HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID MANAGED CARE EXPANSION SCORECARD

HMA ROUNDUP: FLORIDA HOSPITAL RATE NEGOTIATIONS CONTINUE; WE EXPECT GEORGIA TO OFFSET DUPLICATE MEMBER RECOUPMENT; ILLINOIS REVEALS PLANS FOR HOSPITAL PAYMENT CYCLE DELAY

OTHER HEADLINES: CALIFORNIA TO CARVE ADULT DAY CARE INTO HMO CAPITATION RATES; AETNA, COVENTRY PROTEST LOUISIANA CONTRACT AWARDS; INDEPENDENCE BLUE CROSS AND BLUE CROSS BLUE SHIELD OF MICHIGAN PARTNER TO SUPPORT AMERIHEALTH MERCY GROWTH STRATEGY

HMA WELCOMES: MIKE NARDONE (HARRISBURG, PA), STEPHEN WEISS (WASHINGTON, D.C.)

MEDICAID MANAGED CARE RFP CALENDAR UPDATED: KENTUCKY RBM ANNOUNCEMENT DELAYED, HAWAII RFP RELEASED, NEBRASKA RE-BID TO INCLUDE RURAL COUNTIES

AUGUST 10, 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

In Focus: Medicaid Managed Care Expansion Scorecard **2**

HMA Medicaid Roundup **5**

Other Headlines **8**

Private Company News **11**

RFP Calendar **12**

HMA Welcomes… **12**

HMA Recently Published Research **13**

Upcoming HMA Appearances **14**

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: MEDICAID MANAGED CARE EXPANSION SCORECARD

With last week's earlier than anticipated announcement of the Texas Medicaid managed care contract awards, results for the large RFP opportunities we have been discussing all year are now completed. As we discuss in more detail below, we estimate that $22 billion worth of Medicaid managed care contracts have either been awarded or implemented in 2011, no doubt the most active year in this regard in the program's history. While we expect more RFPs to be released in the Fall, at this time we are not anticipating any more new business will be awarded in 2011. Accordingly, we are taking this opportunity to summarize the results of all the new business introductions that have begun this year.

Without a doubt, more Medicaid spending has shifted from fee for service or PCCM payment systems to a capitated managed care model than in any year in the program's history. As the table below illustrates, we estimate that $22 billion worth of business was in play this year, of which approximately $15 billion was transitioned to a capitated model for the first time. This figure includes some contracts that were awarded in 2010 but did not begin implementation until 2011 (Mississippi, Illinois) as well as some contracts that were awarded in 2011 but likely won't be fully implemented until 2012 (Texas, Louisiana). The $22 billion in spending represents approximately 5% of total Medicaid expenditures and compares to approximately $80 to $90 billion of annual Medicaid spending on capitated comprehensive managed care prior to this year. We note that the managed care expansions are occurring in both blue (California, Illinois) and red states, and that all eligibility categories are being captured, including aged, blind and disabled beneficiaries. Moreover, the contracts are becoming more inclusive from a benefit standpoint as well with many categories previously carved-out of managed care contracts (such as behavioral health, pharmacy and long term care services) now included in the plan's capitation rate.

Of course, this story is not yet over. Later this year, we expect RFPs to be released in Washington, Ohio, New Hampshire, Hawaii, Missouri and Nebraska. These will involve re-procurements of existing business as well as program expansions. We also expect that long term care benefits will be carved-in to the Medicaid MCOs in New York. Next year, the Florida RFP will likely garner significant attention (we estimate the overall opportunity, both re-bid and expansion spending, to be on par with this year's Texas procurement) and Georgia is scheduled to re-bid its current contracts. Of course, this doesn't even include the dual eligible opportunity we have been discussing at length which, if fully realized, has the potential to exceed the total amount of spending currently running through Medicaid managed care plans. In other words, despite the record amount activity this year, the Medicaid managed care pipeline remains full.

In the table below, we estimate the amount of Medicaid managed care business that was in play this year and the amount that went to each company. We note that the goal of the table is to identify how much business has gone out to bid or been awarded through contract extensions and who won it. It is not meant to identify how much incremental revenue each company has won because some of the contracts are re-bids of existing contracts. For example, we estimate that Amerigroup won over $2 billion worth of contracts

in Texas. Approximately half of this amount relates to business it had already had but which it was able to defend in the re-bidding process. In addition, the table is not meant to identify how much revenue each company generates in each state because not all of the business was in play this year. For example, in South Carolina, where the state expanded the services areas covered by the incumbent players, we just listed the contract values of the new business, not the total amount in the state. If you have any questions about what is included in the table, please don't hesitate to contact us.

2011 Medicaid Managed Care New Business Activity

	Arizona (MLTC)	California (SPD)	Illinois	Kentucky	Louisiana	Mississippi	South Carolina	Texas	New Jersey (MLTC)	Total	*% of Total*
Aetna	$378,734	$0	$144,647	$0	$0	$0	$0	$145,631	$0	$669,012	3.1%
Amerigroup	$0	$0	$0	$0	$302,384	$0	$0	$2,275,549	$150,000	$2,727,933	12.5%
Amerihealth	$0	$0	$0	$780,000	$302,384	$0	$0	$0	$0	$1,082,384	5.0%
Centene	$223,740	$0	$144,647	$817,849	$302,384	$180,000	$30,624	$2,147,976	$0	$3,847,220	17.6%
Coventry	$0	$0	$0	$817,849	$0	$0	$0	$0	$0	$817,849	3.7%
Health Net	$0	$483,952	$0	$0	$0	$0	$0	$0	$0	$483,952	2.2%
HealthSpring	$0	$0	$0	$0	$0	$0	$0	$260,385	$0	$260,385	1.2%
Molina	$0	$128,434	$0	$0	$0	$0	$0	$985,985	$0	$1,114,419	5.1%
United	$398,614	$0	$0	$0	$24,834	$180,000	$27,667	$810,523	$150,000	$1,591,638	7.3%
WellCare	$0	$0	$0	$817,849	$0	$0	$0	$0	$0	$817,849	3.7%
WellPoint	$0	$261,122	$0	$0	$0	$0	$0	$0	$0	$261,122	1.2%
Other/Local	$0	$1,405,340	$0	$0	$24,834	$0	$152,909	$6,284,771	$300,000	$8,167,854	37.4%
Total	**$1,001,088**	**$2,278,848**	**$289,293**	**$3,233,547**	**$956,820**	**$360,000**	**$211,200**	**$12,910,821**	**$600,000**	**$21,841,617**	

Source: Barclay's Capital and HMA estimates

Note: MLTC is managed long term care in Arizona and New Jersey. SPD is "seniors and persons with disabilities" in California.

With that, we share the following observations

- **Perhaps the most surprising element of this wave of RFP announcements has been the states' punctuality.** In years' past, it was not uncommon for contract awards to be delayed weeks past the listed announcement date. If memory serves, the last time Texas conducted an RFP, the awards were originally expected to be announced in February of 2005 but weren't actually announced until that June. In contrast, all of the contract awards this year have been announced on time or close to it (Kentucky was a few days late). While states are certainly getting more sophisticated about what they are looking for and have a more structured process for soliciting and evaluating bids, our sense is that the timeliness is more likely driven by budget demands. In most cases the decision to expand the Medicaid managed care programs was driven in part by projected savings in the current fiscal year. In order to hit those targets, the programs need to begin on time.
- **This is a bidder's market.** With all of the opportunities available to them, health plans are being more selective in which ones they choose to pursue. For example, WellPoint did not even submit a bid in either Kentucky or Louisiana, nor did Molina. Amerigroup's technical score put the company in position to win a contract in Kentucky, but the company walked away because it wasn't comfortable with the economics. Similarly, Centene walked away from a contract it won last year in Puerto Rico due to unfavorable rates.

- **Multi-state managed care organizations are taking share from local plans.** Approximately 63% of the business up for grabs this year went to multi-state plans. Arizona shut out all of the local incumbent plans that bid on the MLTC contract. Kentucky extended Passport Health Plan's contract for a year but with no assurances beyond that and Illinois, Mississippi, Louisiana and New Jersey are in the hands of multi-state, for profit plans exclusively. Only in Texas, where local plans maintain a strong incumbency advantage, and California and South Carolina, where the business did not go out to bid but was simply transitioned to existing plans, did local plans maintain or gain market share.
- **Overall, Centene has been the big winner of the 2011 RFP season.** According to our estimates, the company has garnered 17.6% of the $22 billion in business that has been introduced this year, with wins in all of the key RFP states – Illinois, Mississippi, Kentucky, Louisiana, Arizona and Texas. The company has been successful with RFPs that have been largely price-based as well as RFPs that heavily weighted to technical scores. We attribute the company's success to its experience, both in managing the population and in developing strong RFP responses, as well as its local market approach. In fact, we note that Amerigroup and Centene have combined to win 30% of the new business that has been introduced this year suggesting that experience and focus on the Medicaid population have been winning themes in this year's contract awards.
- **On the opposite side of the spectrum, Aetna's performance has been a disappointment.** Despite winning a contract in Illinois last year, the company's bids in Kentucky and Louisiana were both unsuccessful and Aetna failed to expand its market share in Texas.
- **WellCare's performance has been mixed.** Clearly, the contract win in Kentucky was a positive surprise. On the other hand, the failure to win new business in Louisiana and Texas suggests that it hasn't been able to fully separate itself from its past legal/regulatory issues. This was clearly evident in the Louisiana scoring where the company was penalized more than its competitors in the categories related to legal and regulatory issues. The question for WellCare becomes whether or not the company can win a competitive procurement that isn't heavily price-weighted, particularly with two of its largest existing markets, Florida and Georgia, going out to bid next year.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Gary Crayton

Preliminary hospital Medicaid rates released last month (July 15) are being recalculated to meet hospital inpatient and outpatient rate cuts set in the FY 2012 budget. The published rates from last month did not meet the 12.5% rate cut that was called for. The Florida Hospital Association predicts most hospitals and systems will see their rates revised downwards in revised rate-setting. As the article below indicates, HCA has quantified the impact to be $50 million over the course of the fiscal year.

In the news

- **Medicaid to favor FL HMOs**

  A little-noticed clause in the state overhaul of Medicaid could mean a bonanza for WellCare Health Plans and Blue Cross & Blue Shield of Florida. In determining which companies win contracts to enroll 1.5-million Medicaid recipients, the law says, the Agency for Health Care Administration should give preference to those based in Florida. BCBS-FL, which covers 4 million Floridians, has not contracted with Medicaid before. It announced in May that it will begin enrolling Medicaid recipients in 2012. (Health News Florida)

- **Task force to seek reform of ALF industry**

  Gov. Rick Scott's Assisted Living Workgroup, which includes 14 appointees from the industry, the state Legislature and advocacy groups, will meet Monday from 1 p.m. until 4 p.m. And beginning in the fall, a panel of state senators will begin drafting broad new legislation, including proposals to ramp up inspections of ALFs, to beef up the requirements for administrators and to increase penalties for facilities that fall short. The twin efforts followed a three-part series in The Miami Herald that showed state regulators repeatedly caught homes breaking the law — including sometimes deadly abuse and neglect of frail elders — but failed to shut down or even seriously punish the worst offenders. The newspaper found that administrators with the state Agency for Health Care Administration could have shut down 70 homes in 2008 and 2009 for such violations as abuse and neglect leading to death, but closed just seven homes. (Miami Herald)

- **HCA warns investors about the cost of Medicaid cuts**

  Hospital corporation HCA warned investors in a Friday filing that reductions in Florida's Medicaid program could cost the company $50 million over the next year. The company's latest financial report filed with the Securities and Exchange Commission also notes that Florida and Texas account for nearly two thirds of its uninsured patients. The disclosure offers an indication of the effects budget cuts to safety net programs can have on health care providers, and comes on the heels of a decision by the Florida Medical Association, which represents the state's doctors, to oppose a plan to

shift the state's Medicaid program to a managed care system, which HCA notes could also be costly to hospitals (Florida Independent)

- **Florida doctors organization opposes Medicaid overhaul**

  Florida Medical Association officials voted in a closed door session last weekend to take a position in opposition to the state's proposed Medicaid overhaul. A number of doctors have been opposed to the shift of most Medicaid patients into managed care, but few would say so publicly. Health News Florida reported that FMA leaders passed a resolution Sunday to discourage the federal Centers for Medicare & Medicaid Services from approving the waiver that would allow for revamping the system. The FMA's new president, Dr. Miguel Machado, said the group would send a letter to CMS making its opposition known. (Miami Herald)

- **Need is great for dentists to serve Medicaid patients locally**

  As Florida and Alachua County continue to struggle with providing dental health care to their poorest residents, a new survey shows the overwhelming reason children and adults on Medicaid don't have a regular dentist: Out of 102 people surveyed, more than 40 said they simply can't afford it, while nearly 40 percent said they can't find a dentist who accepts Medicaid. (The Gainesville Sun)

Georgia

HMA Roundup – Mark Trail

According to a recent article in the Atlanta Business Chronicle (link below), the state has collected over $100 million from Medicaid managed care organizations for duplicative payments going back to 2006. Of this total, Amerigroup has quantified its liability at $13.8 million with the rest split between the other plans in the state, Centene and WellCare. We note that after collecting the payments, the state is working with the plans to quantify the impact that the recoupment for duplicate members will have on Medicaid health plans' rates. We expect that the state will make an upward adjustment to plans rates to reflect higher PMPM spending, partially offsetting the impact of the recoupment.

In the news

- **State overpaid $100 million for Medicaid**

  Georgia paid $105 million to $110 million in overpayments to three insurers — Amerigroup Corp, WellCare and Peach State Health Plan. The companies provide health insurance to about 1.1 million Georgia Medicaid beneficiaries. In return, the state pays a monthly fee for each member. The state's Department of Community Health (DCH) discovered the overpayments, which have since been recovered, after a review revealed Medicaid membership record problems, dating back to 2006. (BizJournals.com)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The state has revealed plans for handling the delayed hospital payment cycle. As we have reported previously, the state opted to defer payments to hospitals rather than implement rate cuts. The Illinois Hospital Association summarized the key points in the payment cycle plan:

- The state is accelerating Hospital Assessment Program payments to all hospitals, making 12 months of payments in the first six months of this fiscal year.
- For non-expedited hospitals, payments based on claims will be held for the first 160 days of the state fiscal year.
- In August, expedited hospitals will receive 1 or 2 payments based on their claims (as opposed to supplemental payments).
- Beginning in September, expedited hospitals will be paid for their claims on a weekly basis, based on the day parameters set by HFS and communicated to those hospitals.
- Expedited hospitals that receive 40% or more revenues from medical assistance will receive one month of supplemental payments during August and monthly thereafter.
- For all other expedited and non-expedited hospitals, the long-term plan is to pay supplemental payments monthly; however the date when this will begin is undetermined at this time.

There has been additional discussion from the state on the role of hospital payment reform within the context of state Medicaid reform. The state has reiterated that hospital rate reform must be accomplished to allow for large-scale risk and managed care coordination.

In the news

- **Gov. Quinn ready to set charity-care standards for non-profit hospitals**

  The Quinn administration is poised to decide as soon as this month how much free care hospitals must provide to remain non-profit, a move likely to intensify a fierce debate over the role of charity in a multibillion-dollar industry. At risk are property-tax exemptions worth millions of dollars a year for nine local health care providers, including prominent institutions such as Northwestern Memorial HealthCare, which spent 2.8% of its 2010 revenue on free care, and Children's Memorial Hospital, which spent just 0.2% on charity. More than 30 health care providers statewide have been waiting for rulings since March 2010, when the Illinois Supreme Court upheld a state Department of Revenue decision stripping tax-exempt status from a Downstate hospital that spent 0.7% of revenue on charity care. Denying tax-exempt status to cash-rich hospitals could be appealing to Gov. Pat Quinn, who still prides himself on his populist roots. But it would also put him at odds with hospitals, one of the largest employers in the state, and their influential board members. (Crain's Chicago)

OTHER HEADLINES

California

- **State aims to mitigate loss of funds for adult day care**

  State health officials are circulating a plan they say will help keep about 35,000 elderly and disabled Californians out of institutionalized care when Medi-Cal stops offering an adult day healthcare benefit in December. The plan released late Friday relies primarily on Medi-Cal managed care plans to find alternatives for beneficiaries, including additional hours of in-home supportive services, physical and occupational therapy, and social services. But care providers say the approach could fail because appropriate alternatives aren't always available and families would be forced to shuttle patients around town to obtain the services now offered at more than 300 adult day healthcare centers. (LA Times)

- **California stakeholders urge feds to reject Gov. Brown's Medicaid cuts**

  Some 20 members of a broad coalition of California healthcare stakeholders met with Medicaid agency chief Don Berwick on Thursday and urged him to reject the state's request for deep cuts to the state-federal program for low-income people. Gov. Jerry Brown has asked federal regulators for permission to cut the program by $1.4 billion to help the cash-strapped state plug its $26.6 billion budget gap. Stakeholders say the cuts would devastate a program that's critical to the success of Democrats' healthcare reform law — in California alone, the law would add 3 million people to state Medicaid rolls starting in 2014. (The Hill)

Hawaii

- **Medicaid health providers bidding to participate in Hawaii**

  Health care providers are bidding to participate in state of Hawaii Medicaid programs for low-income residents, known as QUEST. The Department of Human Services said Monday it will issue new contracts by the end of the year that are aimed at lowering costs to the state, improving health access and increasing the use of technology. Hawaii Gov. Neil Abercrombie says changing the way Medicaid programs operate will help address the soaring costs of health care. The health plans must cover at least 10 annual inpatient days, 20 yearly outpatient visits, prescription medications, diabetes supplies, vaccines and emergency services. The state's current QUEST providers are AlohaCare, HMSA, Kaiser Permanente, Kapiolani HealthHawaii, Queen's Hawaii and StraubCare Quantum. (The Republic)

Louisiana

- **Two companies sue state for share of Medicaid privatization contracts**

  Aetna Inc. and Coventry Health Care Inc. have challenged a decision by the Louisiana Department of Health and Hospitals to deny their subsidiaries a share of a $2.2 billion Medicaid privatization program. Aetna Better Health Inc. and Coventry Health Care of Louisiana Inc. say that Gov. Bobby Jindal's administration did not follow its own rules in scoring 10 firms' proposals for managed-care networks that will serve more than two-thirds of Louisiana's 1.2 million Medicaid recipients. The firms also are dis-

puting the state health agency's decision not to release all of its scoring documentation and the winning proposals. (NOLA.com)

- **3 companies file suit to have Medicaid bid information shielded**

  Three companies planning to participate in Louisiana's new health care delivery system for the poor are suing to shield proprietary information in their winning proposals. Centene, AmeriGroup and United Healthcare filed suit in state court in Baton Rouge. The private insurance companies oppose the state Department of Health and Hospitals' plan to release the full proposals they submitted as they competed for $2.2 billion in state Medicaid program business. Company attorneys are arguing that some of the information should be off limits to the public and competitors. United's request came after an unsuccessful competitor filed a public records request seeking its complete filing. (The Republic)

North Carolina

- **NC Medicaid committee hears options for extra cuts**

  The Division of Medical Assistance outlined a range of extra cuts it could be forced to make as it falls short of the $356 million decrease that state budget writers ordered this year. Several of the Legislature's cost-cutting instructions require federal approval, which could take up to six months for some changes. That means the savings will be smaller than lawmakers forecast, forcing more still more cuts on the program's nearly 1.5 million recipients and more than 70,000 doctors, therapists and other providers. (Business Week)

Pennsylvania

- **Independence Blue Cross and Blue Cross Blue Shield of Michigan partner to expand services to Medicaid beneficiaries nationally through AmeriHealth Mercy**

  Two of the nation's largest not-for-profit Blue health insurers, Independence Blue Cross (IBC) and Blue Cross Blue Shield of Michigan (BCBSM), announced this morning that they will be partnering to expand services to Medicaid beneficiaries nationally through the AmeriHealth Mercy Family of Companies, a top-tier, best-in-class Medicaid managed care organization headquartered in Philadelphia. IBC is the leading health insurer in Southeastern Pennsylvania with 3.1 million members and BCBSM is the leading health insurer in Michigan with 4.3 million members. IBC has shared equal ownership of AmeriHealth Mercy since 1996 with the area's largest Catholic health system, Mercy Health System. Through the transaction announced today, Mercy Health Plan's (a subsidiary of Mercy Health System) interest in AmeriHealth Mercy will be acquired and IBC and BCBSM will provide additional capital to support AmeriHealth Mercy's expected growth. AmeriHealth Mercy is one of the country's largest Medicaid companies, serving almost 800,000 members in Medicaid managed care plans in three states. AmeriHealth Mercy also offers other services such as pharmacy benefits management and behavioral health care to an additional 3.2 million Medicaid, Medicare, and SCHIP beneficiaries in 11 states. (AmeriHealth Mercy News)

Tennessee

- **Medicaid cuts force hospitals onto auction block**

  Cutbacks in federal reimbursements on Medicaid programs initiated in recent years are hitting nonprofits like Catholic Health Partners the hardest; CHP has opted to sell six medical centers in Knoxville. Many small operators are fleeing for the exits and getting absorbed by bigger, more resilient chains. Larger, more risk-averse facilities are substituting for the homegrown community hospital. Moody's Investors Service recently issued a study examining the issues for nonprofit hospitals. It says Medicaid funding pressures could put stress on hospital credit ratings for at least the next several years. (Market Watch)

Texas

- **Texas switching Medicaid recipients to cards**

  Texas has stopped mailing monthly, proof-of-coverage letters to the more than 3 million people on Medicaid. Instead, the Health and Human Services Commission has begun issuing plastic cards. The change is designed to save about $30 million over four years by replacing the monthly paper mailings with the new cards. Until this month, the state spent nearly $1 million a month to print and mail paper forms that poor people on Medicaid could take to the doctor's office as proof they're enrolled and qualify for coverage. The majority of Texas Medicaid recipients are enrolled in managed-care plans, and the percentage will soon skyrocket after budget-cutting provisions that lawmakers recently passed. Goodman said even if they now receive a card from their private insurance company, they'll still receive a new plastic card from the state. (Dallas News)

Utah

- **Utah Medicaid reforms bad medicine for Utah kids, say national groups**

  Utah's plan for reforming Medicaid is capturing national attention — but more for its faults than its virtues. Eighteen national advocacy, provider and disease groups urged the Obama administration on Wednesday to reject elements of the reform proposal they say will limit access to health care for low-income kids. Like many states, Utah is looking to redesign its Medicaid program to contain costs. A blueprint submitted in July for federal approval calls for moving Medicaid patients into managed care networks that would be paid a fixed amount per patient and would share in any leftovers or absorb any losses. (Salt Lake Tribune)

Washington

- **Competition Heats Up To Insure Poor People In Washington**

  For the past decade, two comparatively small insurance companies have handled the bulk of that in-business in Washington. But now major national insurers are looking to get into the state as insuring poor people can be profitable. For the past decade, Community Health and Molina Healthcare, a now for-profit California company, have been the two major players in Medicaid managed care in Washington. But that may soon change. This fall, for the first time in a decade, Washington will throw open the doors

to competition. The state will invite bids from companies that want a piece of Washington's $1.5 billion a year Medicaid managed care program. (KUOW.org)

United States

- **Democrats Challenging Administration on Medicaid**

  In an unusual break with the White House, the Democratic leaders of Congress told the Supreme Court on Monday that President Obama was pursuing a misguided interpretation of federal Medicaid law that made it more difficult for low-income people to obtain health care. The Democratic leaders said Medicaid beneficiaries must be allowed to file suit to enforce their right to care — and to challenge Medicaid cuts being made by states around the country. The Obama administration maintains that beneficiaries and health care providers cannot sue state officials to challenge cuts in Medicaid payment rates, even if such cuts compromise access to care for the poor. (New York Times)

PRIVATE COMPANY NEWS

- **Eagle Hospital Physicians**, a portfolio company of **Flexpoint Ford** and **Highlander Partners**, has acquired **PrimeDoc Management Services**, an Asheville, N.C.-based hospitalist practice management company. No financial terms were disclosed. www.eaglehospitalphysicians.com
- **Clearview Capital** in July acquired **Pyramid Healthcare**, an Altoona, Penn.-based provider of drug/alcohol and mental health treatment centers, the firm said. Terms of the deal were not released. Pyramid Healthcare operates 21 treatment facilities throughout Pennsylvania. Clearview Capital is a Connecticut-based private equity firm. More here…
- **The Blackstone Group** is acquiring a majority stake in **Emdeon Inc.**, via a $3 billion deal that will take private the healthcare revenue and payment management company. Blackstone is investing out of its Blackstone Capital Partners VI L.P. Existing shareholder **Hellman & Friedman** will maintain "a significant minority equity interest" in Emdeon, the company said Thursday. Along with Hellman & Friedman, buyout shop **General Atlantic** is currently one of the company's largest shareholders. More here…

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. Notable events this week include an update on the Kentucky RBM timeline, the QUEST re-procurement in Hawaii and the introduction of Nebraska's plan to expand its Medicaid managed care program to about 60,000 beneficiaries in rural counties.

Date	State	Event	Beneficiaries
August 22, 2011	Kentucky RBM	Bids due	N/A
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	Bids due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
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 Welcomes…

HMA continues to expand our office locations, services and expertise with the opening of our twelfth office in Harrisburg, Pennsylvania, and the addition of several new colleagues since the first of the year. Our growth is strategic, purposeful and with client service in mind. With each new office and each new colleague, we are expanding our ability to innovate, anticipate and respond to client needs, and deliver results for our clients.

Mike Nardone - Principal

Mike Nardone joins HMA as a Principal in the new Harrisburg, PA office. Mike comes to HMA after serving as a senior public official in Pennsylvania for many years. Most recently, Mike served as the Acting Secretary of the Department of Public Welfare, where he led this $21 billion department and more than 17,000 employees, administering basic health and human services programs for more than 2 million Pennsylvanians. In this

role, Mike oversaw programs for medical assistance, mental health, developmental disabilities, income maintenance, and child welfare. Previously, Mike directed the state's Medicaid program as the Deputy Secretary of the Office of Medical Assistance Programs. During his tenure, Mike developed, implemented, and oversaw initiatives including the integration of pay-for-performance programs in MCO and enhanced primary care case management contracts, the development of provider pay-for-performance in support of chronic care disease management and access to dental care, and the establishment of a "never events" policy to limit payments to hospitals that provide substandard care. Mike also served as an elected member of the Executive Committee of the National Association of State Medicaid Directors. Prior to his service at the Department of Public Welfare, Mike served as the Executive Director of the Governor's Long Term Living Council. Mike earned his Master in Public Affairs degree at Princeton University, and his Bachelor of Arts degree at Haverford College.

Stephen Weiss – Senior Consultant

Stephen Weiss joins HMA as a Senior Consultant in our Washington, DC office. Before relocating to the DC area, Stephen served as Senior Policy Advisor at the Oklahoma Health Care Authority, where he prepared analysis and reports on state and federal issues related to the State Medicaid program, the Children's Health Insurance Program, uncompensated care, and the uninsured. Stephen also worked with the Oklahoma Congressional delegation on matters related to Medicaid, prepared State Plan Amendments on Medicaid reimbursements, and developed new state policies and allocation formulas for the Oklahoma Disproportionate Share Hospital program. Prior to his service at the Oklahoma Health Care Authority, Stephen was Senior Fiscal Policy Analyst for the Appropriations and Budget Committee and the Joint Committee on Federal Funds in the Oklahoma House of Representatives. Stephen earned his Master of Public Affairs degree at the University of Texas, and his Bachelor of Arts degree at Texas A & M University.

HMA Recently Published Research

Children's Health Care: Making Great Strides

Jennifer Edwards, DrPH, HMA 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 evidence1 - 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 non-profit 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 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

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