HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: STATE OPTIONS IN HEALTH INSURANCE EXCHANGE DESIGN

HMA ROUNDUP: CA ABD ROLL-OUT BEGINS TODAY, MICHIGAN BUDGET INCLUDES 1.7% HMO RATE INCREASE; MICHIGAN BUDGET REPLACES "USE TAX" WITH 1% TAX ON ALL PAID HEALTH CLAIMS.

OTHER HEADLINES: NO SURPRISES AMONG LOUISIANA BIDDER'S CONFERENCE ATTENDEES; BRAVO HEALTH BEGINS ENROLLING STAR+PLUS BENEFICIARIES IN TEXAS; MA LOOKING AT HOSPITAL PAYMENT DISCREPANCIES; NY GETTING AGGRESSIVE WITH MEDICAID PAYMENTS TO PROVIDERS; TX GOV. ORDERS SPECIAL SESSION ON SCHOOLS, MEDICAID BUDGET;

PRIVATE CO. NEWS: JUDGE APPROVES STEWARD PURCHASE OF TROUBLED LANDMARK MEDICAL CENTER; CGI RENEWS PAYMENT OVERSIGHT CONTRACT WITH PA FOR 6 YEARS, $45M

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JUNE 1, 2011

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IN FOCUS: STATE OPTIONS IN HEALTH INSURANCE EXCHANGE DESIGN

This week, our *In Focus* section considers the options available to states in determining the structure of a Health Insurance Exchange. Many state legislatures have introduced or passed legislation to begin the process of establishing an Exchange. However, apart from two very different examples in Massachusetts and Utah, there is still considerable uncertainty as to how an Exchange may operate and what features may differ from state to state. In the following discussion, we evaluate some of the key decision points available to states in contemplating the design of an Insurance Exchange, focusing on advantages and disadvantages to each option. The tables and analysis come from a report prepared for the St. Luke's Health Initiative in Arizona by HMA Principals Eileen Ellis, Vern Smith and Donna Strugar-Fritsch.

A link to the full report is available here.

Geographic Scope of the Exchange

The table below examines the pros and cons of several decision points regarding the geographic scope and administration of the exchange. First, a state must decide whether to operate a state-based exchange or defer to the federal government to establish and maintain the exchange in that state. Second, the Affordable Care Act (ACA) grants the authority for multiple states to join together to create a multi-state Exchange. The third and fourth sections in the table below compare the advantages and disadvantages of a statewide Exchange with a regional Exchange within a state. In a regional Exchange, a state would be divided into multiple areas, similar to the way many states divide their Medicaid Managed Care programs into regions.

State-Based Exchange		
Advantages	**Disadvantages**	**State Exchange Decisions**
Preserves state self-determination on a range of issues, including role the Exchange plays in insurance markets, interplay between the Exchange and non-Exchange markets and coordination of the Exchange with Medicaid. Avoids the difficulty of joint federal and state regulation of insurance markets - state insurance agency would regulate Exchange and non-Exchange markets.	Creates obligation on the state to pass laws and regulations to establish the Exchange. Obligates state support of the Exchange if it is not self-sustaining by 2015.	Approaches in CA, IL, OR, NV and RI all create state-based Exchanges. Governors in TX and NM have refused to pass legislation introduced to create state-based Exchanges.
Multi-State Exchange		
Advantages	**Disadvantages**	**State Exchange Decisions**
Creates potential efficiencies from combining Exchange operations across states and assembling an enrollment base large enough to sustain the Exchange's operations and spread risk. May increase consumer choice in markets without robust competition.	Requires extensive cooperation with multiple governors, regulatory agencies and legislatures. Requires a more complicated governing structure. Requires reconciling insurance market differences across states.	Of the states reviewed, none have proposed a multi-state Exchange.

Statewide Exchange		
Advantages	**Disadvantages**	**State Exchange Decisions**
Greater efficiency by avoiding duplication of Exchange governance and operations. Could more easily facilitate regulation of the commercial market and coordination with Medicaid. Could increase options and competition in some regions. Could spread promising initiatives developed in one region throughout the state.	May be less responsive to unique regional markets. Regional variations in plan prices may be easier to address through regional Exchanges.	Of the states reviewed, all propose statewide Exchanges.
Regional Exchanges		
Advantages	**Disadvantages**	**State Exchange Decisions**
Creates the opportunity to tap local expertise to create smaller Exchanges more responsive to local market conditions.	Adds overall cost through duplicative governance and administrative functions. Could present difficulties for small employers with employees in multiple regions. Could hamper regulation of the commercial market and coordination with Medicaid. Could limit competition in some regions. Smaller risk pool may lead to higher cost.	Of the states reviewed, none have proposed regional Exchanges.

Despite some opposition to establishing state-based Exchanges in many states, we believe that most states will elect to establish their own state-based Exchanges rather than allow the federal government to control the design and administration process. Based on the states reviewed above, it appears unlikely at this time that any states will form multi-state Exchanges. It also appears unlikely at this time that any states will break the Exchange into sub-state regions, electing rather for a statewide Exchange.

Individual and Small Business Exchanges

The table below highlights the advantages and disadvantages of a combined or separate Exchange for individuals and for Small Business Health Option Programs or SHOP Exchanges. There appears to be a recurring theme in the decision and design process of efficiency versus adaptability. On one hand, broader scope of an Exchange allows administrative efficiencies, broader competition and enrollee choice, and a larger risk pool. On the other hand, narrower definitions of an Exchange allows for a structure tailored to the unique population enrolled.

Combined Individual and SHOP Exchange		
Advantages	**Disadvantages**	**State Exchange Decisions**
May offer enrollees more choices if insurers were required to participate in both markets. Could have one Exchange (governance and operations) with separate risk pools for individuals and small businesses. Combining functions such as certification and rating of qualified health plans could be cost effective and could produce economies of scale. Could ease transition of individuals moving between individual and employer-based coverage.	May add administrative complexity because some operations, such as billing and enrollment processes, are different for employer groups and individuals.	Massachusetts - (begun pre-ACA) *Commonwealth Choice* offers coverage to unsubsidized individuals and small businesses; *Commonwealth Care* offers coverage to subsidized individuals. Both operate under a single Exchange.

Separate Individual and SHOP Exchange		
Advantages	**Disadvantages**	**State Exchange Decisions**
Separate Exchanges could specialize in servicing the unique needs of individuals and small businesses, respectively, including billing and enrollment.	Two Exchanges would create administrative duplication, as each would have to determine eligibility for Medicaid, CHIP and premium subsidies.	It appears that in most legislation, the issue of a single or combined SHOP and Individual Exchanges is not explicitly addressed, leaving the question to the Exchange itself.

There is no clear indication from the states reviewed as to what decisions will ultimately be made regarding separate Individual and SHOP Exchanges. However, if states look to the Massachusetts experience for guidance in the Exchange process, it is possible that more states would follow the model of a combined set of coverage options for unsubsidized individuals and small businesses, with a separate program for subsidized individuals, all under a single Exchange umbrella.

Administration of the Exchange

This last table lays out some of the advantages and disadvantages of different options for organizational authority over the Exchange. These options include a state agency, a new quasi-governmental authority or independent public agency, or a new non-profit organization. Within the state agency option, the report looked at creating a new cabinet-level agency, a new agency, or operating within an existing state agency.

Organizational Options			
	Advantages	**Disadvantages**	**State Exchange Decisions**
Any State Agency Option	May allow some shared infrastructure. Direct ability to coordinate with other state agencies. Can require governing board.	May duplicate existing capacity. Restricted to state procurement practices. Restricted to state hiring practices, including freezes. Decision making and operations politicized.	N/A
New Cabinet-Level Agency	May promote important interagency collaboration.	Requires start-up of human and other resources.	No state reviewed chose this option.
New State Agency	Single focus, avoids conflicting priorities and objectives within agency.	Requires start-up of human and other resources. May not be influential with other agencies whose cooperation is required.	No state reviewed chose this option.

Existing Agency in State Government	Enables use of existing staff and skills, administrative systems and procedures.	Objectives may overwhelm or conflict with existing functions or objectives of host agency.	No state reviewed places the Exchange in an existing agency.
New Quasi-Government Authority or Independent Public Agency	Less politicized. Flexibility to use or not use state procurement and personnel rules for any or all purchasing or hiring. Maintains public accountability.	Requires governing board. May be difficult to obtain cooperation of Medicaid and other state agencies. May be less transparent.	CA, RI, OR and NM place the Exchange in a quasi-governmental organization.
New Nonprofit Organization	Less politicized. More flexible in hiring and procurement practices. More independent and flexible.	Requires governing board. No access to government purchasing or hiring advantages or processes. Less public accountability and transparency. Little ability to influence or gain coordination of state agencies. Some Exchange functions are inherently governmental and likely cannot be delegated to the private sector.	Of the states reviewed, none place the Exchange in a non-profit organization.

Of the states reviewed, the trend looks like states will develop quasi-government authorities or independent public agencies to organize and administer the Exchange. However, with only four confirmed states, it is too early to understand if this is a trend. Additionally, with a potential difficulty in cooperation with Medicaid agencies, and the interaction of Medicaid and the Exchange a key necessity for the success of an Exchange, this could pose a potential obstacle in the Exchange design process.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

The enrollment process begins today, June 1, 2011, for aged, blind and disabled (ABD) Medi-Cal beneficiaries in 15 counties into mandatory managed care plans. Enrollment packets are being distributed to eligible enrollees by order of date of birth and will continue over the coming months. In total, an estimated 380,000 ABD beneficiaries will be transitioned into managed care. Los Angeles County, with nearly 80% of current managed care enrollment, may see an increase of 10-12% enrollment through the ABD expansion rollout. Managed care enrollment for ABD Medi-Cal beneficiaries was previously optional. In the table below we estimate each plan's potential new enrollees based on their current market share in the county or counties where they operate.

Plan Name	Enrollment Jan-11	% of total	County Total	Current Share in County	ABD Incremental	Enrollment Growth
L.A. Care Health Plan	854,928	26.3%	1,297,399	66%	104,770	12%
Health Net	737,407	22.6%	2,247,699	33%	80,659	11%
Total Anthem	409,094	12.6%	1,080,382	38%	43,520	11%
Total Inland	409,657	12.6%	508,997	80%	40,164	10%
Total Molina	189,561	5.8%	933,766	20%	21,406	11%
Alameda Alliance For Health	102,147	3.1%	130,581	78%	16,759	16%
Community Hlth Grp Partner	103,563	3.2%	226,965	46%	13,860	13%
San Francisco Health Plan	39,952	1.2%	51,427	78%	12,596	32%
Santa Clara Family H.P.	101,905	3.1%	135,441	75%	12,160	12%
Kern Family Health Care	108,192	3.3%	140,936	77%	9,341	9%
Health Plan of San Joaquin	79,645	2.4%	106,645	75%	8,860	11%
Contra Costa Health Plan	62,210	1.9%	73,889	84%	8,619	14%
Total Kaiser	41,254	1.3%	425,765	10%	4,930	12%
Care1st Partner Plan, LLC	16,160	0.5%	226,965	7%	2,163	13%
	3,255,675				**379,808**	**12%**

Source: California Department of Health Care Services and HMA estimates

In the news

- **Medi-Cal shifting seniors, disabled to managed care**

  California's budget crisis will hit about 380,000 seniors and disabled people in the state's Medi-Cal program today when they will be required to begin enrolling in a managed health care plan to receive care. The change, which involves Medi-Cal patients in San Francisco and 15 other counties, is not intended to affect the level of care these people receive but could limit their choice of doctors. Some advocates are concerned that it could cause disruptions in care. (San Francisco Chronicle)

Florida

HMA Roundup – Gary Crayton

With the budget passed and hospital rates for Medicaid inpatient and outpatient services reduced by 12%, attention will soon shift to managed care rate setting. Based on the hospital rate reduction, we would expect managed care rates to be lowered to an actuarially equivalent degree though other factors may potentially mitigate some portion of this impact. We will continue to monitor the process as it develops in the coming weeks and months.

Georgia

HMA Roundup – Mark Trail

A public notice was issued in the last week regarding hospital add-on payments. Due to lower than expected hospital provider tax collections, inpatient and outpatient add-on reimbursement rates will decline from 11.88% to 10.49% effective July 1, 2011. A commensurate reduction will be applied to managed care organization rates.

There continues to be speculation on executive action from the Governor's office regarding the establishment of a state Exchange over the summer.

Illinois

HMA Roundup – Jane Longo / Matt Powers

The General Assembly passed a budget and sent it to Governor Quinn before the May 31st deadline. While the details are not entirely clear yet, included in the budget are the following impacts on Medicaid enrollees:

- The proposed 6% rate cut for hospitals and nursing homes will not take place. Payments will be delayed to partially make up for the foregone rate cut.
- IL Cares Rx, a prescription drug assistance program, appears to have been cut back. This program helps people with expensive drugs and will be cut to $29,000 from $36,000 for family of two
- Copay increased for clients utilizing a hospital emergency department for non-emergencies
- Lawmakers endorsed paying higher rates to hospitals that work with patients to reduce unnecessary readmissions and less that allow the practice, with reported savings as high as $40 million
- Elimination of coverage of over-the-counter drugs for Medicaid

There were no legislative changes to the managed care expansion that passed in January 2011.

In the news

- **Illinois Medicaid begins enrolling some in private health plans**

  Illinois' Medicaid health insurance program for the poor has begun enrolling 40,000 people into two private health plans, the beginning of a broader initiative to provide better coordinated and more cost-effective medical care for some elderly and disabled patients. The Illinois Department of Healthcare and Family Services, which runs the state Medicaid program for the poor, said today the program will serve seniors and adults with disabilities in suburban Cook, DuPage, Kane, Kankakee, Lake and Will counties. They will have to enroll in a health plans operated by Aetna Inc. or the other private plan contracting with the state that is run by Centene Corp. subsidiary known as IlliniCare. (Chicago Tribune)

Michigan

HMA Roundup – Esther Reagan

On May 26, 2011, both Houses of the Michigan Legislature completed their work on the State Budget for Fiscal Year (FY) 2011-12 and sent all appropriation bills to Governor Rick Snyder for signature. With this action, the Legislature succeeded in complying with the Governor's request that the State Budget be completed before the end of May.

Senate Bill 172, the FY 2011-12 DCH appropriation provides $14.1 billion Gross / $2.4 billion in General Fund / General Purpose (GF/GP) funding, a change of $117.2 million Gross / $349.7 million GF/GP from the current year-to-date DCH appropriation. The bill

also includes boilerplate language (Section 1901) specifying the allocation of an additional $53.0 million Gross / $22.1 million GF/GP for several one-time efforts.

A summary of major decisions affecting the Medicaid program includes:

- **Medicaid Caseload Consensus:** The DCH appropriation updates base Medicaid funding over the levels provided in the Executive and Legislative proposals to account for assumed changes in Medicaid caseload, utilization and inflation for FY 2011-12. This estimate was reached through the May Medicaid caseload consensus process by the Office of State Budget, House Fiscal Agency and Senate Fiscal Agency ($219.0 million Gross / $55.0 million GF/GP).
- **Actuarial Soundness Adjustment:** The Executive, House and Senate proposals initially assumed that an adjustment in rates paid to Medicaid HMOs and Prepaid Inpatient Health Plans (PIHPs) to meet federal actuarial soundness requirements was not necessary. The appropriation assumes a 1.7 percent ($50.1 million Gross / $17.0 million GF/GP) increase in Medicaid managed care rates and a 1.2 percent ($24.9 million Gross / $8.4 million) increase in PIHP rates.
- **Graduate Medical Education:** The DCH appropriation assumes an 8.7 percent reduction in Medicaid Graduate Medical Education (GME) payments. This is not as significant a reduction as originally proposed by the Executive and House proposals (both assumed a 40 percent cut) and the Senate proposal (for full elimination). The net change in GME funding from FY 2010-11 is -$14.7 million Gross / -$5.0 million GF/GP. However a portion of GME funding ($17.1 million Gross) is included as a one-time funding provision.
- **Managed Care Expansion:** The appropriation assumes savings through the implementation of mandatory managed care for Medicaid beneficiaries also enrolled in the Children's Special Health Care Services (CSHCS) program (-$11.0 million Gross) and implementation of managed care for Medicaid beneficiaries dually eligible for Medicare (-$29.6 million Gross / -$10.0 million GF/GP).
- **Assumed Policy Savings:** The appropriation assumes GF/GP savings associated with efforts to increase third party liability recoveries from auto insurers (-$22.0 million Gross / -$7.5 million GF/GP), enhanced Medicaid estate recovery efforts (-$16.6 million Gross / -$5.6 million GF/GP) and including behavioral health drugs on the Medicaid Preferred Drug List (-$18.7 million Gross / -$6.3 million GF/GP).
- **Claims Tax:** Language in the DCH appropriation concurs with an Executive proposal to eliminate assessment of the Michigan Use Tax on Medicaid HMOs and PIHPs and replace the Use Tax with a 1.0 percent tax on all paid health claims in the state. We believe the net effect of this change is positive for Medicaid HMOs but negative for commercial and Medicare HMOs in the state.

OTHER HEADLINES

Arizona

- **Arizona Medicaid fees loom for smokers, obese**

  The governor of Arizona has proposed a novel way of helping to pay burgeoning Medicaid costs -- imposing a fee on smokers, diabetics and obese people who receive the state aid. The proposal would include an annual fee of $50 on childless adults who smoke. Medicaid recipients who are obese or diabetic would face similar penalties if they don't get into shape. (CNN)

Colorado

- **Colo. gov vetoes fees on kids' health care program**

  Gov. John Hickenlooper cited concerns that children would lose coverage as he announced a veto Tuesday of a bill requiring some Colorado families to contribute more to a health insurance plan for low-income children. The legislation would have increased costs for some families by 1,000 percent through a monthly premium based on family income, forcing as many as 2,500 children to drop out. (Beaumont Enterprise)

Iowa

- **Iowa Senate approves mental health reform bill**

  The Iowa Senate approved a bill Thursday that establishes a framework for reform of Iowa's mental health system, although differences must still be resolved with House members. Senate File 525 was approved on a 36-9 vote. It calls for a plan to be developed in the coming months to redesign Iowa's mental health system, which costs $1.3 billion annually to operate. The Iowa Legislature would be asked to take action on the proposals during its 2012 session, with the new system implemented by July 1, 2013. (Des Moines Register)NM

Louisiana

- **RFP update:**

  Procurement resources, including letters of intent and conference attendee lists, for the Coordinated Care Network Shared Savings and Prepaid RFPs have been updated. (CCN Shared Savings RFP). (CCN Prepaid RFP).

- **House approves $25 billion budget with new health-care cuts**

  The Louisiana House approved a $25 billion budget blueprint late Thursday after a series of closed-door meetings helped resolve a stalemate over the use of one-time money to pay for recurring government expenses. The 93-4 vote came after lawmakers agreed unanimously, and with no debate, to cut next year's health-care budget by $81 million. While the cuts would be directed at a new managed-care program for Medicaid recipients, members of Gov. Bobby Jindal's administration said it would lead to lower payments to hospitals, nursing homes and other health-care providers that treat the poor and elderly. (NOLA.com)

Massachusetts

- **Stark hospital fee disparities found**

  A new report from Governor Deval Patrick's administration confirms previous findings that hospitals are paid widely varying amounts for providing similar care. But it also shows that some are paid a lot more even for common procedures that many hospitals do well. The administration also found that those more expensive hospitals treat a high percentage of patients, creating a double hit on insurers and on employers and employees who pay the premiums. The governor recently proposed legislation that would allow the insurance commissioner to scrutinize contracts setting the amounts insurers pay hospitals and doctors and reject health insurance premium increases based on excessive fees for providers. The administration has scheduled four days of hearings starting June 27 on how to control health care costs. Legislators held their own hearing this month and are grappling with whether to support the governor's bill, a process they have warned could take months. (Boston Globe)

New Mexico

- **NM paying contractor nearly $2M to redesign Medicaid**

  Gov. Susana Martinez's administration will pay a contractor $1.7 million to revamp the Medicaid program, which provides health care to more than a fourth of New Mexico's population. The department said it's using federal money to pay Washington, D.C.-based consulting firm Alicia Smith & Associates for 12-18 months of work. (The Republic)

New York

- **N.Y. slow to set up health exchange**

  The legislature and Gov. Cuomo's office are reportedly in negotiations on a bill authorizing a health insurance exchange, and had hoped to complete the process by the end of May. If an authorization bill doesn't pass by the end of the legislative session, which is over in mid-June, the state runs the risk of losing out on millions in establishment grants. (Politico)

- **Website will track Medicaid costs**

  Gov. Andrew Cuomo is using the Internet to hold the feet of Medicaid providers to the fiscal fire. One of the hallmarks of this year's budget was the governor's plan to greatly reduce Medicaid spending through the work of a redesign team that included representatives of the state's health care industry, labor leaders, advocates and lawmakers. They were ultimately assigned to find $2.3 billion in Medicaid savings and limit the state share of the program to $15.1 billion. If the redesign team's recommendations don't work, Cuomo's Health Commissioner Nirav Shah can make many of the cuts himself. (Times Union)

North Carolina

- **Insulin for diabetics, other 'optional' Medicaid services may be trimmed in NC to save money**

North Carolina's Medicaid program, second only to public schools in state spending, could be offering fewer services to save money before a wave of new consumers that is expected to enroll soon because of the federal health care overhaul. Republicans in charge of the General Assembly are considering eliminating several medical services the federal government doesn't require the state to cover for adults through Medicaid, the government's health insurance program for low-income families, people with disabilities and poor elderly residents. It's part of a method to cut state spending in the agency that operates Medicaid by more than $350 million for the year starting July 1 and $400 million the following year, to about $2.9 billion annually. (The Republic)

Ohio

- **Seniors fear Medicaid cuts are passport to a nursing home**

  On May 5, the Ohio House passed a $112 billion two-year state budget bill that the governor's office says would cut federal and state Medicaid spending on PASSPORT and a similar but smaller program known as Choices by 1 percent from $518.7 million this year to $513.7 million for the fiscal year starting July 1. The cuts to the PASSPORT program have seniors and advocates concerned about higher rates of nursing facility institutionalization in coming years. (Canton Rep)

Texas

- **Perry orders special session for school finance plan, Medicaid costs**

  Texas lawmakers return in a special session Monday at the behest of Gov. Rick Perry to deal with a school finance plan blocked by Democrats, Medicaid cost savings and any other issues the GOP governor decides to add to the agenda. Rep. Garnet Coleman, D-Houston, and others said they would pressure their colleagues to use more money from the rainy day fund, estimated to have about $6.5 billion in uncommitted funds. However, some legislators countered that is needed as a backstop to accounting maneuvers including a decision not to fund $4.8 billion in Medicaid caseload costs - a bill that will come due in 2013. (Houston Chronicle)

- **Managed Care Update:**

  Bravo Health completed its readiness review and began enrolling beneficiaries into its STAR+PLUS plan in Tarrant County. As of May 1, the company covered 691 out of the 29,439 beneficiaries in the county. Over the next few months, we expect membership to increase at Bravo Health and decline at AMERIGROUP, the other STAR+PLUS plan in Tarrant County.

Vermont

- **Vermont: Governor Signs Health Care Law**

  Gov. Peter Shumlin signed a bill last Thursday that sets Vermont on a path to creating the nation's first publicly financed health care system. The law calls for something close to a single-payer system, with doctors and hospitals billing one entity, the state government, for their services. All 620,000 of the state's residents would be eligible for coverage under the system, which proponents say would be cheaper than the current patchwork of insurers. A board appointed by the governor will determine payment rates for doctors, benefits and other details. (Kaiser Health News)

United States

- **Administration Opposes Challenges to Medicaid Cuts**

  Medicaid recipients and health care providers cannot sue state officials to challenge cuts in Medicaid payments, even if such cuts compromise access to health care for poor people, the Obama administration has told the Supreme Court. States around the country, faced with severe budget problems, have been reducing Medicaid rates for doctors, dentists, hospitals, pharmacies, nursing homes and other providers. Federal law says Medicaid rates must be "sufficient to enlist enough providers" so that Medicaid recipients have access to care to the same extent as the general population in an area. (New York Times)

- **Managed care explained: Why a Medicaid innovation is spreading**

  At least a dozen other states are considering expanding managed care programs this year. That growth comes atop expansions in 20 states last year and 13 states the year before. Although most health care experts say managed care can improve care while lowering Medicaid costs, consumer advocates say states should proceed with caution. This Stateline article provides a primer on how Medicaid managed care works and why so many states are turning to it now. (Stateline)

PRIVATE COMPANY NEWS

- **R.I. judge clears sale of hospital to Steward**

  A judge in Rhode Island ruled yesterday that Steward Health Care Systems LLC of Boston can move forward with negotiating a takeover of financially troubled Landmark Medical Center in Woonsocket, which has been in court-appointed receivership for the past three years. (Boston Globe)

- **CGI triage of Pennsylvania Medicaid system saves millions**

  CGI will continue to provide Medicaid payments oversight for the Commonwealth of Pennsylvania under a six-year contract renewal worth almost $45 million. The award from the Pennsylvania Department of Public Welfare calls for CGI to help prevent, detect, deter and correct provider improper payments within its Medicaid Medical Assistance program, according to a May 31 company statement. (Washington Technology)

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. This week we added the timeline for the Massachusetts behavioral health RFP.

Date	State	Event	Beneficiaries
June 1, 2011	California ABD	Implementation	380,000
June 2, 2011	Massachusetts Behavioral	Vendor conference	386,000
June 24, 2011	Louisiana	Proposals due	892,000
June 24, 2011	Kentucky RBM	Contract awards	N/A
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey	Implementation	200,000
June 24, 2011	Kentucky RBM	Implementation	N/A
July 15, 2011	Washington	RFP Released	880,000
July 19, 2011	Massachusetts Behavioral	Proposals due	386,000
July 25, 2011	Louisiana	Contract awards	892,000
August 3, 2011	Washington	Bidder's conference	880,000
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
October 1, 2011	Arizona LTC	Implementation	25,000
July 19, 2011	Massachusetts Behavioral	Contract awards	386,000
October 17, 2011	Washington	Proposals due	880,000
December 19, 2011	Washington	Proposals due	880,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 1, 2012	New York LTC	Implementation	120,000
March 1, 2012	Texas	Implementation	3,200,000
July 19, 2011	Massachusetts Behavioral	Implementation	386,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
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
January 1, 2015	Florida	DD RFP released	2,800,000
October 1, 2016	Florida	DD enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

States in Action: States' Role in Promoting Meaningful Use of Electronic Health Records

The Commonwealth Fund

Principal Renee Bostick provided the following update to The Commonwealth Fund's April/May 2011 newsletter, *States in Action:*

This issue of States in Action discusses the responsibilities, opportunities, and challenges for state Medicaid agencies in implementing programs to encourage providers to adopt electronic health records (EHRs). It focuses on the Medicaid Electronic Health Record In-

centive Program, established by the Health Information Technology for Economic and Clinical Health (HITECH) Act in the American Recovery and Reinvestment Act of 2009 and jointly administered by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies. Rather than formal Snapshots of particular states' efforts, the issue includes lessons from states' early experiences in implementing the Medicaid EHR Incentive Program.

The EHR Incentive Program is just one of many health information technology (HIT) initiatives supported and encouraged by the federal government. With state Medicaid agencies facing competing demands as well as limited resources, states can benefit from aligning their efforts to promote health information technology, and collaborating with other agencies, states, and stakeholders to share or reduce costs, limit duplication, and avoid confusion for providers. (Link to Brief)

HMA Speaking Engagements

The National Council Live Webinars series: *Medicaid Health Home State Plan Option*

Alicia D. Smith, Senior Consultant

June 7, 2011, 2:00 - 3:30pm eastern

AcademyHealth's Annual Research Meeting 2011*: Topics in System and Payment Reform*

Dr. Jennifer Edwards, Principal

June 12-14, 2011

Seattle, Washington

National Hispanic Caucus of State Legislators – 'Promoting Healthy Lifestyles' conference: *Topic: Health Care Reform Financing at the State Level*

Juan Montanez, Principal

June 17, 2011

Miami, Florida