HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: PENNSYLVANIA OUTLINES MCO EXPANSION PLAN

HMA ROUNDUP: CMS DELAYS MICHIGAN DUAL ELIGIBLE TRANSITION PLAN, TEXAS HHSC ANNOUNCES CHANGES TO STAR CONTRACT AWARDS IN TRAVIS COUNTY; ILLINOIS GOVERNOR THREATENS CUTS TO INSTITUTIONAL FACILITIES

OTHER HEADLINES: CALIFORNIA RATE REGULATION BILL FAILS; MAGELLAN SECURES LOUISIANA BEHAVIORAL HEALTH RFP; PARKLAND CEO REMOVED FOLLOWING FAILED INSPECTION

HMA WELCOMES:
DR. ART JONES, PRINCIPAL – CHICAGO
DENISE SOFFEL, PRINCIPAL – NEW YORK
STACY MITCHELL, PRINCIPAL – HARRISBURG

UPCOMING EVENTS: KAISER FAMILY FOUNDATION POLICY BRIEFING, COMPREHENSIVE 50-STATE SURVEY OF MEDICAID MANAGED CARE PROGRAMS - VERNON K. SMITH, PRESENTER. SEPT. 13, 2011

SEPTEMBER 7, 2011

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

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In Focus: Pennsylvania Outlines MCO Expansion Plan

This week, our *In Focus* section reviews the planned expansion of Pennsylvania's HealthChoices program, a capitated managed care program for Medicaid enrollees. The Pennsylvania Department of Public Welfare outlined plans for a statewide expansion of the HealthChoices program in an August 23, 2011 public discussion paper. HealthChoices currently serves approximately 1.2 million Medicaid lives in three zones – Southeast, Southwest, and Lehigh/Capital – comprising 25 out of Pennsylvania's 67 counties. HealthChoices is the sole Medicaid enrollment option for most beneficiaries in these three zones. The Department is planning to expand the HealthChoices program, alongside the existing ACCESS Plus enhanced primary care case management (PCCM) plan, in the remaining 42 counties. The ACCESS Plus plan is managed by APS Healthcare.

Current Market

Table 1 details March 2011 MCO plan enrollment in the 25-county HealthChoices program where enrollment is mandatory. AmeriHealth Mercy is the largest plan in the program followed by UnitedHealthcare. We note that the existing HealthChoices contracts will not be re-bid in conjunction with this proposed expansion.

Table 1 – March 2011 Enrollment Snapshot of HealthChoices Counties

	HealthChoices	%
AmeriHealth Mercy (incl. Keystone)	417,541	35%
Gateway Health Plan	238,794	20%
UnitedHealthcare	180,961	15%
Health Partners of Philadelphia	167,232	14%
UPMC Health Plan	139,000	12%
Aetna	41,484	3%
Coventry	12,102	1%
Total	**1,197,114**	

Source: PA Department of Public Welfare. Managed Care Statistical Information. March 2011.

In the 42 counties slated for expansion, 25 currently offer MCO plan participation in a Voluntary Managed Care program. Under the Voluntary Program, individuals are given the choice to enroll in the ACCESS Plus (PCCM) program or an MCO plan. Plans may voluntarily choose to participate in the Voluntary Program. Currently, nearly 75,000 Medicaid beneficiaries across these 25 counties have voluntarily enrolled in a MCO plan, an increase of roughly 20,000 lives since 2009. Table 2 details March 2011 MCO plan enrollment in the 25 voluntary counties.

Table 2 – March 2011 Enrollment Snapshot of Voluntary Program Counties

	Voluntary	%
AmeriHealth Mercy (incl. Keystone)	4,258	6%
Gateway Health Plan	10,768	15%
UnitedHealthcare	47,148	66%
Health Partners of Philadelphia	-	-
UPMC Health Plan	8,774	12%
Aetna	-	-
Coventry	-	-
Total	**70,948**	

Source: PA Department of Public Welfare. Managed Care Statistical Information. March 2011.

Planned Expansion

Under the proposed statewide expansion, HealthChoices will enter the remaining 42 counties not currently served by the HealthChoices program. The counties will be divided into two zones – New West and New East – bringing the number of MCO plan zones from three to five. Current Medicaid enrollment for the two new zones is detailed below.

	New West	%	New East	%
ACCESS Plus	148,500	55%	188,800	64%
Voluntary MCO	51,300	19%	23,600	8%
FFS/Other	70,200	26%	82,600	28%
Total	**270,000**		**295,000**	

The New West zone comprises 19 counties and roughly 270,000 Medicaid lives, the majority of which are currently enrolled in the ACCESS Plus program. The New West zone contains only six of the 19 counties in which voluntary MCO enrollment is not an option; this accounts for a higher current voluntary MCO enrollment than the New East zone. The New East zone comprises 23 counties and roughly 295,000 Medicaid lives, the majority of which, again, are enrolled in the ACCESS Plus program. Nearly half of the counties in the New East zone do not currently offer voluntary MCO enrollment.

Plans will be invited to bid on either the New West, New East, or both zones. The state will award two MCO contracts per zone, to be offered to Medicaid enrollees alongside the ACCESS Plus plan. At the time of implementation, the state will terminate existing contracts with Voluntary Program MCO plans in the New West and New East zones. Plan selection and auto-assignment will be handled under the following parameters:

- Individuals currently enrolled in a plan that is awarded a contract will have a choice to remain in their current MCO, switch to the other MCO offered in their zone, or enroll in ACCESS Plus. If they do not select a plan option, they will remain in their current MCO.

- Individuals currently enrolled in a plan that is not awarded a contract will choose between the two offered MCO plans and the ACCESS Plus plan. If they do not select a plan option, they will be auto-assigned to a plan, with a higher percentage of auto-assignment going to the vendor (MCO or ACCESS Plus) with the lowest current market share.
- Individuals currently enrolled in the ACCESS Plus plan will have the option to enroll in the two offered MCO plans in their zone. However, if they do not select a plan option, they will remain in ACCESS Plus. This is significant in that nearly 340,000 of the 565,000 Medicaid lives in the New West and New East zones are currently enrolled in ACCESS Plus and potentially excluded from the auto-assignment process.

Market Opportunity

Between the New West and New East zones, there are roughly 565,000 TANF and ABD Medicaid lives that will be bid under the HealthChoices expansion. Assuming a PMPM capitation rate of $360, these two zones represent an annual market opportunity of nearly $2.5 billion. However, given the presence of ACCESS Plus and the auto-assignment exclusion of current ACCESS Plus enrollees, the value of MCO expansion lives could be significantly less. The state reports that in Voluntary Program counties, when given the choice between ACCESS Plus and an MCO plan, enrollees selected an MCO plan 23% of the time. Under this very conservative MCO enrollment scenario, we estimate a combined market opportunity of more than $560 million in annualized revenue.

RFP Process and Timeline

As noted above, plans will have the opportunity to bid on one or both of the two HealthChoices expansion zones. While we will not know the precise scoring criteria until the RFP is released, believe the state will set capitation rates, thus cost will not be a component of the scoring criteria. Additionally, given that the state refers to the high quality scores and overall national ranking of its Medicaid health plans, we expect quality to be a significant factor in the scoring criteria. A tentative RFP schedule follows:

Schedule	Date
Public Comment Period Ends	September 30, 2011
RFP Released	October 2011
Proposals Due	November 2011
Selection Process Begins	December 2011
Implementation - New West Zone	September 1, 2012
Implementation - New East Zone	March 1, 2013

HMA MEDICAID ROUNDUP

Illinois

HMA Roundup – Matt Powers / Jane Longo

It is reported that Gov. Pat Quinn plans to issue layoff notices to thousands of state workers this week as part of a strategy to a budget shortfall in the hundreds of millions of dollars. The governor reportedly intends to announce the closing of several state facilities, including a prison, juvenile detention center and homes for the mentally ill and developmentally disabled.

The legislative veto session begins October 25 through 27 and finishes November 8 through 10. The session will be important given the significant Medicaid cuts written in by Governor Quinn in early July. The General Assembly can approve or reject the Governor's veto cuts with a simple majority. The big question is whether state revenues have improved and whether that may help mitigate budget cuts.

In other news

- **Hospitals fear loss of tax exemption in Illinois**

  Illinois hospitals got their first major warning about losing charitable tax exemptions when the state Department of Revenue first removed Provena Covenant Medical Center's exemption in 2006, then yanked Carle Foundation Hospital's exemption. Last year, after the state Supreme Court ultimately found Provena Covenant was taxable, the Department of Revenue began looking at a stack of applications from other hospitals in Illinois seeking tax exemptions. In August, the department preliminarily denied exemptions for three more hospitals, in Chicago, Naperville and Decatur. Illinois Hospital Association President Maryjane Wurth says her organization has been trying to work out a solution with the Department of Revenue, Attorney General Lisa Madigan's office and others with a stake in the charity care issue. The hospital organization has asked the department both to withdraw its latest three hospital exemption denials and to hold off on further decisions for now, but Department of Revenue spokeswoman Sue Hofer says more preliminary decisions may be forthcoming. (The News Gazette)

Indiana

HMA Roundup – Cathy Rudd

Broader discussion of health policy in Indiana has taken a back seat to the key health care issue in the state, the condition of Peyton Manning's neck. It was announced today, September 7, that the Colts quarterback will miss the season opener against the Houston Texans on Sunday, creating even greater concern regarding his status for the remainder of the NFL season.

Michigan

HMA Roundup – Esther Reagan

The plan to voluntarily open managed care plan enrollment to dual eligible Medicaid beneficiaries beginning October 1 has been delayed. Reportedly, CMS has questioned some of the wording in the waiver needed to enroll these individuals. The state is waiting on a response from CMS, from which point the state will issue a bulletin announcing the plan, after which the state must wait at least 30 days before enrolling duals into managed care plans. Additionally, there are questions as to how notices will be distributed to eligible individuals. The broadest approach would be to send a notice to all dual eligible individuals, aside from those in an institutional setting. A much narrower approach would be to notify only those who are nearly eligible for Medicare, or approaching age 65.

Texas

HMA Roundup – Dianne Longley

On August 31, 2011, the Texas Health and Human Services Commission announced tentative contract awards for the Medicaid and CHIP MCO to include Amerigroup for STAR and CHIP services in the Bexar Service Area. Additionally, HHSC announced tentative contract awards to Blue Cross Blue Shield of Texas and Sendero Health Plans for STAR and CHIP services in the Travis Service Area, while Amerigroup is being dropped from the Travis Service Area.

In other news

- **Parkland expects CMS report by Sept. 15**

  The chairwoman of the board that oversees Parkland Memorial Hospital said Tuesday that she remains hopeful the facility will retain its ability to receive government health care reimbursements, but she offered no assurances. The Dallas County hospital's Board of Managers met in executive session Tuesday evening for a briefing about a follow-up inspection by the Centers for Medicare & Medicaid Services. No official action was taken. The hospital's Medicare and Medicaid funding could be cut off effective Sept. 30 if the hospital has not remedied problems found in an earlier inspection. (Dallas Business Journal)

OTHER HEADLINES

California

- **Hard Times for Nursing Homes May Get Harder**

  In June, Gov. Jerry Brown (D) signed a budget package calling for a 10% reduction in Medi-Cal payments for skilled-nursing facilities and other providers. The cutback, subject to CMS approval, is scheduled to begin early next year and be in effect for 14 months. The temporary Medi-Cal cut comes on top of an 11.1% reduction in Medicare payments. Beginning Oct. 1, California nursing facilities will see a $380 million cut in

their annual Medicare payments under a new payment structure CMS announced earlier this year. Part of the new payment scenario includes more restrictive guidelines on payments for therapy. (California HealthLine)

- **Rate regulation bill stalls in Senate**

  Backers of a bill to give the state the power to approve or reject health insurance premium increases shelved the measure for the year Wednesday, saying they lacked the votes in the Senate to send it to Gov. Jerry Brown. The bill, AB 52, was strongly opposed by health plans and insurers, who built a broad coalition of interests around the state to block the measure from becoming law. Opponents included business and government groups and the California Medical Association. (HealthyCal.org)

Florida

- **State clamps down on 17 ALFs**

  More than two dozen assisted living facilities have been targeted by state officials in the past three months in the most sweeping crackdown on assisted living facilities in years. After failing to clamp down on the state's worst homes, regulators have launched investigations into dozens of troubled ALFs, imposing thousands in fines and forcing the closure of eight homes. So far, regulators have slapped the state's harshest penalties on 17 homes — banning new residents and slashing Medicaid funding — more than triple the number of any other time in the past five years. From Miami to the Panhandle, nearly 100 residents have been removed from shuttered homes and placed in other ALFs. (Miami Herald)

Louisiana

- **State judge temporarily blocks state from proceeding with Medicaid reform plan**

  A state judge, granting the request of Aetna Inc., has issued a temporary restraining order blocking the Louisiana Department of Health and Hospitals from implementing its plan to shift more than 800,000 Medicaid recipients and their $2.2 billion in claims to private insurers. Aetna is protesting the state's selection of three-firms -- Louisiana Healthcare Connections Inc., a subsidiary of Centene; Amerihealth Mercy of Louisiana Inc.; and AmeriGROUP Louisiana Inc. -- to run "pre-paid coordinated care networks." Aetna went to a Baton Rouge district court after Health Secretary Bruce Greenstein rejected its administrative appeal of his initial decision. (NOLA.com)

- **Louisiana hires Magellan to overhaul and expand mental health services for Medicaid patients**

  Louisiana's state health agency Thursday tapped a publicly traded managed-care specialist to run an overhaul and expansion of mental health and addiction services for the state's Medicaid and uninsured populations. The impending contract for Magellan Health Services Inc. is part of Gov. Bobby Jindal's push to convert much of the Medicaid insurance system from the existing fee-for-service model to a system of coordinated-care networks. Separately, the Jindal administration is in the late stages of contracting with five firms to run coordinated care networks for about $2.2 billion in Medicaid business for more than 800,000 residents. The new program is set to launch March 1, 2012. (NOLA.com)

Massachusetts

- **Legislator seeks cuts to highest health payments**

  Ronald Mariano, the House majority leader, planned to file legislation this week that would force insurers to cut payments to the most expensive hospitals and doctors, a bold proposal that is likely to meet opposition from many providers. The amount the insurers saved would be used to increase payments to the lowest-paid hospitals and doctors, and to reduce health insurance premiums for employers and consumers. Mariano, a Quincy Democrat, said his plan could shave roughly $267 million off premiums, based on a previous analysis by Governor Deval Patrick's staff. (Boston Globe)

Missouri

- **Indiana company quits Missouri Medicaid contract**

  An Indiana company hired to assess the needs of thousands of Missouri Medicaid patients has quit after barely three months on the job following numerous complaints about its service and disagreements with state officials. The CEO of SynCare LLC told the Associated Press on Thursday the contract she viewed as a mission to help the disabled and elderly had become a public relations debacle — in part, because of the state's actions — and was no longer worth continuing. State officials countered that SynCare quit because it was about to be fired and had failed to live up to a contract — worth up to $5.5 million annually — to determine whether Medicaid recipients qualified for home-based health care and help with performing daily activities such as cooking, bathing and getting dressed. The Missouri Department of Health and Senior Services said Thursday it will immediately begin taking over the duties that were supposed to be performed by SynCare, which so far had been paid $1.3 million. The agency previously handled the state's caseload prior to hiring a private company. (News Tribune)

New York

- **City Medicaid near critical condition**

  The number of city residents qualifying for Medicaid has hit a record that's likely to go even higher next year when enrollment will almost certainly reach the milestone 3 million mark -- or more than 37 percent of the population, officials said yesterday. As of July, a record 2,927,952 people here were getting their health insurance covered by the government. Although the numbers fluctuate slightly from month to month, the annual trend is headed in one direction: up. Five years ago, in July 2006, the city's Medicaid rolls stood at 2,573,610. (NY Post)

South Carolina

- **No thanks: Haley to reject fed health exchange funds**

  Gov. Nikki Haley said she will let federal deadlines slip by and not accept millions in federal funds to help South Carolina set up its own health insurance exchange. Health insurance exchanges, the centerpiece of federal health care reform, are online marketplaces, to be set up by each state, where the uninsured could compare insurance plans from private insurance companies and buy the one that best fits their needs. Uninsured people who meet certain federal poverty guidelines could buy coverage using federal

tax credits. But Haley and Tony Keck, whom Haley appointed to head the state's Department of Health and Human Services, say the federal plan is not the right fit for South Carolina. (The State)

United States

- **Whistleblower lawsuit accuses 3 drug makers**

  Three generic drug makers are being accused in a whistleblower lawsuit of scheming to overcharge the government by tens of millions of dollars for medicines. The U.S. Attorney's office on Tuesday joined in the lawsuit, brought by a Chicago pharmacist. His attorneys alleged in a 162-page complaint unsealed Tuesday afternoon that Par Pharmaceuticals Companies Inc. of Woodcliff Lake, N.J., and two foreign generic drug makers overcharged the Medicaid program by getting pharmacies to dispense different, more-expensive, dosage forms than what was prescribed. Damages and penalties could exceed $300 million, given the triple damages allowed in whistleblower cases. (CBS Money Watch)

- **High-risk health care plans fail to draw crowd**

  The high-risk program was intended to be a bridge to 2014, when state-run health insurance exchanges will offer affordable coverage for everyone, regardless of health status. Speculation varies as to why it has been slow to take off. A year into the program, only 21,000 out of an estimated 25 million uninsured people with "high-risk" conditions such as cancer, heart disease and diabetes have signed up. When the law was enacted last year, administration officials projected enrollment would reach 375,000 and many worried that funding would run out. So far, only 2 percent of the $5 billion subsidy has been spent. The biggest sticking point, according to a new report from the U.S. Government Accountability Office, is that only people who have been uninsured for at least six months are eligible. Congress added that provision to limit the number who would qualify. Others say the cost of premiums in the high-risk pool—though generally lower than for other available policies—is still too high for most patients to afford. (Stateline)

- **Medicaid transparency push riles state officials**

  A federal push for more transparency in how states run their Medicaid programs is pitting patient advocates and medical providers against state officials who fear being hamstrung. The transparency effort comes as states seek ever greater flexibility in how they manage their Medicaid programs to cope with historic budget woes. Federal regulators have expressed sympathy for states' concerns, but they are also required to answer Congress's calls for more public information about what states are up to. Advocates, however, say a dearth of rules has allowed states to get away with major changes to programs on which millions of vulnerable people depend with very little oversight. (The Hill)

Private Company News

- **RegionalCare Hospital Partners to Merge with Essent Healthcare**

  RegionalCare Hospital Partners Inc., a Warburg Pincus portfolio company, today announced it has signed a definitive agreement to merge with Essent Healthcare, Inc., a portfolio company of Vestar Capital Partners and Cressey & Company. Brentwood, Tennessee-based RegionalCare is the owner and operator of four market-leading, non-urban hospitals located in Florence, Alabama; Muscle Shoals, Alabama; Ottumwa, Iowa and Wilmington, Ohio, while Nashville-based Essent is the owner and operator of three market-leading, non-urban acute care hospitals located in Sharon, Connecticut; Waynesburg, Pennsylvania and Paris, Texas. The merger, which is conditioned on customary regulatory reviews and approvals, is expected to close by the fourth quarter of this year. Terms of the deal were not disclosed. (Regional Care)

- **Health Enterprise Partners** is planning to begin raising its second fund in Q4 with a $150 million target, according to VentureWire. The New York-based firm plans to invest in companies that "can help the medical system expand access to care while simultaneously curbing costs."

- **UnitedHealth Buys California Group of 2,300 Doctors**

  UnitedHealth Group Inc. will acquire the operations of a major southern California physician group, in the latest example of how lines are blurring between insurance companies and health-care providers. The purchase of the management arm of Monarch HealthCare, an Irvine, Calif., association that includes approximately 2,300 physicians in a range of specialties, establishes United's Optum health-services unit as a formidable presence in the region. (Wall Street Journal)

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
September 15, 2011	Washington	RFP Released	880,000
September 15, 2011	Nebraska	RFP Released	60,000
September 15, 2011	Kentucky RBM	Contract awards	N/A
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 1, 2011	Kentucky RBM	Implementation	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
October, 2011	Pennsylvania	RFP Released	565,000
November 14, 2011	Hawaii	Contract awards	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Hawaii	Implementation	225,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	270,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	295,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA WELCOMES…

Dr. Art Jones, Principal – Chicago, Illinois

Art has more than twenty five years of experience as a founding physician and CEO at a large urban community health center, called Lawndale Christian Health Center. He has lived in the impoverished community that he has served since 1980. The health center has been at the forefront of delivering care under a near global capitation payment system for more than twenty years, and now covers approximately 15,000 lives. It is has earned top ratings among community health centers nationally for its financial performance under managed care, and has reinvested those margins into caring for the uninsured, as well as innovative efforts of improving health. Art also worked, for four years, as a part time medical director for a managed care organization focused on the Medicaid population. Art is considered a pioneer in the Accountable Care Organization (ACO) movement, and along with his work at HMA, will devote one day a week to serving as

the Chief Medical Officer for Medical Home Network (MHN). MHN (a client of HMA) is a foundation-funded demonstration project to improve the health status of Southside and Southwest-side Chicago area residents by taking a population health approach to organizing healthcare providers to enhance quality, improve access, reduce costs, and reinforce the medical home. Art earned his Bachelor of Arts degree at Taylor University, and his medical degree at the University of Illinois Medical School. He completed his internal medicine residency, chief residency, and cardiology fellowship at the University of Chicago, and now holds a position as Clinical Associate in the Department of Internal Medicine at the University of Chicago Medical School.

Denise Soffel, Principal – New York, New York

Denise has more than twenty five years in health policy and planning, most recently as the Executive Director of the Committee on Health with the New York State Senate. In this capacity, Denise was the lead policy advisor to the committee and coordinated efforts with the Governor's office, Department of Health, Assembly and Senate on an ambitious health reform agenda. She also worked with the Executive branch on federal health reform implementation in the State of New York. Prior to her work in the New York Senate, Denise was Health Policy Coordinator for the National Center for Law and Economic Justice, and developed and implemented policy advocacy strategy and programs to improve and strengthen public health insurance programs. Denise also spent much of her career as a Senior Policy Analyst for Health in the Department of Public Policy at the Community Service Society of New York. Her specific areas of focus included public health coverage programs, outreach and education efforts to diverse and vulnerable populations, and access to care and the maintenance of the health care safety net. Denise started her career in the Peace Corps as a Health Extension Agent in Paraguay, South America, and is fluent in Spanish (written and spoken). Denise earned her Bachelor of Arts degree at Clark University, and her Masters degree and Ph.D. in Public Administration at Wagner Graduate School of Public Service at New York University. She also was a Postdoctoral Fellow in the Pew Health Policy Program at the Institute for Health Policy Studies at the University of California, San Francisco.

Stacy Mitchell, Principal – Harrisburg, Pennsylvania

Most recently, Stacy served as the Deputy Secretary for Quality Assurance in the Pennsylvania Department of Health. In this role, Stacy was responsible for the licensing and regulation of over 4,500 health care facilities, service providers, and insurance plans. Prior to this post, Stacy was the Director of the Bureau of Managed Care where she was responsible for all activities to license and monitor managed care plans and other regulated entities. In the mid-to-late 90s, Stacy spent several years in Hawaii, and worked as the Executive Director and Chief Financial Officer of the Hawaii Credential Verification Service, as the Director of Physician Services and Provider Network Management at the University Health Alliance (a Hawaii IPA), and as the Executive Director of the Primary Care Physicians of Hawaii. Stacy started her career with HealthAmerica Pennsylvania (a HMO), where over nearly a decade she served in positions of increasing responsibility from Sales Account Representative to General Manager of Special Projects. Stacy earned her Bachelor of Science degree at the Pennsylvania State University, and her Master of Public Health degree at the University of Hawaii at Manoa.

HMA Recently Published Research

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 system, 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. (Link to report)

Florida Reviews Taxpayer Funded Hospitals

Elaine Peters, HMA Principal

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

Upcoming HMA Appearances

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

Dennis Litos, featured speaker

September 9, 2011

Monterey, California

Kaiser Family Foundation Policy Briefing, Comprehensive 50-State Survey of Medicaid Managed Care Programs

Vernon K. Smith, presenter

September 13, 2011

Washington, DC

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

America's Health Insurance Plans – Medicaid Conference

Vernon K. Smith, faculty

September 14, 2011

Washington, DC

Western Association of Medicaid Pharmacy Administrators

Vernon K. Smith, keynote speaker

September 19, 2011

Anchorage, Alaska

Nixon Peabody - Investing in Health Care: Current challenges and opportunities

Greg Nersessian, featured speaker

October 19, 2011

Boston, Massachusetts