get to choose which program to join. (NWI Times)

New York

HMA Roundup – Denise Soffel

On December 27th 2011, the Department of Health announced an implementation delay in the health homes program. Specifically, due to a delay in receiving an approved State Plan Amendment (SPA), all list based assignments to provider-led designated Health Homes will be delayed until February 1, 2012. This delay includes both fee for service members and Managed Care Plan members. The new implementation schedule is as follows:

- **Phase I - 10 counties:**
  - Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, Washington
  - HH application due date for Phase I counties only is November 1, 2011.
  - Implementation is scheduled for February 1, 2012
- **Phase II** – 16 Counties:**
  - Albany, Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Suffolk, Sullivan, Ulster, Westchester,
  - HH application due date for Phase II counties only is February 1, 2012.
  - Implementation is tentatively scheduled for April 1, 2012.

- **Phase III** – 36 Counties:**
  - Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates
  - HH application due date for Phase III counties only is April 21, 2012.
  - Implementation is tentatively scheduled for July 1, 2012.

The link below provides the list of approved applicants as well as the managed care plans approved for participation in Phase 1. Link

In the news

- **Nowhere to Go, Patients Linger in Hospitals, at a High Cost**

  Hundreds of patients have been languishing for months or even years in New York City hospitals, despite being well enough to be sent home or to nursing centers for less-expensive care, because they are illegal immigrants or lack sufficient insurance or appropriate housing. As a result, hospitals are absorbing the bill for millions of dollars in unreimbursed expenses annually while the patients, trapped in bureaucratic limbo, are sometimes deprived of services that could be provided elsewhere at a small fraction of the cost. Medicaid often pays for emergency care for illegal immigrants, but not for continuing care, and many hospitals in places with large concentrations of illegal immigrants, like Texas, California and Florida, face the quandary of where to send patients well enough to leave. Officials in New York City say they have many such patients who are draining money from the health system as the cost of keeping people in acute-care hospitals continues to escalate. (New York Times)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

In late December 2011, Budget Secretary Charles Zogby announced in a mid-year budget briefing that Pennsylvania is facing a $500 million shortfall for the current fiscal year. Subsequently, the Corbett Administration announced a salary freeze for members of Gov. Corbett's cabinet and management employees in the executive branch. Corbett is expected to give his budget address in February.

On the healthcare front, the state began transitioning to the 5010 format for transaction processing on January 1, 2012, three months before the federal deadline for certification. Additionally, the state also announced that it will establish a health insurance exchange to comply with the federal Affordable Care Act. We note that Pennsylvania is among the states suing to declare the Affordable Care Act unconstitutional, a decision made by Governor Corbett in his prior role as Attorney General.

Finally, the state provided an update on the implementation of electronic health records. As of Wednesday, December 28th, 2011, 2,717 Eligible Professionals in Pennsylvania were registered at the CMS R&A website and of those 2,006 have either begun or com-

pleted their Pennsylvania Medical Assistance Provider Incentive Repository (MAPIR) application. 102 Eligible Hospitals registered at the CMS R&A website and of those 91 have either begun or completed their Pennsylvania MAPIR application. To date, Pennsylvania has made payments of more than $32 million for Eligible Professionals and more than $61 million for Eligible Hospitals.

OTHER HEADLINES

Alaska

- **State moves ahead on health care exchange**

  Josh Applebee, deputy director for health care policy for Alaska's health department, says states have until next January to certify that they're able to establish an exchange. The state plans to sign a contract with Boston-based Public Consulting Group to evaluate such things as the cost of the exchange and its impact on the market. (Anchorage Daily News)

Delaware

- **Regulator Lets Highmark Make a (Complicated) Deal**

  Delaware Insurance Commissioner Karen Weldin Stewart has given Blue Cross Blue Shield of Delaware permission to become an affiliate of Highmark Inc., but she also has created a set of 49 conditions the companies must meet to consummate the deal. Highmark, Pittsburgh, runs Blue Cross and Blue Shield plans in Pennsylvania and West Virginia with a total of 4.8 million enrollees. Delaware Blue, Wilmington, Del., is a nonprofit health care service corporation that provides or administers coverage for 395,000 people in Delaware. Stewart has put tight limit on how lose Delaware Blue's affiliation with Highmark could be. States view nonprofit companies as entities that hold their assets for the benefit of the people of the state. Insurance regulators often require for-profit buyers of nonprofit health insurers or hospitals to make large contributions to charity, to compensate the people of the state for converting nonprofit assets to for-profit use. Stewart will require Highmark to contribute the value of Delaware Blue's assets to a foundation if it dissolves Delaware Blue, among numerous other requirements. (Life Health Pro)

Florida

- **Scott panel cannot compare Florida hospitals**

  A panel appointed by Gov. Rick Scott, who once headed the nation's largest for-profit hospital chain, told him on Tuesday that it could not determine whether Florida's public hospitals provide better or worse care than private ones. A study commissioned by the seven-member Commission on Review of Taxpayer Funded Hospital Districts said it was difficult to compare the quality of care at various types of hospitals because they are very diverse and have complex business models. The commission noted a third of Florida's publicly owned hospitals are in rural areas that have too few patients to generate data comparable to urban hospitals. The report did conclude that patient expens-

es are up to 12 percent higher in public hospitals. A public hospital economist attributed the difference largely to Miami's Jackson Memorial Hospital. Scott created the panel last March to determine if it's in the public's best interest to continue having government-operated hospitals. Florida has 30 active hospital districts but only 16 have the authority to levy taxes or receive tax money. The panel recommended a number of changes in its final report to Scott and the Legislature, but it stopped short of calling for an end to public hospitals. A key proposal is that voters should be given a chance every eight to 12 years to determine if local hospital districts should continue receiving taxpayer funds. The panel also urged the districts to pay for indigent care at private as well as public hospitals and clinics. The commission also agreed with the Republican governor's push to make Medicaid reimbursements more uniform for public and private hospitals alike. Scott has proposed cutting Medicaid reimbursements in his annual budget proposal to the Legislature. (Miami Herald)

Kansas

- **Governor's plan for managed care raising concerns**

Gov. Sam Brownback's plan to have managed care companies provide services for those with developmental disabilities is raising concerns. Under the proposal, those with developmental disabilities may be forced to change the support staff that they have depended on for years, they say. Most states that have gone the managed care route for Medicaid have excluded the developmentally disabled from those changes. But organizations that care for those with severe disabilities say that managed care companies aren't familiar with the long-term needs of their clients, some of whom require round-the-clock attention. (LJWorld.com)

Kentucky

- **Beshear to meet with partners in Tenn. hospital merger proposal that he rejected**

Talks are continuing on a proposal to create a new health care system in Kentucky by merging University Hospital in Louisville and Jewish & St. Mary's with St. Joseph Health System in Lexington. Gov. Steve Beshear rejected a proposed partnership of the three last week, but his spokeswoman told The Courier-Journal that Beshear plans to meet with the partners. A time frame for the meeting has not been established. Beshear's rejection was the final word in a proposal to merge University with the religiously-affiliated hospital systems. Critics had questioned how the merger would affect reproductive health care in the state's largest city. In rejecting the merger, Beshear said his main objection was the loss of a public asset in University Hospital, but he also pointed to questions about constitutional church-and-state issues and transparency. A report from the attorney general's office said the issues would be extremely hard to work out with the merger as it was proposed. (The Republic)

Maine

- **Republicans say they won't support some of LePage's cuts to MaineCare**

  One of the most controversial cuts in Gov. Paul LePage's proposal to overhaul MaineCare hit a roadblock Tuesday after Republican lawmakers refused to back the plan. Rep. Patrick Flood, House chairman of the Legislature's Appropriations Committee, said his colleagues oppose the governor's proposal to save $60 million by eliminating funding for private nonmedical institutions, facilities that serve the elderly, the mentally and physically disabled and patients of substance abuse treatment programs. The PNMI cut is among the largest LePage is proposing to close an estimated $220 million shortfall in the Department of Health and Human Services budget. Flood said the GOP caucus has agreed it won't support the PNMI cut and will work with the administration to find another solution. (Bangor Daily News)

Texas

- **Texas Consumer Health Assistance Program to close after losing federal funding**

  With funds from the federal health reform law, the Texas Consumer Health Assistance Program was launched last January. A $2.8 million grant allowed the state to hire nine employees to staff a toll-free hotline. More than 6,000 Texans called in during the past year, seeking advice on how to find affordable coverage, or help filling out an insurance application, or fighting a denied claim. But less than a year after it opened, the Texas Consumer Health Assistance Program is preparing to shut down, a victim of Congress's inability to agree on a federal budget for next year. (Washington Post)

Wisconsin

- **State's decision to halt health exchanges worries insurers**

  A recent decision by Gov. Scott Walker could give the federal government greater influence over the state's health insurance market - and that worries some in the industry. Walker announced late last month that the state would halt work on the online marketplaces, or exchanges, required under federal health care reform until the U.S. Supreme Court rules on the constitutionality of the law. There's a risk in halting the work on the exchanges until the Supreme Court rules: If the law is upheld, the state would have only about six months to put together a plan. Whether that can be done in that time frame is a question. It also is a concern for health insurance companies. One worry is that health insurers would face stricter regulations from the federal government than from the state Office of Free Market Health Care. (Journal Sentinel Online)

- **Walker plans to lift cap on long-term care**

  Gov. Scott Walker announced a plan Wednesday to lift the enrollment cap on a state long-term care program - a move he made two weeks after federal authorities told his administration it had to take that step. Walker touted the $80 million plan with advocates for the elderly and disabled at a Capitol news conference, but he made no mention of a recent order from CMS directing his administration to lift the cap in the Family Care program. Family Care provides a variety of services to help people who are elderly and disabled stay in their homes rather than enter nursing homes. Walker proposed the Family Care cap in his state budget to help reduce the state's deficit, and his

fellow Republicans in the Legislature went along with it. The cap on enrollment, which went into effect July 1, frustrated local officials and advocates for the elderly and the disabled. Shortly after the budget passed in June, Walker said he hoped to modify or drop the cap this year. Ending the cap will require a change in state law, and a key Republican lawmaker offered stiff resistance to Walker's proposal. (Journal Sentinel Online)

United States

- **Report: Medicaid short in offsetting nursing home costs**

  The nation's nursing homes lose money caring for people whose stays are covered by Medicaid, according to a report by the American Health Care Association, a trade group headed by former Kansas Gov. Mark Parkinson. The industry's unreimbursed costs of caring for Medicaid residents were expected to exceed $6.3 billion in 2011, according to the report. At the same time, at least 30 states either cut or froze their Medicaid rates last year. In nine of the 38 states cited in the report, nursing homes were expected to lose more than $25 per Medicaid resident per day. (Kansas Health Institute)

- **States to Get U.S. Bonuses for Covering Uninsured Children**

  Twenty-three states will share $296.5 million in U.S. payments for encouraging low-income families to enroll their children in public health programs. Bonuses announced in late December reward states that streamline eligibility for Medicaid, the federal-state health program for the poor, or the Children's Health Insurance Program. The effort is aimed at children younger than 19 from households with annual incomes of as much as $45,000 for a family of four, though some states have more generous criteria. Despite the flagging economy, the number of uninsured children decreased to 5.9 million in 2010 from 6.9 million in 2008, according to a study by the Georgetown University Health Policy Institute in Washington. (Bloomberg)

- **Health law explained: The states gain new flexibility in setting policies**

  On December 16, the Obama administration announced its intention to let states determine their own "essential benefits" for plans sold within their boundaries—rather than setting one national benefit standard. The national health law lists 10 categories of health care that all insurance policies must cover: hospitalization, emergency care, outpatient services, maternity and newborn care, mental health and substance abuse services, prescription drugs, laboratory testing, preventive and wellness care, pediatric services (including dental and vision examinations), rehabilitative care and habilitative care such as services for children with developmental disabilities. But within those categories, the federal government is allowing each state to determine its own basket of essential benefits by choosing a "benchmark" package offered by any of a variety of insurers. They can pick from:

  - One of the three largest (by enrollment) small group plans in the state;
  - One of the three largest state employee health plans;
  - One of the largest federal employee health plan options;
  - The largest HMO plan offered in the state's commercial market

If a state does not select any of these, the largest plan in the small group market will be the default. If a state selects a benchmark which does not cover one or more of the 10 required categories, it would need to "supplement" the benchmark to include all 10. (Stateline)

PRIVATE COMPANY NEWS

- **Coventry Health Care Completes Acquisition Of Children's Mercy's Family Health Partners**

  Coventry announced today that it has completed its previously announced acquisition of the business of Children's Mercy's Family Health Partners, a Medicaid health plan that was operated by Children's Mercy Hospital, Kansas City. With the addition of Children's Mercy's Family Health Partners, Coventry now serves nearly 900,000 Medicaid recipients across 10 states and more than 1.5 million members in its seven-state Midwest region. In addition, Coventry and Children's Mercy Hospital have entered into a long-term contractual partnership for Children's Mercy to deliver hospital and physician services to Coventry members as part of the transaction. (Market Watch)

- **Coventry Health Care to run Nebraska program**

  Coventry Health Care of Nebraska will be the new health plan administrator for Nebraska's Comprehensive Health Insurance Pool. The state program is designed to provide health insurance for Nebraskans who can't get affordable coverage without restrictions because of medical problems. Coventry Health Care of Nebraska is a wholly owned subsidiary of Coventry Health Care Inc., a national managed-care company. The Lincoln Journal Star says the Health Insurance Pool board of directors selected Coventry as health plan administrator at a meeting last week. Coventry will administer benefits for the program starting April 1. The benefits currently are administered by Blue Cross and Blue Shield of Nebraska. (KLKN TV)

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 Ohio is scheduled to release its managed care RFP this month. This RFP will re-procure the state's existing CFC (TANF) and ABD programs.

Date	State	Event	Beneficiaries
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 27, 2012	Virginia Behavioral	Proposals due	265,000
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 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
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 WELCOMES…

Gina Eckart, Principal

Gina Eckart joins HMA as a Principal in our Indianapolis office as of January 1, 2012. Most recently, Gina has served as the Director of the Indiana Division of Mental Health and Addiction and been responsible for policy and funding of the public mental health and addiction system of care across the state, including six state psychiatric hospitals and over 2,200 employees. Prior to her appointment as Director, Gina was the Assistant Director of the Division of Mental Health and Addiction. Before joining the State of Indiana, Gina was Manager of Acute Care Services at Midtown Community Mental Health Center, and she began her career there as a Crisis Clinician. Gina has also served as an Adjunct Professor at the Indiana University School of Social Work, and on the Board of the National Association of State Mental Health Program Directors. Gina earned both her Master of Science degree and Bachelor of Science degree at Indiana University.

Amy Shin, Principal

Amy Shin joins HMA as a Principal in California's Bay Area as of January 1, 2012. Amy comes to HMA from On Lok Senior Health Services, a staff model provider group and dually capitated (Medicare and Medicaid) health plan, where she has served as the Chief Administrative Officer for over eight years. In her role as Chief Administrative Officer, Amy was responsible for the health plan section of the organization, including business development, marketing and enrollment, regulatory affairs, information systems, Medicare Part D operations, quality assurance, provider network contracting and relations, facilities management, purchasing, fund development, and oversight of delegated provider groups. Prior to her position at On Lok, Amy was Senior Vice President, Professional Services for Pharmaceutical Care Network, a pharmacy benefits management company. Earlier in her career, Amy served as a Senior Director of the Alameda Alliance for Health, the public HMO of Alameda County. Amy earned her Bachelor of Arts degree at University of California, Berkeley, and her Doctor of Pharmacy degree at University of Southern California.

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)