HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WE REVIEW A RECENT GAO REPORT ON INVESTOR-OWNED NURSING HOME PERFORMANCE

HMA ROUNDUP: MINIMUM MLR BACK ON THE TABLE IN FLORIDA; INITIAL SCHEDULE FOR GEORGIA MANAGED CARE RFP INTRODUCED; MICHIGAN PROVIDER CLAIMS TAX PASSES HOUSE, AWAITS GOVERNOR'S SIGNATURE

OTHER HEADLINES: AETNA PURSUES PROTEST OF LOUISIANA MANAGED CARE RFP AWARDS; MOLINA, ACS DROP PROTESTS OF LOUISIANA MMIS RFP AWARD; HEALTHLEADERS LOOKS AT PRIVATE EQUITY INVESTMENTS IN NOT FOR PROFIT HOSPITALS

UPCOMING APPEARANCES: STIFEL NICOLAUS HEALTHCARE CONFERENCE, SEPTEMBER 7-8, BOSTON MASSACHUSETTS

AUGUST 24, 2011

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

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Contents

IN FOCUS: GAO REPORT ON PRIVATE INVESTMENT NURSING HOME PERFORMANCE

This week, our *In Focus* section reviews a report released last month by the U.S. Government Accountability Office (GAO) on the performance of private investment (PI) nursing homes compared with other for-profit nursing homes and non-profit nursing homes. Given Medicare and Medicaid rate reductions that threaten to pressure profit margins, as well as ongoing consolidation in the space by private owners, we felt the GAO's analysis was a timely evaluation of the differences in quality and efficiency across ownership types. The report focused on three measures: (1) deficiencies as cited on state surveys, (2) nursing staffing levels, and (3) financial performance. The GAO was asked by members of Congress to examine the impact of PI ownership on the quality of care provided and on nursing homes' financial performance. This report is a follow-up to a September 2010 GAO report on the extent of PI ownership in the nursing home industry. Below, we highlight the key findings of the GAO report within the context of the nursing home industry. Overall, the study found no significant differences in the incidence of deficiencies at PI nursing homes. The study also found that PI nursing homes have operated more efficiently and profitably than their counterparts, in part due to lower nurse staffing ratios and a more favorable payor mix.

Nursing Home Industry Landscape

According to the GAO, nursing home revenue in 2009 was roughly $89 billion in Medicare and Medicaid funding alone. The CMS Actuary's National Health Expenditure report projects Medicare and Medicaid nursing facility spending in 2011 of roughly $100 billion, with another $45 billion in private expenditures. Looking forward, nursing facility spending is expected to exceed $218 billion in 2020, of which $155 billion will be funded by Medicare and Medicaid.

Of the nearly 15,700 certified nursing homes in the U.S., roughly 68% (10,700) are under private, for-profit ownership. The not-for-profit and government-owned facilities make up roughly 27% (4,100) and 6% (900) of the market, respectively. The GAO's report tracks performance measures in 1,900 nursing homes acquired by PI firms between 1998 and 2008. This represents nearly 18% of the for-profit nursing home market, and more than 12% of the nursing home market as a whole. Below, we highlight the top five and bottom five states in terms of for-profit nursing home ownership, measured both by total number of for-profit facilities and by for-profit facilities as a percentage of total facilities.

Top 5 States: For-Profit Nursing Home Ownership					
By Total #			By % of Total		
Texas	987	84%	Oklahoma	276	86%
California	975	80%	Texas	987	84%
Ohio	735	76%	Rhode Island	68	83%
Illinois	551	70%	Utah	80	82%
Florida	478	71%	Arkansas	189	82%

Source: Kaiser State Health Facts, 2009

Bottom 5 States: For-Profit Nursing Home Ownership					
By Total #			By % of Total		
Alaska	2	13%	North Dakota	5	6%
North Dakota	5	6%	Alaska	2	13%
DC	9	47%	Minnesota	108	28%
Wyoming	16	42%	South Dakota	36	33%
Hawaii	24	50%	Wyoming	16	42%

Source: Kaiser State Health Facts, 2009

The GAO distinguishes between full PI ownership, in which the firm has acquired both the operations and real estate of a facility, partial PI ownership, in which the firm has acquired only the operations or real estate. Below are the top 10 PI firms that have acquired nursing homes between 1998 and 2008 and still maintain ownership (as of 2008).

Top 10 Private Investment Nursing Home Chain and Real Estate Acquirers 1998-2008				
PI Firm	**Chain(s) Acquired**	**Number of Homes**	**Real Estate Only**	**Total**
Abe Briarwood/National Senior Care	Integrated Health Services, Mariner Health Care	382	-	382
Fillmore Capital Partners	Beverly Enterprises	324	-	324
The Carlyle Group	HCR ManorCare	279	-	279
Formation Capital	Genesis HealthCare	180	65	245
SMV/SWC	N/A	-	189	189
GE Capital	N/A	-	162	162
Warburg Pincus	Centennial HealthCare, Florida Healthcare Properties	115	-	115
Onex	Skilled Healthcare	75	-	75
The Straus Group	CareOne	20	38	58
Lydian Capital	Trilogy Health Services	49	-	49

Source: "Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data." GAO. September 30, 2010. http://www.gao.gov/products/GAO-10-710

GAO Report Findings

Below we summarize the major findings and conclusions from the GAO report.

- **PI-acquired nursing homes had no higher incidences of deficiencies than other for-profit homes.**

  Data on reported deficiencies, compiled from state survey reports, indicate that PI nursing homes exactly mirrored other for-profit nursing homes. Nonprofit nursing

homes averaged 20-30% less total deficiencies than both PI and other for-profit homes. While average total deficiencies reported increased across the nursing home industry as a whole from 2003 through 2009, there is no indication that PI nursing homes increased at a differential rate than any other ownership type.

- **PI-acquired nursing homes have a higher proportion of homes reporting a serious deficiency. However, PI-acquired homes outperformed all others in reducing serious deficiencies from 2003 through 2009.**

  In 2003, PI nursing homes had a slightly higher incidence of serious deficiencies than other for-profit homes, and a noticeably higher incidence of serious deficiencies than nonprofit homes. However, PI nursing homes have significantly reduced their incidence of serious deficiencies compared with only modest reductions in other for-profit and nonprofit homes. PI nursing homes now have only a slightly higher incidence of serious deficiencies than nonprofit homes, and a lower incidence than other for-profit homes.

- **PI-acquired nursing homes maintain lower nursing staffing ratios, but grow on track with industry. PI-acquired homes demonstrated a significant increase in registered nurse (RN) staffing ratios compared with other for-profit and nonprofit homes.**

  PI nursing home nursing staffing ratios are noticeably lower than other ownership types, but grew on track with the industry as a whole from 2003 through 2009. Additionally, the report notes that all three ownership types met the "preferred" ratio under CMS standards but fell short of the "optimal" ratio threshold. PI homes increased their ratio of RNs as a component of staffing mix from 2003 through 2009. RN staffing ratios for PI homes exceed that of other for-profit homes and are on par with nonprofit homes.

- **RN staffing ratios are significantly higher when PI firm acquires both operations and real estate.**

  In 2009, RN staffing ratios were roughly 50% higher in PI homes where both operations and real estate were acquired than in instances where just one component was acquired.

- **PI-acquired nursing home margins far outperform both other for-profit and nonprofit nursing homes.**

  Of the facilities reviewed by GAO, PI nursing homes averaged 2008 operating margins of more than 6%, an increase from 4.5% in 2003. Other for-profit homes averaged 2008 margins of slightly over 2%, an increase from less than 0.5% in 2003. Nonprofit homes averaged 2008 margins of roughly -1%, a decline from 2003 margins around 0.1%.

Report Conclusions

- PI nursing homes did not experience an increase in the likelihood of serious deficiencies and instead made greater progress than other for-profit homes and nonprofit homes in reducing the incidence of serious deficiencies.

- Despite having lower nursing staffing ratios, PI homes increased registered nurse (RN) staffing, particularly in instances where both operations and real estate were acquired by the same firm.
- Contrary to concerns raised about cost-cutting, PI homes actually increased total facility costs, while consistently improving facility margins. PI home facility costs are on par with nonprofit homes, yet PI homes average greater than 6% margins, while nonprofit homes average -1% margins.
- The report suggests that PI homes were able to increase margins while also increasing costs due to the prevention of future costly episodes of care and by attracting wealthier, better-paying residents through investments to increase the attractiveness of their facilities.
- PI homes perform significantly better when a single firm owns both operations and real estate. Homes in which ownership was split between firms or entities reported lower RN staffing ratios, higher costs, and lower margins.

HMA Medicaid Roundup

Florida

HMA Roundup – Gary Crayton

The state is continuing to work with CMS on a three-year extension of its current Section 1115 waiver. CMS has indicated that it would like the state to adopt a minimum medical loss ratio (MLR) for Medicaid managed care plans operating in the state and would also like to phase out the low income pool (LIP) by 2014. We don't believe the minimum MLR would have a significant adverse effect on the Medicaid managed care industry in the state as the plans operate at higher levels. The phase-out of the LIP may have adverse implications on safety net hospitals, however. We note that, while these recommendations were made specifically with respect to the extension of the current waiver, we would expect CMS to advocate for similar provisions in the waiver associated with the Florida's Medicaid managed care expansion in 2012/13. Discussions on that waiver will begin once the current waiver extension is settled.

The resignation of AHCA Deputy Secretary for Medicaid, Roberta Bradford, came as a surprise to many amid the waiver negotiations. It is believed her resignation was due to a family relocation decision. We have no further information at this time.

In the news

- **Negron says he's open to changes in his Medicaid plan**

  State Sen. Joe Negron, R-Stuart, said he is open to changes in the Medicaid overhaul he helped craft this past spring as the state and the Obama administration continue to hammer out differences it has over a waiver the state needs to move forward with the program. The state is seeking a waiver to continue a five county Medicaid pilot program that started in 2006. The program, which focuses on managed care, was set to expire earlier this summer, but federal authorities approved extensions while the state

and federal government continued to negotiate. The pilot program will be the building block for the new state model, which expands managed care statewide. In particular, the state and the Centers for Medicare and Medicaid are at odds over the exclusion of a medical loss ratio in the state's Medicaid plans. The Florida Current reported that state officials and CMS met earlier this week for another round of negotiations, but that the MLR was a major sticking point. (Orlando Sentinel)

- **Florida fines Humana $3.3 million for slow reports of suspected Medicaid fraud**

  The state has fined Humana Inc. $3.3 million for failing to promptly report Medicaid fraud or abuse to state investigators, as the law requires. The company did not disclose what it knew about suspected fraud and abuse by Medicaid providers — such as doctors and hospitals — or recipients back as far as Sept. 1, 2009, health regulators said in two letters sent last week to Humana's Miramar office. Humana and its CarePlus subsidiary together make up Florida's largest and most profitable HMO with 568,000 members — most of them in Medicare — and 2010 profits of $330 million. Nationwide, the company is the second-largest Medicare insurer, with 4.3 million members. It's unclear if the fine is related to an internal investigation the company is making in South Florida, which the company says it has disclosed to federal prosecutors, Medicare and state Medicaid officials. (TC Palm)

- **Gov. Rick Scott's top Medicaid official resigns**

  Florida's top Medicaid official, Roberta Bradford, has resigned, leaving a critical vacancy in Gov. Rick Scott's administration as the state seeks federal approval for a plan to move Medicaid patients into managed care programs. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

With the state finalizing its contract with Navigant Consulting on the Medicaid redesign, we can report rough timeline for the Medicaid redesign process. The state is projecting the release of a draft RFP by June 2012, with a final RFP release slated for July 2012. Contract awards are projected to be announced in January 2013, a full year before the scheduled implementation date of January 2014. We note that this schedule does appear to provide some flexibility for delays in the process.

Indiana

HMA Roundup – Cathy Rudd

The state issued an RFI on August 12 in preparation for issuing an RFP for its Enterprise Medicaid system, specifically for a data warehouse and decision support system.

Additionally, the state awarded the Exchange provider and insurance carrier data quality consulting contract to IHIE. IHIE is a nonprofit formed around 2004 by the Regenstrief Institute (associated with Indiana University) and hospitals in the Indianapolis area.

Michigan

HMA Roundup – Esther Reagan

As predicted, the House took action today, Wednesday, August 24, to pass the claims tax bill, which now goes to Governor Snyder for approval. The bill places a tax on all insurance claims paid. Last week's roundup includes a description of the changes made in the appropriations committee, which include a cap on total funds raised and a sunset provision.

Governor Snyder is negotiating with state employees over $100 million in concessions in pay and health benefits to avoid layoffs. Several state employee unions have collaborated in the negotiations and are proposing alternatives, such as decreasing unnecessary levels of employee supervision.

As one of the winners of CMS funding for Medicaid and Medicare dual integration funding, the state is currently in the midst of a stakeholder engagement process to design its dual integration program. Michigan has proposed to become the sole fiduciary party under both Medicaid and Medicare in a capitated structure. Because of this proposal to combine funding streams, the state may take advantage of the opportunity to issue a joint state and federal Medicaid/Medicare managed care RFP, as proposed in a CMS letter to state Medicaid directors from July 8.

In the news

- **Mich. AG reviews Blues plan to invest $215M in Pa. firm**

  Michigan Attorney General Bill Schuette said Friday his office is reviewing Blue Cross Blue Shield of Michigan's proposal to spend up to $215 million to invest in a Pennsylvania-based insurance company. The nonprofit Blues announced last week that it and Philadelphia-based Independence Blue Cross plan to spend $170 million to buy Mercy Health System's 50 percent interest in AmeriHealth Mercy Family of Companies, an insurer serving about 800,000 people in Medicaid managed care plans in three states. Independence Blue Cross currently owns half of AmeriHealth Mercy. The Blues, the state's insurer of last resort, would gain an about 40 percent interest in AmeriHealth Mercy just as enrollment in Medicaid is expected to soar as part of health care reform. (Detroit News)

- **Blues look to expand Wayne Co. Medicaid**

  BlueCaid of Michigan wants to expand its Medicaid service area to cover all of Wayne County, with hopes the move could help add 10,000 members in two years, according to an application filed with the state. About 1,160 of its BlueCaid enrollees currently are in western Wayne County, said Helen Stojic, a spokeswoman for Blue Cross Blue Shield of Michigan, the state's largest insurer. BlueCaid is a nonprofit and an independent licensee of the Blue Cross and Blue Shield Association. BlueCaid projects its enrollment in Michigan could grow to 29,407 by September 2013 from 19,349 today if the expansion is granted, though net income is expected to increase by just $17,500 with the expansion, according to the Blues and its application. (Detroit News)

OTHER HEADLINES

Arkansas

- **Ark. gov. zeroes in on 9 areas for Medicaid reform**

  Arkansas officials have identified nine areas that they want to focus on as they look at changing the way Medicaid pays for services, including neonatal care and developmental disabilities, Gov. Mike Beebe told federal health officials in a letter released Monday. The state in May was given initial approval to move forward with developing plans to switch from a fee-for-service model that Medicaid uses. The state instead hopes to pay partnerships of local providers for "episodes" of care rather than each individual treatment. The areas targeted are pregnancy and neonatal care, attention deficit hyperactivity disorder, type 2 diabetes, back pain, cardiovascular disease, upper respiratory infections, developmental disabilities, long term care and prevention, according to an Aug. 10 letter Beebe sent to U.S. Department of Health and Human Services Secretary Kathleen Sebelius. (Houston Chronicle)

California

- **Letter Out, Senate ADHC Hearing Set for Thursday**

  The Department of Health Care Services has sent 26,000 notification letters to adult day health care program participants in California, notifying them that ADHC no longer will be a Medi-Cal benefit as of Dec. 1. Beneficiaries have until Oct. 1 to choose a managed care plan or opt to remain in a fee-for-service day center. Those who choose a managed care plan, according to DHCS, will be assessed and then receive services similar to what they get in ADHC centers. Those who don't make a choice by Oct. 1 will be automatically enrolled in a managed care plan, according to DHCS officials. (California HealthLine)

- **Budget Trailer Bills Might Rescue Healthy Families Program**

  The answer to save the Healthy Families program may lie in two bills -- ABX1 21 and SBX1 9, budget trailer bills left over from the previous session. The bills would extend the gross premiums tax. It's that managed-care tax that was funding a large portion of the Healthy Families program. According to one representative, the Legislature will take it up -- quickly, since the current session only lasts a month. (California HealthLine)

- **Private Medicaid Plans See Opportunity In Low-Wage Workers**

  Private health plans that oversee care for Medicaid patients have seized on a federal health law provision that could compound the boom their industry already expects in 2014, when the law steers 16 million more members into the state-federal partnership for low-income people. They are lobbying states to form so-called “basic health plans” that would cover people earning up to 200 percent of the federal poverty line, about $22,000 a year for an individual, under Medicaid-like rules. The law already expands Medicaid to those earning about $15,000. Molina, a $4 billion company, is joining smaller nonprofit plans to lobby California and other states to adopt the program. California’s Medicaid program, which contracts with Molina and other plans to manage

patients' care, will add more than 2 million members beginning in 2014. The BHP could push more than 700,000 additional people into the potential market for such insurers. (Kaiser Health News)

Kentucky

- **Hospitals slow to sign up for Medicaid Managed Care**

  The state plans to be up and running with its new managed care delivery of Medicaid services by Oct. 1 — but as of last week, only 15 or so of the state's hospitals had signed on with one of the three managed care providers. The State would like to see about 89 hospitals join one or more of the three networks but the contracts provide for "out of network" services if enough hospitals don't join in rural or isolated areas. (Richmond Register)

- **New Kentucky Medicaid programs on track for Oct. 1, official says**

  Despite a request for delay, Kentucky is still working to move more than half a million Medicaid patients into new managed care programs by Oct. 1. An advisory council recently asked the cabinet to delay implementation of the ambitious plan to shift most Medicaid members outside the Jefferson County region into a managed care system. Within two weeks, 560,000 Kentuckians should receive by mail information packets about which of three private companies will manage their care through the federal-state health plan for the poor and disabled. Membership cards are to be mailed in September. (Courier Journal)

Louisiana

- **Medicaid privatization firm selection challenged again**

  Aetna Better Health Inc., a subsidiary of Aetna Inc., already lost an appeal with Louisiana Health and Hospitals Secretary Bruce Greenstein, who in July announced the selection of five firms slated to run the planned managed-care networks. Now the firm has asked Commissioner of Administration Paul Rainwater to throw out Greenstein's selections. Among several claims, the insurer alleges in a letter to Rainwater that Greenstein's agency did not follow the parameters of its requests for proposals to participate in Gov. Bobby Jindal's signature health initiative. The company also notes that Greenstein rejected Aetna's appeal of the selection on Aug. 11, just a day after the company submitted "supplemental information" to its Aug. 8 appeal. (NOLA.com)

- **Firms drop protest of Medicaid pact award**

  Two firms have dropped their protests of the award of a lucrative state contract for Medicaid claims processing to a Maryland company with ties to Louisiana's health chief. ACS State Healthcare and Molina Medicaid Solutions notified Commissioner of Administration Paul Rainwater they will not pursue further appeals of the contract award to Client Network Services Inc. State health chief Bruce Greenstein is a former executive of Client Network Services Inc. Controversy surrounded its selection with which Greenstein said he had nothing to do. Dropping the protests cleared the way for contract negotiations to start Monday between Client Network Services Inc. and the state Department of Health and Hospitals. (The Advocate)

- **Would-be Louisiana coordinators for mental-health and substance-abuse services submit bids**

  Four companies have submitted bids to the Department of Health and Hospitals to oversee and coordinate the state's mental-health and substance-abuse services, including an estimated 2,500 children with behavioral problems who are considered at risk of needing institutional care. The bidders are Value Options Louisiana; Cenpatico of Louisiana Inc;, Perform Care Behavioral Health Solutions, an AmeriHealth company; and Merit Health Insurance Company, an affiliate of Magellan Health Services, Inc. The health department is expected to announce the winning bidder on Sept. 1, and the revamped system will go into effect March 1, 2012. (NOLA.com)

Mississippi

- **Launch near for health care exchange**

  A one-stop shop for health insurance customers in Mississippi could be up and running early next year, as other states refuse to carry out programs tied to the federal health care overhaul. "The idea of an exchange has been around for a long time," state Insurance Commissioner Mike Chaney said. "This is about health care for our citizens." Mississippi this month received $20 million from the federal government to move forward on starting its health care exchange program. Twelve other states and Washington, D.C., also received grants totaling $165 million, but Mississippi's was among the highest. "We're ahead of just about all of the other states (in creating the program)," Chaney said. "We've gone around a lot of the roadblocks." (Clarion Ledger)

Ohio

- **Glitch leaves Medicaid providers unpaid**

  Ohio's Aug. 2 switch to a new Medicaid claims submittal system has resulted in hundreds of Medicaid health care providers not receiving payments for weeks, through no fault of their own. While the lack of payment for some providers has stemmed from erroneous claim submittals, the Ohio Department of Job and Family Services has identified 450 providers who correctly submitted claims but have not been paid for any of them, department spokesman Benjamin Johnson confirmed. Payments are being rushed to those providers and should be received by Thursday, Johnson said. Department officials identified the error this week, Johnson said. Other Medicaid providers may not have been paid for some claims, but the state doesn't know how many, Johnson said. There are several glitches with the new system. Some have been fixed, but others have not. Hewlett-Packard Co., the system's supplier, will have technicians working through the weekend and into next week to fix the remaining problems. (Dayton Daily News)

United States

- **Administration may give states second chance to avoid fully federally run insurance exchange**

  The Obama administration said Tuesday that states that have not adopted their own insurance exchanges may get a second chance to avoid getting one run solely by the federal government. Only 11 states have fully embraced the idea of taking federal

money to set up their own state-run insurance exchange, a U.S. Department of Health and Human Services official said Tuesday. U.S. Department of Health and Human Services officials told Montana legislators Tuesday that the agency is working on a new partnership model to let state agencies help run the exchange — perhaps without the need for legislative authorization. (Washington Post)

- **Hospitals seek more ER patients even as Medicaid tries to lessen demand**

  Efforts to reduce unnecessary ER visits by patients in Medicaid are proliferating as states search for ways to control the soaring costs of the program. But state officials complain that their efforts are sometimes hampered by hospitals' aggressive marketing of ERs to increase admissions and profits. ER visits totaled 124 million in 2008, an increase of about 31 percent since 1997, according to the Centers for Disease Control and Prevention. The average wait time for treatment is 33 minutes, up from 22 minutes. HCA, the nation's largest for-profit hospital chain, launched a major ER marketing campaign in the past year in Virginia, Florida, Texas and other states. The campaign includes billboards highlighting average ER waiting times and a service that provides waiting times to smartphone users. Officials at HCA and other hospitals reject the assertion that marketing the efficiency of their ERs attracts patients who don't belong there. (Washington Post)

- **CHIP Outreach Gets More Kids Covered**

  The number of children eligible for Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled fell to 4.3 million in 2009 from 4.7 million the prior year, according to a report out today. The drop is significant because it occurred even as the number of children eligible for the programs rose by 3 million as a result of the economic downturn. Researchers and federal officials attributed part of the improvement in signing up uninsured kids to the March 2009 reauthorization of the CHIP program, which spurred states to increase eligibility in the program as well as provided new federal funding to increase outreach and streamline enrollment efforts. The report comes from the Urban Institute and the Robert Wood Johnson Foundation. Last Thursday, the U.S. Department of Health and Human Services awarded $40 million in additional outreach and enrollment grants to states and non profit groups in 23 states. More than $40 million had already been awarded in 2009 and 2010. The latest round of grants will focus on using technology to ease renewals and help enroll teens, among other things. (Kaiser Health News)

- **Private Equity Interest In Nonprofit Hospitals Growing**

  Though some nonprofit hospitals and health systems continue to turn to debt leveraging as a means to pursue growth opportunities, others are turning to and being welcomed by private equity firms. A Pepperdine University survey of private equity executives at the end of 2010 found that 11% planned to invest in healthcare, more than double what it had been just six months prior, 4.8%. What makes these opportunities so appealing to private equity firms now has much to do with the Patient Protection and Affordable Care Act. Fitch Ratings recently reported that although nonprofit hospitals still face financial challenges, they will benefit from increases in patient volume and "dramatic reductions" in uncompensated care, and be helped by provisions in the

legislation that will promote "efficiency and effectiveness in the delivery of care" via pilot programs and payment incentives. Nonprofit hospitals or systems that traditionally served a large proportion of the poor and uninsured are expected to benefit from the legislation, which will extend insurance to 32 million previously uninsured. (Health Leaders Media)

PRIVATE COMPANY NEWS

- **ValueOptions® Partners with Audax Health™ to Launch Personal Health Management Pilot for Medicaid Beneficiaries**

  ValueOptions® and Audax Health™ (Audax) today announced a joint agreement to pilot an interactive health management program for Medicaid beneficiaries that aims to improve health outcomes by using social networking and game mechanics to engage members and assess their needs. As part of the six-month pilot program, ValueOptions will use the Audax Careverge® platform to engage its Medicaid members in their own health management to identify and address their potential health issues. The platform enables ValueOptions to engage with members to assess their health, to build personal health management plans, and also, to send personal messages to help members keep their appointments and take their medications. It also provides online communities, where members may interact with experts in the field and share their experiences with others facing the same challenges. (PR Newswire)

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.

Date	State	Event	Beneficiaries
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
September 15, 2011	Washington	RFP Released	880,000
September 15, 2011	Nebraska	RFP Released	60,000
September 15, 2011	Kentucky RBM	Contract awards	N/A
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 1, 2011	Kentucky RBM	Implementation	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
November 14, 2011	Hawaii	Contract awards	225,000
December 1, 2011	Hawaii	Implementation	225,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

Children's Health Care: Making Great Strides

Jennifer Edwards, DrPH, HMA Managing Principal

It is an often-repeated criticism that we have not seen monumental change in health care quality in the past decade despite the "call-to-arms" of the Institute of Medicine's seminal report, *Crossing the Quality Chasm*. Just quantifying the problem - 98,000 lives a year lost to medical errors and a finding that less than 50 percent of care meets standards of clinical evidence - has not mobilized enough changes in health care delivery to register much improvement in health outcomes. There is some new work quietly percolating, though, that has the potential to make major improvements in health outcomes for children. (Read more)

California 1115 Medicaid Waiver

Stan Rosenstein, HMA Principal Advisor

The historic renewal of the California 1115 Medicaid waiver will bring billions of new federal dollars to the state's hospital safety net, enabling California to begin full-scale implementation of national health care reform and jump start reform of its public hospital delivery systems. The 1115 waiver provides California flexibility to use Medicaid funding in new ways to improve its program. (Read more)

Florida Reviews Taxpayer Funded Hospitals

Elaine Peters, HMA Principal

The new Florida Commission on Review of Taxpayer Funded Hospital Districts is considering "whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health care access for the poor." Governor Rick Scott, a former for-profit hospital executive, has said he is "confident this new Commission will protect Florida taxpayers, and at the same time, the Commission's guidance will help provide Floridians a high-quality health care system." The Commission will evaluate how effectively privately owned and nonprofit hospitals can care for the uninsured and low-income populations, a role generally filled by public hospitals. Expected outcomes include a more rational approach to compensating hospitals. (Read more)

Achieving Efficiency: Lessons from Four Top-Performing Hospitals

Sharon Silow-Carroll, HMA Managing Principal

Jennifer Edwards, DrPH, HMA Managing Principal

Aimee Lashbrook, HMA Senior Consultant

Despite widespread acknowledgment of waste and inefficiency in the U.S. health care system, there have not been dramatic breakthroughs that point to more cost-effective alternatives. But changes under way at leading health care organizations suggest significant improvements in quality and value can be achieved.

A new report synthesizing findings from four hospital case studies showcases opportunities for all hospitals to achieve greater efficiency. The case studies focus on four of the 13 Leapfrog Group–designated "Highest Value Hospitals." (Link to Report)

UPCOMING HMA APPEARANCES

Aging Services of Michigan, Annual Leadership Institute

Vernon K. Smith, keynote speaker

August 25, 2011

Traverse City, Michigan

Stifel Nicolaus Healthcare Conference, 2011

Tom Dehner, Dianne Longley, Greg Nersessian

September 7-8, 2011

Boston, Massachusetts

Osteopathic Physicians and Surgeons of California, 22nd Annual Fall Conference

Dennis Litos, featured speaker

September 9, 2011

Monterey, California

Keys to Success: Unlocking Critical Issues Involved in Creating an Arizona Health Insurance Exchange – Sponsored by St. Luke's Health Initiatives

Donna Strugar-Fritsch, featured speaker

September 16, 2011

Phoenix, Arizona

Western Association of Medicaid Pharmacy Administrators,

Vernon K. Smith, keynote speaker

September 19, 2011

Anchorage, Alaska