HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CALIFORNIA GOVERNOR'S BUDGET PROPOSES MEDICAID CHANGES

HMA ROUNDUP: GEORGIA GOV. BUDGET PROPOSAL RELEASED TODAY; OHIO RELEASES LONG-AWAITED MEDICAID MANAGED CARE RFP; ILLINOIS PHASE I CARE COORDINATION RFP DUE NEXT WEEK; PENNSYLVANIA CUTS IMPACTING MEDICAL TRANSPORTATION AVAILABILITY

PRIVATE COMPANY NEWS: UNIVERSAL AMERICAN TO ACQUIRE APS HEALTHCARE (HMA ADVISED UNIVERSAL AMERICAN ON THE TRANSACTION)

OTHER HEADLINES: FLORIDA HOSPITALS WARN OF GOV. BUDGET MEDICAID CUT IMPACT; ILLINOIS HOSPITALS MAKE CASE FOR TAX EXEMPT STATUS; KANSAS LEGISLATURE PREPARES FOR HEALTH CARE-LOADED SESSION; NEW YORK GOV. PUSHES HEALTH EXCHANGE

RFP CALENDAR: OHIO MEDICAID MANAGED CARE RFP ADDED; KANSAS EXTENDS RFP SUBMISSION DEADLINE AGAIN

JANUARY 11, 2012

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

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IN FOCUS: CALIFORNIA GOV.'S BUDGET PROPOSES MEDICAID CHANGES

This week, our *In Focus* section reviews California Gov., Jerry Brown's proposed 2012-2013 state budget, focusing particularly on several important changes to Medi-Cal, the state's Medicaid program. The budget proposal, released last Thursday, January 5, proposes $4.4 billion in new taxes, which must be approved by voters, and includes trigger cuts to take place if the tax initiative fails at the voting booths. We note that these trigger cuts would not impact Medi-Cal or any other health and human services programs. California's Medi-Cal program, which accounts for the second largest share (19 percent) of state general fund expenditures, has not been immune to spending reductions, however. The 2011-12 budget included $2 billion in Medi-Cal reductions, including the following:

- Mandatory copayments for all Medi-Cal enrollees for hospital stays, emergency department (ED) visits, physician office visits, prescription drugs, and dental office visits;
- 10 percent reduction in provider rates;
- Caps on certain physician visits and other services; and
- Elimination of the optional Adult Day Health Center (ADHC) benefit.

At best, these changes will be only partially implemented, meaning California will not achieve the total projected budget savings associated with them. Most of the major Medi-Cal budget cuts require approval by the federal Centers for Medicare and Medicaid Services (CMS), which could change the total fiscal impact. While CMS has yet to act on the State's proposals to impose copayments and to cap certain physician visits and other services, CMS approved most, but not all, of the provider rate reductions on October 27, 2011. The provider rate reductions are currently in litigation, and, on December 28, 2011, the federal court issued temporary injunctions to block some of the reductions. In addition, a legal settlement was recently reached to postpone elimination of the ADHC benefit from December 2011 to February 2012 and to maintain eligibility for approximately half of the current ADHC participants.

In addition, the 2011-2012 automatic spending reductions discussed above included two relatively small reductions in Medi-Cal spending:

- $100 million reduction to the In-Home Supportive Services (IHSS) program in the form of service cuts and fraud and abuse savings; and
- $8.6 million reduction from extending the Medi-Cal reductions enacted in March 2011 to all Medi-Cal managed care plans. While previously the State had projected a budget deficit of $13 billion, the Governor's Budget puts the deficit at $9.2 billion, with a current year shortfall of $4.1 billion plus an additional $5.1 billion shortfall in the coming fiscal year.

Below, we highlight several key changes to the Medi-Cal program under the Governor's proposed 2012-2013 budget, including the following:

- Expansion of Managed Care dual-eligible pilot program

- Medi-Cal Managed Care expansion to all counties
- Healthy Families (CHIP) moved into Medi-Cal
- FQHC payment model changes

The Department of Health Care Services (DHCS) has prepared a summary of Governor Brown's 2012-2013 budget, available here.

A Note on Budget Estimates

The budget estimates prepared by the Governor's administration include a 10 percent provider rate cut enacted in 2011. As we have previously reported, a federal district court judge issued a ruling preventing the State from implementing the cut for pharmacies and hospital-based nursing facilities under the Medi-Cal program. Assuming the State appeals the decision, the fight will 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. 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.

Medi-Cal Managed Care Duals Expansion

As part of the State's effort to coordinate care for dual eligible beneficiaries receiving both Medicaid and Medicare services, Medicare benefits for duals would be moved to the Medi-Cal managed care program over a three-year period. The first step in this transition would be the expansion of the duals managed care pilot program from four to eight to 10 counties. This initial transition would take place over a 12-month period, beginning January 1, 2013. By the end of 2013, 800,000 of the State's 1.2 million dual eligibles would be covered under a managed care plan. The additional counties will be selected based on their existing capacity to coordinate care for dual eligible Medi-Cal beneficiaries. The budget proposal sets general fund savings estimates at $678.8 million in FY 2012/13 and $1 billion in FY 2013/14. DHCS data indicates that in 2009, the State paid approximately $10 billion in total funds for claims for dual eligibles.

Additionally, we note that in late December 2011, California DHCS released a request for solutions (RFS) pertaining to the State's dual eligible demonstration project. The RFS sought comment from the stakeholder community on the draft selection criteria. Comments were due to DHCS on January 9, 2012. The release of final criteria is expected in mid-January, with applications due in mid to late February.

Medi-Cal Managed Care Rural Expansion

Medi-Cal currently operates managed care in 27 of the State's 58 counties, and roughly 50 percent of all beneficiaries are enrolled in some form of managed care. Under the Governor's proposal, rural counties served exclusively under Medi-Cal fee-for-service would be transitioned into the Medi-Cal Managed Care program beginning in June 2013. This is expected to generate general fund savings of $2.7 million in FY 2012/13 an $8.8 million in FY 2013/14.

Healthy Families Transition to Medi-Cal

Healthy Families, the State's CHIP program, currently enrolls approximately 875,000 beneficiaries. Beginning in October 2012, the Governor's proposal would transition these 875,000 to Medi-Cal over a nine-month period. The Governor's Budget summary provided by DHCS states that this transition will (1) simplify eligibility for children and families, (2) improve coverage through retroactive benefits, increased access to vaccines, and expanded mental health coverage, and (3) eliminate premiums for lower-income beneficiaries. However, this proposal includes a 25.7 percent rate reduction for Healthy Families managed care plans, amounting to savings of $64.4 million in FY 2012/13 and $91.5 million in FY 2013/14.

FQHC Performance, Risk-Based Payment Model

Under the Governor's proposal, the payment methodology for federally qualified health centers (FQHCs) and rural health clinics (RHCs) will be redesigned to "provide more efficient and better care." Payments made to FQHCs and RCHs under Medi-Cal managed care contracts will change from a cost and volume-based payment to a fixed payment system for a broad set of services. This is estimated to generate $27.8 million in FY 2012/13 savings, and $58.1 million in FY 2013/14.

Other Health and Human Services Proposed Changes

- There is an extension of the hospital fee ($255 million GF in 2011-12; $472 million in 2012-13) and gross premium tax on Medi-Cal managed care plans ($161.8 million in 2012-13 and $259.1 million in 2013-14).
- Nursing homes have their 10 percent provider rate reduction ($171.2 million GF) and supplemental payments (totaling $245.6 million GF) restored.
- The Department of Developmental Services will receive an additional $200 million GF reduction, to be negotiated with stakeholders.
- There will be a new Department of State Hospitals to operate the long-term care facilities for the mentally ill and sexually violent predators. All other functions of the Department of Mental Health and Department of Alcohol and Drug will be absorbed by the Department of Health Care Services.
- CalWORKs (TANF) is being cut by over $1.1 billion. Aid will be limited to two years (instead of four) if the parent doesn't participate in work requirements. Adults that participate in work requirements can remain up to 48 months.
- The Department proposes to eliminate domestic and related in-home supportive services for recipients in shared living arrangements and minor recipients living with parents ($163.8 million savings in 2012-13).

For any questions or additional information, please do not hesitate to contact me at: gnersessian@healthmanagement.com

HMA Medicaid Roundup

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

Gov. Deal released his budget today, January 11, outlining Amended Fiscal Year 2012 and Fiscal Year 2013 budget proposals. Below is a list of Medicaid/CHIP budget highlights for AFY 2012 and FY 2013. HMA is in the process of gathering detail on several of these items.

- In AFY 2012, restores funds to maintain provider reimbursement and removes the 0.5 percent provider rate cut.
- Funds a provider rate increase for PeachCare beginning in AFY 2012 (effective date has not been confirmed but it appears to be January 2012). The rate increase is for physician evaluation and management codes and is also intended to ensure parity between Medicaid and PeachCare rates due to the ACA required primary care rate increase in FFY 2013 to 100 percent of Medicare. Note - the PeachCare proposal would increase rates to 100 percent of Medicare.
- Fully funds 12 months of Care Management Organization (CMO) capitation payments in AFY 2012 and FY 2013.
- Funds the PeachCare enrollment increase in both fiscal years that resulted from qualifying SHBP children enrolling in the program.
- Increases the Nursing Home Provider Fee and uses the funds to update from the 2006 cost report to the 2009 cost report.
- Uses $19 million in increased federal funds from the Balancing Incentive Payment Program to develop long-term care services and supports. The Balancing Incentive Payment Program provide qualifying states with either a 2 or a 5 percentage point increase in their FMAP for Home- and Community-Based Services (HCBS) costs. Participating states must make certain program changes designed to increase HCBS usage.
- Funds Medicaid and CHIP program growth using FY 2011 reserves ($50 million) in AFY 2012 and $26 million state general funds in FY 2013. Details on projected growth are not yet available.

In the news

- **Some mentally disabled lose services**

  Under stringent Federal rules, the state Department of Community Health has had to carefully reassess on a case-by-case basis whether Service Options Using Resources in a Community Environment (SOURCE) participants require a nursing home level of care, in some cases leading to loss of services, which include housekeeping, transportation to adult day centers, care management. That includes people with physical disabilities whose health may have improved over time. If the state doesn't strictly follow the new guidelines for the Medicaid-funded program, it could risk losing federal money.

SOURCE continues to serve mentally ill and developmentally disabled individuals who also have physical impairments. Those discharged keep their other Medicaid benefits, such as hospital and pharmacy services. More than 19,000 Georgians receive services through SOURCE, which was launched in 1997. Through it, case managers and primary care doctors work together to coordinate individuals' long-term care. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The Medicaid Advisory Committee (MAC) Care Coordination Subcommittee met on Tuesday, January 10. At the meeting, the Department of Health and Family Services (HFS) announced that the RFP for Phase I of the Care Coordination Innovations Project would be released by the end of next week (January 20, 2012). The Phase I RFP encourages non-MCO partnerships of providers and others as Care Coordination Entities (CCEs) or Managed Care Coordination Networks (MCCNs). A Phase II RFP for managed care plans will be released in the following months. Additionally, HFS updated the Committee on the Illinois budget, noting that the current $1.5 billion shortfall in Medicaid and other HFS funding is expected to grow to $2 billion by the end of the year. There is significant pressure on all state agencies to find cost-containment options.

In the news

- **Hospital lobbying group highlights benefits as charity care fight with state brews**

  Even as Illinois hospitals wage a publicity and lobbying campaign to preserve their tax-exempt status, the value of their public programs and services declined in 2010 from the year before, a trade association report said. The hospitals provided programs and services — such as free care and doctor training — worth about $4.6 billion in 2010, according to a report the Illinois Hospital Assn. issued Wednesday. That total is down about 5% from the $4.86 billion hospitals provided in 2009. An IHA spokesman said several factors could be attributed to the decline, including the way hospitals report bad debt, meaning bills patients don't pay that aren't classified as charity care. The value of hospital public benefits has risen 26% over the past five years, the Naperville-based group of 200 hospitals said. The IHA's fifth annual report is intended to tout the broad community benefits provided by non-profit hospitals as they seek to preserve their property tax exemptions. Recommendations on the proposed statute determining tax-exempt status are expected to be unveiled in March. (Crain's Chicago)

Indiana

HMA Roundup – Cathy Rudd

Indiana Family and Social Services Administration released an RFI soliciting information from potential providers of innovative solutions for an Asset Verification System (AVS) to provide comprehensive verification and reporting of Medicaid applicants and beneficiaries' assets in the most efficient and cost effective delivery model available. Responses will be used in RFP design. The due date is February 28, 2012. Available here.

Ohio

HMA Roundup – Alicia Smith

The Ohio Department of Job and Family Services (ODJFS) announced today, January 11, that it has issued a request for applications (RFA) from qualified managed care organizations. Letters of intent will be due on February 27, 2012 with applications due on March 19 2012. A link to the RFA announcement is available here. Links to the RFA and Appendices are available here: RFA; Appendices.

In the news

- **State ends Medicaid contracts with companies involved in care of dead teen**

  State officials announced they would end Medicaid contracts worth tens of millions of dollars with the two private companies responsible for the care and oversight of 14-year-old, who died March 1, 2011 of medical and nutritional neglect. The Ohio Department of Job and Family Services announced Monday it will terminate its contract with Huber Heights-based Exclusive Home Care, and will not renew its contract with CareStar of Ohio. (Dayton Daily News)

- **Proposal aims for better coordination between Medicare, Medicaid for Ohioans in both programs**

  State officials want to change the way health care is delivered to the 190,000 enrollees in both Medicaid and Medicare, so that the beneficiaries only have to work with a single entity to receive the services. A draft proposal of the plan was released Tuesday. State officials want to gather feedback from those enrolled in the programs, as well as from health providers and advocate groups such as AARP, before they submit a final plan to federal officials for their approval. Under the initiative, the state would contract with an entity to become the single point of contact for beneficiaries. The draft lays out some functions of the future contractor. For instance, the entity must place "heavy emphasis" on periodic visits to the beneficiaries' homes. A health care professional must be able to take enrollees' calls, assess their situation and take action at any time of day. The contractor must also keep a centralized record available to all practitioners involved with the enrollee's care. The draft proposal calls for a phased-in approach, beginning with larger, urban areas. (The Republic) (Link to Draft Proposal)

- **Ohio begins value-based measure for Medicaid**

  The state of Ohio today launches a formal effort to shift the health care industry's business model from one based on volume to one based on value. When the state's Medicaid program rebids contracts this year for 2013, it will base a greater portion of its payments to managed care plans on how effectively patients are treated. The Medicaid program also will require that managed care plans develop incentives for health care providers to improve enrollees' health. The new contracts will be based on language developed by Catalyst for Payment Reform, a San Francisco-based nonprofit that uses the collective purchasing power of large employers and groups such as General Electric Co., Walmart Corp. and California Public Employees' Retirement System to push for greater value in health care. Ohio's Medicaid program is the first in the nation to participate in Catalyst's efforts, officials said. (Dayton Daily News)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Due to cuts in funding for the Medical Assistance Transportation Program, which limited what the State will reimburse per-mile for self-arranged medical transportation, Medicaid beneficiaries are increasingly unable to find willing transportation. Per-mile reimbursement was cut by more than 50 percent in the past year. This does not include the Philadelphia area, which is served under a transportation broker.

According to an article in the *Pittsburgh Post Gazette*, Pennsylvania plans to make the amount of food stamps that people receive contingent on the assets they possess. Specifically, the Department of Public Welfare said that as of May 1, people under age 60 with more than $2,000 in savings or other assets will no longer be eligible for food stamps. For people over 60, the limit is $3,250.

As a final note, bids are due next week, January 18, in response to the Medicaid MCO expansion RFP.

OTHER HEADLINES

Florida

- **Hospitals fear cuts to Medicaid**

  Gov. Rick Scott's proposed $66.4 billion budget calls for a new reimbursement formula for the low-income health insurance program, changes that could result in an estimated $20.9 million in payment cuts to the health system. Scott said his plan would reduce escalating health care costs and provide a more fair means of distributing Medicaid funds to Florida hospitals. Health system officials have called the plan's impact potentially "catastrophic" for them. The governor has proposed a new, more "flat" means of calculating Medicaid reimbursements to hospitals, new payment limits on emergency department use and a reduction in the allowable hospital days for which Medicaid would pay. (News-Press)

- **Blues plans create Medicaid HMO**

  Florida's huge and growing Medicaid managed-care market is gaining a new, formidable player: Florida True Health Inc. Blue Cross and Blue Shield of Florida announced late Thursday that it is forming the joint venture with an experienced Medicaid managed-care organization based in Philadelphia, AmeriHealth Mercy Family of Companies. BCBS-FL spokesman John Herbkersman said the application to state insurance officials will go in shortly, and the business is expected to open in mid-2012. (Health News Florida)

- **Miami-Dade judge blocks cuts to disability treatment centers**

  A Miami-Dade Circuit Court judge has issued a preliminary injunction against a plan by the Florida Agency for Health Care Administration (AHCA) to slice millions of dollars in payments to facilities that serve people with developmental disabilities. Intermediate-care facilities throughout the state filed a lawsuit Dec. 21 in an attempt to block AHCA from moving forward with the Medicaid funding cuts. The facilities argue that AHCA improperly approved the plan and that it would hurt the quality of care provided to people with severe disabilities. In an order dated Friday, Circuit Judge Valerie Manno-Schurr made clear that she was not ruling on the merits of the facilities' arguments. But she ordered AHCA to "maintain the status quo" in payment rates until the case can be decided. (Miami Herald)

Kansas

- **Health issues facing the 2012 Legislature**

  With the launch of the 2012 Legislature this week, policymakers face a variety of health-related issues. Perhaps the most significant among them will be Gov. Sam Brownback's proposed realignment of the state's Medicaid program, which includes reorganization of three major agencies. But there also will be a raft of other issues ranging from legislation to expand the work that can be done by dental technicians to efforts to boost spending on tobacco-use prevention and a possible move to limit medical malpractice awards should the state Supreme Court strike down the existing cap. KHI News Service has compiled and summarized the agendas of the administration and the state's major health-related groups and agencies. (Kansas Health Institute)

Kentucky

- **OMHS won't offer MCO Kentucky Spirit immediately**

  Owensboro Medical Health System will not have a contract with Kentucky Spirit Health Plan (Centene), one of three managed care organizations providing Medicaid insurance in the state, but that may change next summer, according to OMHS spokesman Gordon Wilkerson. In the meantime, OMHS is contracted with MCOs WellCare of Kentucky and CoventryCare of Kentucky, and the hospital will provide emergency services to all patients regardless of insurance coverage or ability to pay, according to Wilkerson. "Negotiations with Kentucky Spirit (Health Plan) ceased in mid-December for a variety of reasons, including operational and financial issues that made the contract an impasse," Wilkerson said. (Insurance News Net)

Massachusetts

- **Massachusetts Health Plan Extended to Immigrants**

  Massachusetts cannot bar legal immigrants from a state health care program, according to a ruling issued Thursday by the state's highest court, a decision that edges the state closer to its goal of providing near-universal health care coverage to its residents. The ruling said that a 2009 state budget that dropped about 29,000 legal immigrants who had lived in the United States for less than five years from Commonwealth Care, the subsidized health insurance program central to this state's 2006 health care overhaul, violated the State Constitution. (New York Times)

Maine

- **New study disputes LePage administration on MaineCare's childless adults**

  The childless adults Gov. Paul LePage has proposed dropping from MaineCare are far from young and healthy, despite rhetoric to the contrary, according to a report released Monday by an advocacy group for the poor. More than 40 percent of childless adults covered through MaineCare are older than 45 and many have serious medical conditions, states the report. The childless adult group consists of beneficiaries ages 21 to 64 who don't qualify as disabled under federal guidelines and who have no dependents in the home. Of members receiving services, 47 percent have a diagnosis of disease or cancer, 24 percent have a mental disorder and 11 percent were treated for injury or poisoning, according to April 2010 data cited in the report. (Bangor Daily News)

New York

- **Albany to Tackle Health Exchanges in Coming Months**

  Governor Andrew Cuomo says creating a health insurance exchange for New York is a priority for 2012. Last year, Albany almost passed a bill that would lay the groundwork for an exchange, before hitting an impasse in the Republican-controlled State Senate. (WNYC)

North Dakota

- **DHS sued over Medicaid contract award**

  A North Dakota company is suing the Iowa Department of Human Services, alleging the agency unfairly awarded another company a $140 million contract to manage part of Iowa's Medicaid system. Noridian Administrative Services wants a judge to review the state agency's decision to pay Accenture to handle Iowa's Medicaid Management Information System. According to Noridian, Accenture's bid proposal includes costs that are $23 million more than the costs included in Noridian's proposal. Noridian says that because Accenture's bid is "overly vague" in some areas, it could lead to even greater costs for taxpayers. (Des Moines Register)

Oregon

- **Report projects big savings in proposed Medicaid overhaul, but near-term shortfall remains**

  Gov. John Kitzhaber's proposed health care overhaul would save less than half of the nearly $240 million that Oregon lawmakers assumed when they wrote the state budget, projections released Tuesday showed. The shortfall — $125 million under the most optimistic projection — could require reductions in Oregon Health Plan benefits or even steeper cuts in payments to doctors and hospitals. But state officials said they're hopeful the federal government will provide an influx of money as a sort of down payment that would be recouped with future savings. And the potential for future savings is significant. In the long run, Oregon could eventually save as much as 50 percent on health care by focusing more on preventative medicine and coordinating care, Doug Elwell, managing principal at Health Management Associates, told the Oregon Health Policy Board on Tuesday. (The Republic)

South Dakota

- **SD Medicaid management system update stymied**

  Development of a new computerized Medicaid management system is far behind schedule because of a dispute between the state and the company hired to do the work, a South Dakota official said Monday. The state signed a contract in 2008 with Client Network Service Inc. of Maryland to develop a new $72 million computerized system for managing the program that pays medical expenses for low-income people. But the state terminated the contract in October 2010 because the work was behind schedule and of poor quality. The company then sued the state, which in turn filed a counter-claim in state court. However, the federal Centers for Medicare and Medicaid persuaded the state and Client Network Service to enter mediation in an attempt to resolve the dispute and get the project moving again. (Rapid City Journal)

West Virginia

- **'Almost Heaven' Meets 'Paradise' — Virgin Islands and West Virginia Discuss An Exchange**

  While no commitments have been made, the potential partnership is notable because it's a rare example of states and U.S. territories working together to establish an exchange. The Virgin Islands has also had discussions with Puerto Rico, its larger Caribbean neighbor. The U.S. Territories, such as the Virgin Islands and Puerto Rico, have the option of forming an exchange or using the money to expand Medicaid. Under the law, states have the option to work together on an exchange or with the federal government. Taetia Dorsett, coordinator of the Virgin Islands Healthcare Reform Implementation Task Force, said West Virginia is a logical potential partner because they are already working together on Medicaid. Later this year, West Virginia will begin processing Medicaid claims for the Virgin Islands. She said the Virgin Islands initially considered partnering with Florida or Georgia on an exchange because those states have large individual health insurance markets, but decided against that because of concerns about what efforts those states would make on an exchange. Both states are part of a lawsuit opposing the health law. (Kaiser Health News)

United States

- **Medicaid Expansion in Health Care Law an Unconstitutional Coercion, States Say**

  Limiting the power of Congress to use federal tax dollars to make states adopt certain laws is a "constitutional necessity," the 26 states challenging the health care law argue in a brief dealing with the measure's Medicaid expansion; the brief was filed with the Supreme Court on Tuesday. The states involved in the suit against the law (PL 111-148, PL 111-152), known as the Affordable Care Act, or ACA, have maintained since their case was first heard in federal district court that the Medicaid expansion is not constitutional. But their argument was rejected at both the district and appellate court levels. Tuesday was the deadline for the states' brief; the Department of Justice has until Feb. 10 to reply. The brief uses the example of the health benefit exchanges that every state is to establish to serve as marketplaces for insurance for individuals and small businesses. If a state declines to set up an exchange, there's a federal fallback in the form of a federally run exchange, the brief notes. Nothing similar exists for a state that

might drop out of the Medicaid program rather than take part in the expansion. The states also address the fear that a decision in their favor would jeopardize the federal government's ability to influence other state decisions through its spending power, such as speed limits on interstate highways. They say the health care law is an unusual case. (CQ Healthbeat)

- **Dual eligible report proposes integrated care model**

  The Association for Community Affiliated Plans released a paper proposing to provide states a permanent option to choose a managed care plan to provide services for "dual eligibles" with beneficiary protections and standards for financial integrity set by the federal government. (Association for Community Health Plans)

- **Obama Lawyers Defend Health-Care Law at U.S. High Court**

  The Obama administration defended the 2010 health-care law and its requirement that people obtain insurance, telling the U.S. Supreme Court that the measure addressed a "crisis in the national health-care market." In the first of several rounds of briefs that will be filed before the justices hear arguments in late March, the government argued that Congress could enact the so-called individual mandate under its constitutional authority to regulate interstate commerce. (Bloomberg Business Week)

PRIVATE COMPANY NEWS

- **Universal American Corp. to Acquire APS Healthcare**

  Universal American Corp. announced that it has entered into a definitive agreement to acquire APS Healthcare, Inc., a leading provider of specialty healthcare solutions for $227.5 million. HMA advised Universal American on the transaction. (Universal American)

- **Acadia Healthcare to pay $91M for hospitals**

  Fresh off raising $68 million in a public offering, Acadia Healthcare Co. has agreed to acquire three psychiatric hospitals from Haven Behavioral Healthcare. The deal covers in-patient facilities in three states for a total price of $91 million in cash. The hospitals located in Tucson, Ariz., Wichita Falls, Texas, and Ada, Okla., have 166 acute inpatient psychiatric beds. Combined revenues were roughly $43 million for the 12 months through Sept. 30. Acadia, which operates 29 psychiatric and addiction treatment centers with 1,970 beds in 18 states, said the deal is being funded with proceeds from last month's offering and a partial draw on its revolving credit line. The Franklin-based company expects to close the purchases by April. (The Tennessean)

- SCM Insurance Services, a portfolio company of Torquest Partners, has acquired the independent medical assessment unit of Medisys Corporate Health, a portfolio company of Persistence Capital. No pricing 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 have included the Ohio RFA, released today, January 11. Kansas has extended their submission deadline to February 22, 2012.

Date	State	Event	Beneficiaries
January 11, 2012	Ohio	RFP Released	1,650,000
January 15, 2012	New Hampshire	Contract awards	130,000
January 17, 2012	Hawaii	Contract awards	225,000
January 17, 2012	Washington	Contract awards	800,000
January 18, 2012	Pennsylvania	Proposals due	465,000
January 27, 2012	Virginia Behavioral	Proposals due	265,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
February 22, 2012	Kansas	Proposals due	313,000
February 27, 2012	Ohio	LOIs due	1,650,000
February 28, 2012	Nebraska	Contract awards	75,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
March 19, 2012	Ohio	Proposals due	1,650,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Georgia	RFP Released	1,500,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	100,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	100,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA Recently Published Research

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

Sharon Silow-Carroll, Managing Principal
Jennifer Edwards, Managing Principal

One of the most common types of health care–associated infections is the central line–associated bloodstream infection (CLABSI), which can result when a central venous catheter is not inserted or maintained properly. About 43,000 CLABSIs occurred in hospitals in 2009; nearly one of five infected patients died as a result. This report synthesizes lessons from four hospitals 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 can be found on on WhyNotTheBest.org.

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

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