HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: TENNESSEE'S DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: FLORIDA HOSPITALS AVERT ANOTHER RATE CUT; ILLINOIS SEEKS OPTIONS FOR ITS COORDINATE CARE PLAN; GOVERNOR BROWN VETOES CALIFORNIA BUDGET PROPOSAL

OTHER HEADLINES: LEGISLATURE PUSHES OVERSIGHT BILL ON LOUISIANA CCN; NEW JERSEY GOV. CHRISTIE PROPOSES MCO EXPANSION IN $540M SAVINGS PLAN; UTAH STATEWIDE HEALTH INFORMATION EXCHANGE LAUNCHES; BUDGET BILL GRANTS MEDICAID REDESIGN POWER TO WISCONSIN'S GOV. WALKER; MORE STATES ADD MEDICAID EHR MEANINGFUL USE INCENTIVES; CHANGES TO MEDICAID, MEDICARE PART OF FEDERAL DEBT TALKS; STUDY SHOWS CHILDREN ON MEDICAID FORCED TO WAIT FOR CARE

PRIVATE CO. NEWS: VANGUARD IPO RAISES $450M, 22% LESS THAN EXPECTED

MEDICAID MANAGED CARE RFP CALENDAR UPDATED

JUNE 22, 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

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA
LANSING, MICHIGAN • NEW YORK, NEW YORK • SACRAMENTO, CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Health Management Associates (HMA) is an independent health care research and consulting firm. HMA operates a client service team, HMA Investment Services, that is principally focused on providing generalized information, analysis, and business consultation services to investment professionals. Neither HMA nor HMA Investment Services is a registered broker-dealer or investment adviser firm. HMA and HMA Investment Services do not provide advice as to the value of securities or the advisability of investing in, purchasing or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of, and not influenced by, the interests of other clients, including clients of HMA Investment Services.

IN FOCUS: TENNESSEE'S DUAL ELIGIBLE INTEGRATION PROPOSAL

Yesterday, Melanie Bella, Director of the Medicare-Medicaid Coordination Office, provided testimony to the U.S. House Committee on Energy and Commerce regarding opportunities to improve care coordination for individuals eligible for both Medicare and Medicaid ("dual eligibles"). As a reminder, in April the federal Center for Medicare and Medicaid Innovation (CMMI), a division of the Centers for Medicare and Medicaid Services (CMS), announced that 15 states would be eligible for $1 million grants to support the design of integrated care models for dual eligibles. The states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, North Carolina, New York, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin. Last month, CMS posted summaries of all 15 proposals on its website.[1] In our March 30th Weekly Roundup, we reviewed California's proposal in depth and compared it with Michigan's proposal. We found substantial differences in the methods proposed which is consistent with the agency's goal of testing multiple approaches. In the discussion that follows, we evaluate the proposal submitted by Tennessee, a state that has already established a managed care delivery system for long term care benefits which could be at the center of a fully integrated model.

The development of integrated financing models for dual eligible is a significant issue given the large amount of Medicare and Medicaid spending attributable to this population. Specifically, total annual spending in both programs for this population is estimated at $300 billion annually and comprises 39 percent of all Medicaid expenditures and 27 percent of all Medicare expenditures, while dual eligible enrollment accounts for 15 percent and 16 percent respectively, of Medicaid and Medicare enrollment.[2] Thought of another way, of the approximately 95 million people enrolled in Medicare and/or Medicaid, the federal and state governments are paying an average of $33,000 per year for the 9 million dual eligibles and less than $9,000 per year for the other 86 million beneficiaries. In light of that disparity, the federal government is committing significant resources to identifying more efficient delivery models for this population.

CMMI has identified dual eligible demonstration programs as an opportunity to test innovative service delivery and payment models including risk-based managed care and accountable care organizations (ACOs). Rates of enrollment in managed care plans are significantly lower in the dual eligible population than in the general Medicaid and Medicare populations, with over 90 percent of spending on dual eligibles paid on a fee-for-services (FFS) basis. As such, we view the dual eligible integration grants as a first step toward the creation of an important market opportunity for managed care organizations equipped to deliver both acute and long term care services and supports to this high-cost

[1] Summaries available at: https://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp#TopOfPage

[2] Testimony of Melanie Bella, Director of the Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services to the U.S. House Committee on Energy and Commerce, Subcommittee on Health, June 21, 2011, available at http://energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=8707.

population. Below, we compile enrollment estimates, where available, from the 15 grantee states. We then highlight Tennessee's dual-eligible proposal. We believe Tennessee's existing managed care structure, including care coordination and managed long term care, positions the state to take a leadership role in developing a successful integrated model.

Enrollment Estimates

Each of the 15 states that received design grants provided a description of its initial proposal to CMS, from which we have summarized estimated enrollment data in the table below. States were asked to provide estimated 2012 enrollment and estimated "full implementation" enrollment. Where enrollment figures were provided, we have estimated annualized spending based on an average cost per dual-eligible of approximately $35,000 per year in order to quantify the potential size of the demonstration programs.

	2012		Full Implementation	
State	Enrollment	Estimated $ (M)	Enrollment	Estimated $ (M)
California	151,000	$ 5,285	1,100,000	$ 38,500
Colorado	30,000	$ 1,050	30,000	$ 1,050
Connecticut	20,000	$ 700	120,000	$ 4,200
Massachusetts	TBD	TBD	TBD	TBD
Michigan	220,050	$ 7,702	220,050	$ 7,702
Minnesota	50,000	$ 1,750	107,000	$ 3,745
North Carolina	284,000	$ 9,940	284,000	$ 9,940
New York	TBD	TBD	709,430	$ 24,830
Oklahoma	2,200	$ 77	TBD	TBD
Oregon	59,000	$ 2,065	59,000	$ 2,065
South Carolina	TBD	TBD	TBD	TBD
Tennessee	137,000	$ 4,795	137,000	$ 4,795
Vermont	21,379	$ 748	21,379	$ 748
Washington	25,000	$ 875	101,000	$ 3,535
Wisconsin	20,000	$ 700	53,000	$ 1,855
Total	**1,019,629**	**$ 35,687**	**2,941,859**	**$ 102,965**

*Assumes average cost per dual-eligible of $35,000 per year

Using the initial enrollment projection, if all states were to implement their dual-eligible integration projects, upwards of 1 million dual-eligible lives would be under a care-coordination system that integrates Medicaid and Medicare services. We estimate the total spending associated with this population at almost $36 billion. At full implementation, the number of dual-eligible lives under a care-coordination system that integrates Medicaid and Medicare services could near 3 million. We estimated total spending associated with a fully implemented population of nearly $103 billion.

Tennessee Proposal – TennCare PLUS

TennCare currently provides care to 136,672 dual-eligible enrollees. TennCare currently spends roughly $1.6 billion annually on dual-eligible Medicaid benefits. Based on our estimates above, annual spending could near $4.8 billion in combined Medicaid and Medicare benefits, paid through TennCare PLUS MCO plans.

Integration Structure

Tennessee proposes to integrate care for dual eligibles in the state through the development of the TennCare PLUS program. The state currently enrolls roughly 137,000 full benefit dual eligibles (FBDEs) in TennCare managed care organizations. Under TennCare PLUS, eligible enrollees would receive all Medicare Part A and Part B services through their TennCare PLUS MCO plan (Part D benefits would remain outside of the TennCare Plus payment structure). Additionally, the program will include care coordination for enrollees not already receiving care coordination services under the CHOICES program, the state's Medicaid managed long-term care program. Finally, dual eligibles with certain health conditions will be eligible to participate in disease management programs through TennCare.

Program Readiness

As a strong managed care state, all dual-eligibles are currently receiving care under a TennCare MCO, and have recently been offered two new integrated care programs under their comprehensive benefit package, behavioral health services and long-term care services for elderly and disabled enrollees. The TennCare PLUS program seeks to fold the Medicare benefit into the existing managed care infrastructure, eliminating the confusion and frustration to enrollees created by a division of services.

There are currently three managed care organizations serving the TennCare program, UnitedHealth (46% market share), Blue Cross Blue Shield of Tennessee (38% market share) and Amerigroup (17% market share). There is one dual eligible Special Needs Plan in the state (Windsor Health Plan) that covers under 3,000 members. It is unclear whether these enrollees will be reassigned under the new program.

Financing Structure

Under TennCare PLUS, Medicare funding will be calculated based on what Medicare currently spends on services to dual-eligibles in Tennessee. These funds will be added to the current TennCare capitation payments to MCOs for a combined Medicaid and Medicare benefit package. Tennessee intends to use $500,000 of the CMMI grant award to contract for rate-setting services that combine Medicare and Medicaid funding.

Covered Benefits

TennCare PLUS will provide all Medicare and Medicaid covered benefits, as well as care coordination and disease management. If funding is available, the program may provide payment of Medicare cost-sharing as well as coverage of some Home and Community Based Services (HCBS) not currently provided under the CHOICES managed long-term care program. Enrollees meeting the a nursing facility level-of-care need may also qualify for HCBS delivered through the CHOICES program, provided there is room in the HCBS enrollment cap.

Timeline

The state has provided the following timeline with dates based on award notification. Below, we assume a timeline based on award notification of April 2011.

Date	Major Activities
May 2011	Stakeholder Meetings
	Contract with actuary, Medicare payment expert
July 2011	Develop internal/external stakeholder plan
	Identify relevant waivers
October 2011	Complete description of benefit package
	Progress report to CMMI
January 2012	Determine Medicaid and Medicare funding methodology
	Discuss proposal with Medicaid Medical Care Advisory Committee
March 2012	Submit waiver proposal to TennCare Oversight Committee, Legislature
	Public notice of waiver proposal
April 2012	Submit demonstration proposal to CMMI
	Submit proposed amendment to TennCare to CMS

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

Governor Brown, in a move that surprised many, vetoed the budget bill passed last week, due to too many accounting gimmicks and not enough real state savings or revenue solutions. If the legislature does not vote to continue existing taxes, they will expire July 1. As a result, the tax extension ballot initiative will essentially become a vote on a new tax, which many expect will be harder to pass.

The proposal to transition Healthy Families to Medi-Cal appears to have died, due to oppositions from health plans regarding the extension of the Medi-Cal premium tax, currently used to fund Health Families.

Nursing homes cut a deal with the state that in order to get the provider tax extended, they would accept a 10 percent cut in effect for FY 2011, but would be paid back in September 2012. The 10 percent cut equates to roughly $300-$400 million.

In other news

- **County acts to add more families to Medicaid coverage**

  The county Board of Supervisors Tuesday approved a plan to restructure agreements with its community clinics that allows the county to sign up more low-income residents for Medicaid coverage. Federal health care reform will not take effect until 2014, but under an agreement — known as the California 1115 Medicaid waiver — low-income residents not previously eligible for coverage can be enrolled as early as July 1

in this state. The county hopes to attract more Medicaid-insured patients to help pay for its network of public-private community medical clinics. (LA Independent)

Florida

HMA Roundup – Gary Crayton

Due to a shortfall in Intergovernmental Transfer (IGT) funds, which make up a large part of hospital funding in the state, the Agency for Healthcare Administration (AHCA) gave hospitals less than a week to come up with $45 million or the state would reduce Medicaid rates. The total cut for the six-month period would have meant roughly $130 million to the hospitals in combined fee for service funds. In addition, since many HMOs use fee-for-service rates in setting their rates with hospitals, there would have been another $70 million in reduced rates to hospitals from the HMOs resulting in a roughly $200 million hit to hospitals (roughly 8%). This would have been in addition to the 12% cut planned for FY 2012. The legislature stepped in this week and averted the potential cut, taking the rate roll-back off the agenda for upcoming budget hearings.

In other news

- **FL Lawmakers Block Medicaid Bill That Would Have Cut $123M From Hospitals**

  Florida lawmakers have blocked a bill that would have cut $123 million in Medicaid funding from state hospitals starting July 1, according to a News-Press report. Florida hospitals were required to come up with $45 million to make up for a shortfall in intergovernmental transfers, essentially local funding from hospital taxing districts, among other places. If hospitals failed to come up with the funding by May 31, they would lose $78 million in federal matching funds for Medicaid, bringing the total amount of cuts to $123 million. Still, Florida hospitals face a 12 percent cut in Medicaid payments in the coming year. The measure was passed in the previous legislative session. (Becker's Hospital Review)

- **AHCA Wants More Time on Medicaid Pilot**

  With a June 30 deadline looming, discussions about continuing Florida's Medicaid pilot program appear headed to overtime. The Agency for Health Care Administration sent a letter to the federal government Monday seeking a 30-day extension of the pilot, as state and federal officials try to reach agreement on continuing the program for three more years. The controversial pilot, which requires most Medicaid beneficiaries in five counties to enroll in managed-care plans, is scheduled to expire June 30. The pilot started in 2006. CMS made clear in a letter to state Medicaid officials last August that it wanted changes in the pilot. (Sunshine State News)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Last Thursday, the Medicaid Advisory Committee met and heard from the subcommittee on improvements to the state's Primary Care Case Management (PCCM) Medicaid managed care program. The process of improving the PCCM model will be impacted significantly by both the hospital payment reform process underway and the requirement that

by January 1, 2015, 50 percent of Illinois Medicaid enrollees must be in coordinated care. In a document released last week entitled "The Coordinated Care Program, Key Policy Issues" the state poses a number of questions to stakeholders regarding potential options for complying with the 50% requirement. The brief suggests that the state is open to evaluating options other than risk based managed care that would enable it to meet the requirement.

The budget bill has still not been signed by Governor Quinn as the legislature prepares to return for a special session. In special session, the legislature no longer holds the ability to pass legislation by a simple majority.

Michigan

HMA Roundup – Esther Reagan

The budget bill (HB 4526) was presented to Governor Snyder on June 7, 2011. He had a 14 day window to sign it, finally doing so yesterday, June 21, the last day of the window.

The Claims Tax bill (SB 248) was introduced and was immediately referred to the Senate Committee on Appropriations. It has not had any public action yet. Since there was an assumption of its passage when the Senate and House approved the budget for the Department of Community Health (DCH), failure to pass it would create a significant hole of more than $100 million in the DCH budget. The expectation remains that the bill will pass and that discussions are going on behind closed doors. As a reminder, the state is considering a 1% tax on all health related claims to replace an expiring 6% use tax on Medicaid MCOs.

In the news

- **Study: State Medicaid users face uphill battle**

  Michigan's Medicaid recipients have a harder time than Michiganians with health coverage in accessing preferred doctors and were more likely to delay getting needed treatment than others with health coverage, according to a study released this week. Forty-two percent of Medicaid recipients surveyed said their primary care provider didn't accept their coverage, and 12 percent of Medicaid recipients said their usual source of care was the emergency room, a high cost setting for care. The study also found just 35 percent of the uninsured sought care in a doctor's office vs. 86 percent of those with insurance, and a higher percentage of uninsured used emergency departments and urgent care offices as regular sources of health care compared to those with insurance. (Detroit News)

OTHER HEADLINES

Louisiana

- **Senate passes bill to add legislative oversight on Medicaid reform**

  A bill that would add new layers of legislative oversight to a Medicaid privatization plan was sent to Gov. Bobby Jindal's desk Tuesday after the Louisiana Senate gave its

final approval. But the governor refused to say whether he will sign Senate Bill 207 by Sen. Willie Mount, D-Lake Charles, which requires the state Department of Health and Hospitals to provide detailed annual reports about the new "coordinated care networks" that are scheduled to launch early next year. (NOLA.com)

Massachusetts

- **Fallon Clinic, Atrius accept extra scrutiny to merge**

Fallon Clinic and Atrius Health, two of the state's largest doctor groups, said yesterday that they will join forces, creating a huge doctor-run medical practice that will serve nearly a million Massachusetts patients but also be subject to a new level of oversight by the state. The two medical providers agreed to give Attorney General Martha Coakley the power to review the group's contracts with health insurers and even put pressure on Atrius if its prices jump significantly as a result of the merger. Coakley said she is concerned that the Atrius Health network, which includes Harvard Vanguard Medical Associates and South Shore Medical Center, could use its size to secure higher payments from insurers. (Boston Globe)

New Jersey

- **Christie proposes to slash Medicaid in New Jersey**

New Jersey Republican Governor Chris Christie wants to cut $540 million from the state's Medicaid program by moving more people into managed care and restricting coverage of adults. Under his proposal, released last week, a parent of two children with an income exceeding $5,300 a year would be denied participation, a drastic reduction from the current income ceiling of $24,600. Children in these families would still be covered. To make the changes, Christie would need a waiver from the federal government, because the federal Affordable Care Act generally prohibits states from cutting Medicaid enrollment before 2014, when the program is scheduled for expansion to some 16 million more people. (Stateline)

New Mexico

- **State orders behavioral health firm to pay claims of $1 million**

State officials have ruled that the managed-care company that oversees New Mexico's behavioral-health system won't have to pay all $1.6 million in claims that it flagged earlier this year — at least for now. In a June 10 letter addressed to OptumHealth New Mexico, Human Services Secretary Sidonie Squier and Department of Health Secretary Catherine Torres ordered the firm to pay roughly $1 million in claims that were flagged and submit the other $600,000 by July 1 to a third party that will determine if the services were flagged inappropriately. The ruling showcases New Mexico's oversight role as it scrutinizes a managed-care company it brought in to administer vast amounts of the state's Medicaid dollars in the hopes of saving money. (Santa Fe New Mexican)

Rhode Island

- **Hospitals, health, human services prep for R.I. budget cuts**

Hospital managers, nursing home workers, and human services advocates are bracing themselves for deep cuts to their state funding in the House Finance Committee budget

that is expected to be released on Friday after weeks of closed-door negotiations. On Thursday, they said lawmakers still have not ruled out some of the $60 million in cuts proposed by Governor Chafee to the state's human service programs, which represent nearly $1.3 billion, or about 40 percent, of the state's general revenue budget and include the state's Medicaid program. Chafee's plan would result in about $6.1 million in state savings but lead to the loss of another $6.8 million in federal matching funds, says Quinn. (Providence Journal)

Utah

- **Utah rolls out first statewide health information exchange, seeking patient consent**

  Doctors from all four major hospital networks in the state of Utah stood together Thursday in a show of support for better patient care. They announced a statewide implementation of shared medical information — a first anywhere west of the Rocky Mountains — through the new Clinical Health Information Exchange (cHIE). Physicians from Intermountain Healthcare, MountainStar, IASIS and the University of Utah Health Care systems are already collecting waivers from patients across the state, and when enough have signed up to participate, the sharing of information will begin. (Deseret News)

Wisconsin

- **Budget bill gives Walker more power over Medicaid programs**

  The new state budget bill grants broader power to Gov. Scott Walker's administration to remake BadgerCare Plus and other state health programs with little legislative oversight, a situation that worries advocates for the roughly 1 million people covered by those programs. The major question: how the governor's Department of Health Services will use that authority as it cuts a projected $466 million in costs from the programs over the next two years. The pending cuts work out to about 3% of the $14 billion in state and federal dollars allocated for the programs over the biennium. (Journal Sentinel)

United States

- **No Rush On Duals**

  It's most likely going to take another 10 months before the 15 states who were awarded $1 million grants come up with a game plan to coordinate care for their "dual eligible" populations, according to Melanie Bella, who oversees the new CMS office for duals. Republican members of the House Energy and Commerce health subpanel pressed for details on what kind of savings can be expected from the states' better coordination of the expensive duals, but Bella said it's too early to tell, stressing that states must have considerable flexibility to design their programs. (Politico Pulse - June 22)

- **AP Exclusive: Medicaid for the middle class?**

  The Affordable Care Act would let several million middle-class people get nearly free insurance meant for the poor, a twist government number crunchers say they discovered only after the complex bill was signed. The change would affect early retirees: A married couple could have an annual income of about $64,000 and still get Medicaid, said officials who make long-range cost estimates for the Health and Human Services

department. After initially downplaying any concern, the Obama administration said late Tuesday it would look for a fix. (Yahoo.com News)

- **Two More States Start Medicaid EHR Meaningful Use**

  Fourteen out of the first 15 states live on the program have issued meaningful use incentive payments, double the number in early May. Most states plan to roll out their Medicaid MU programs during 2011; some are likely to not be ready until early 2012. In addition to Pennsylvania and Washington, other states that have their meaningful use programs in operation include Alabama, Alaska, Indiana, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas. (Health Data Management)

- **Changes to Medicare, Medicaid to be discussed in hearings, debt talks**

  The future of Medicare and Medicaid will be a hot topic as negotiations on the debt ceiling continue this week. At least three bipartisan meetings helmed by Vice President Biden have been scheduled, and both parties began to make concessions this past week as a possible deal appeared to emerge. After House Budget Chairman Paul Ryan (R-Wis.) said he's open to keeping traditional Medicare as an option alongside private plans in his overhaul proposal, House Democrats offered their own solutions for preserving Medicare's solvency. (The Hill)

- **Children on Medicaid Shown to Wait Longer for Care**

  Children with Medicaid are far more likely than those with private insurance to be turned away by medical specialists or be made to wait more than a month for an appointment, even for serious medical problems, a new study finds. Sixty-six percent of those who mentioned Medicaid-CHIP (Children's Health Insurance Program) were denied appointments, compared with 11 percent who said they had private insurance, according to an article being published Thursday in The New England Journal of Medicine. (New York Times)

- **States accelerate launch, payments for Medicaid EHR incentives**

  Despite lean budgets, 17 states have launched their Medicaid EHR Incentive Programs, with 11 of them already making payments, totaling $114.4 million, to qualifying physicians and hospitals. Louisiana leads the states in issuing incentives, said Jessica Kahn, technical director for health IT at the Center for Medicaid, Children's Health Insurance Program (CHIP) Survey and Certification in the Centers for Medicare and Medicaid Services. CMS funds states to administer Medicaid, the healthcare program for low income individuals. States have to guess the number of individual providers who might register for and receive the EHR incentives to budget for the payment. (Government Health IT)

PRIVATE COMPANY NEWS

- **Vanguard Health Systems Raises $450 Million in IPO, 22% Less Than Sought**

  Vanguard Health Systems Inc., the hospital operator controlled by Blackstone Group LP (BX), gained as much as 2.5 percent on its first day of stock trading after the company raised $450 million in an initial public offering. The hospital operator cut its offering to attract buyers as the Standard & Poor's 500 Index has fallen 3.7 percent this month amid concern the U.S. economic recovery is stalling. (Bloomberg)

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, proposals are due in Louisiana and in Kentucky for fee based radiology contract.

Date	State	Event	Beneficiaries
June 24, 2011	Louisiana	Proposals due	892,000
June 30, 2011	Kentucky RBM	Proposals due	N/A
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey	Implementation	200,000
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
July 30, 2011	Kentucky RBM	Contract awards	N/A
August 3, 2011	Washington	Bidder's conference	880,000
August 15, 2011	Kentucky RBM	Implementation	N/A
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
October 3, 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
March 1, 2012	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 Incentive 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)