HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MISSOURI MEDICAID MCO RFP

HMA ROUNDUP: CALIFORNIA RELEASES PRELIMINARY TWO-PLAN CAPITATION RATES; GEORGIA GOV. CAUTIOUSLY OPTIMISTIC ON TAX REVENUE; GEORGIA AMENDMENT ALLOWS AMERIGROUP, CENTENE TO GO STATEWIDE; ILLINOIS HOSPITAL ASSOCIATION PUSHES REVAMPED HOSPITAL TAX

OTHER HEADLINES: FLORIDA SOLVES LOW-INCOME POOL OBSTACLE TO CMS WAIVER APPROVAL; KANSAS ANNOUNCES MEDICAID OVERHAUL, MCO EXPANSION; LOUISIANA MCO CONTRACTS TO GO LIVE IN FEBRUARY

RFP CALENDAR: MISSOURI, KANSAS MCO RFPS ADDED TO CALENDAR

NOVEMBER 9, 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
HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
SACRAMENTO, CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

IN FOCUS: MISSOURI MEDICAID MCO RFP REVIEWED

To say this has been a big year for Medicaid MCO RFPs is an obvious understatement. So far this year, there have been four Medicaid MCO RFPs completed (Texas, Louisiana, Kentucky, Arizona LTC) and three contract extensions that didn't involve RFPs (California ABD, Virginia and South Carolina). Right now, there are six MCO RFPs outstanding (Washington, New Hampshire, Missouri, Kansas, Hawaii QUEST and Nebraska) with one more expected by the end of the year (Pennsylvania). Ohio is expected by January 2012, followed by three more in 2013/2014 (Georgia, Florida and Illinois). We estimate that by 2014, an additional 9.4 million people, or approximately 20% of total program enrollment, will have been transitioned to managed care, and a total of 17 million lives will gone out to bid. Moreover, this doesn't count the Medicare-Medicaid eligible (MME) opportunity, which has the potential to meaningfully increase the level of spending through Medicaid MCOs in many states.

Medicaid Managed Care Pipeline:

Medicaid Managed Care Pipeline 2012-2014

State	Roll-out Year	TANF/CHIP	ABD/MLTC	Dual Eligibles*	New MCO	Re-bid
Arizona	2011		25,000			25,000
California	2011		380,000		380,000	
Kentucky	2011	500,000	90,000		590,000	
Louisiana	2011	740,000	110,000		850,000	
South Carolina	2011	80,000	15,000		95,000	
Virginia	2011	30,000			30,000	
Texas	2012	3,100,000	300,000		2,000,000	1,400,000
Florida Healthy Kids	2012	220,000				220,000
Hawaii	2012	225,000				225,000
Kansas	2012	238,000	105,000		105,000	238,000
Missouri	2012	425,000				425,000
Nebraska	2012	55,000	5,000		60,000	
New Hampshire	2012	120,000	50,000		170,000	
New Jersey	2012		30,000		30,000	
New York	2012		75,000		75,000	
Ohio	2012	1,500,000	125,000			1,625,000
Pennsylvania	2012	400,000	165,000		565,000	
Washington	2012	740,000	100,000		100,000	740,000
West Virginia	2012		55,000		55,000	
Florida	2012-2014	1,900,000	900,000		1,450,000	1,350,000
Georgia	2013	1,300,000	350,000		1,300,000	350,000
Illinois	2014	1,200,000	300,000		1,500,000	
Total	**2012-2014**	**12,773,000**	**3,180,000**	**0**	**9,355,000**	**6,598,000**

**States awarded design contracts to develop service delivery and payment models that integrate care for dual eligibles.*
Only included are states where the proposed delivery system contemplates managed care

Source: HMA

Missouri MCO RFP Overview

This week, our *In Focus* section reviews the Missouri Medicaid managed care RFP, released on Monday, November 7. The RFP seeks to rebid the nearly 425,000 lives currently enrolled in Medicaid managed care plans which we estimate represents a market opportunity of approximately $1.3 billion in annualized spending. A pre-proposal conference is set for Thursday, November 10, at 10:00 AM in Jefferson City. Proposals are currently due on December 13, a turnaround of just over six weeks.

Current Medicaid MCO Market

Missouri serves just under 425,000 Medicaid lives through capitated managed care health plans in three regions. The Eastern and Western regions are by far the most populous, encompassing St. Louis (Eastern) and Kansas City (Western), while the Central region covers the mostly rural middle of the state. There are no proposed changes to region definition in the RFP.

	Enrollment	%
Eastern Region	207,106	49%
Central Region	81,251	19%
Western Region	135,932	32%
Total	**424,289**	

Source: State Enrollment Data, as of July 2011.

Coventry, Aetna, and Molina operate plans in all three regions of the state, covering 76% of enrolled lives. WellCare, Blue Cross Blue Shield, and Children's Mercy Family Health Partners (a hospital-owned non-profit plan that Coventry is acquiring) each operate a plan in one of the three regions.

	Eastern	Central	Western	Statewide	%
WellCare	16,150	-	-	16,150	4%
Coventry	126,488	33,509	34,586	194,583	46%
Aetna	5,047	39,121	4,191	48,359	11%
Molina	59,421	8,621	10,625	78,667	19%
Blue-Advantage Plus	-	-	30,738	30,738	7%
Children's Mercy FHP	-	-	55,792	55,792	13%
Total	**207,106**	**81,251**	**135,932**	**424,289**	

Source: State Enrollment Data, as of July 2011.

We expect all of the incumbents to bid for this business. An interesting development to monitor will be Centene's level of interest. The company's headquarters is in Missouri, which may make the RFP attractive to Centene. That said, its ill-fated foray into Missouri through the FirstGuard acquisition in 2004 ended with that company's exiting the market in 2006.

RFP Summary

Below, we highlight some of the key points of the RFP. For the full RFP and attachments, see the Missouri procurement page (available here).

- The state will select up to three plans per region. Currently, there are four plans in the Eastern region and five plans in the Western region. As we note in the scoring criteria, there are bonus points awarded for proposing to serve all three regions.
- As under current contracts, the capitated managed care Medicaid population will exclude dual eligibles, those Medicaid enrollees who are permanently disabled, individuals with severe mental illness, and individuals residing in intermediate care facilities.
- The pharmacy benefit will remain carved-out of the managed care structure, and will continue to be paid on a fee-for-service basis by the state.
- Contingent upon CMS approval, the state will implement a health home program designated by Section 2703 of the Affordable Care Act (ACA) for eligible managed care plan enrollees. This provision will require each MCO comply with the following:
    - The health plan is required to provide coordination with a primary care provider.
    - On a monthly basis, the state agency will notify the health plan which of its members are receiving health home services and a contact person will be provided for each health home to allow for coordination of a member's services.
    - The health plan is not required to provide case management services that duplicate those reimbursed to the Section 2703 designated health home.
    - The health plan must inform the health home of any inpatient admission or discharge of a health home member within twenty-four hours.
    - The health plan should include any Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home.
- Enrollees will have 15 days to voluntarily select a plan in their region, after which time they will be auto-assigned per the following methodology:
    - Within each region, plans will share equally 40% of the auto-assignment lives.
    - The remaining 60% will be allocated to plans based on a score that include RFP response scoring criteria, HEDIS measures, inclusion of FQHCs and other clinics in the plan network, and the inclusion of an acute care safety net hospital in the plan network.

Proposal Scoring Criteria

As mentioned previously, the RFP offers a five point scoring bonus (an amount equal to 2.5% of the total points available) for proposing plans in all three regions. The state has, with the assistance of Mercer, prepared actuarially sound, fixed capitation rates. As such, price is not a factor in contract award decisions.

Scoring Criteria	Points	%
Organizational Experience	15	7.5%
Method of Performance	35	17.5%
Quality	60	30.0%
Access to Care	80	40.0%
Minority/Women Business Enterprise	10	5.0%
Total	**200**	
Bonus: Propose All Three Regions	*5*	*2.5%*

Proposal Timeline

Following the pre-proposal conference on Thursday, November 10, proposals will be due on December 13, unless an extension is issued. The contract award date has not been announced, however, awarded plan contracts will be effective July 1, 2012.

Market Opportunity

Based on July 2011 managed care plan enrollment data and the proposed fixed PMPM rates in the RFP, we estimate current market opportunity at nearly $1.3 billion. Medicaid MCO plan enrollment trends have been up and down over the past year, but we can estimate the market opportunity of awarded contracts in the range of $1.2 to $1.4 billion by next July.

	Enrollment	PMPM	Market Opportunity
Eastern Region	207,106	$263	$653,651,389
Central Region	81,251	$275	$268,401,303
Western Region	135,932	$230	$375,009,202
Total	**424,289**	**$255**	**$1,297,061,894**

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein / Jennifer Kent

The Department of Health Care Services (DHCS) released the preliminary capitation rates for the 2011-12 rate year for the Two-plan (TPM), Geographic Managed Care, and County Organized Health System Managed care models to the contracting health plans on November 3, 2011. The aforementioned rates are preliminary as they have not yet been approved by the Centers for Medicare and Medicaid Services (CMS); CMS approval is expected in 2012. Preliminary capitation rates available here: (Link to rates announcement). Individual preliminary plan capitation rates for 2011-12 will be posted to the DHCS website on Tuesday, November 8, 2012.

In the news

- **Hospital group sues over cuts to Medi-Cal program**

  The trade group for California's hospitals has sued state and federal officials to block a 10% cut in government reimbursements for healthcare providers who treat low-income patients. The California Hospital Assn. said in its suit, filed in federal district court in Los Angeles, that cuts to the Medi-Cal insurance program will threaten the ability of many hospitals to continue operating skilled nursing facilities. The 10% cuts, part of the 2011-2012 budget deal signed by Gov. Jerry Brown, are retroactive to June 1. They required federal approval, which the Obama administration gave last week. (Los Angeles Times)

Georgia

HMA Roundup – Mark Trail

The state of Georgia's net tax collections for the month of October totaled $1.3 billion, an increase of $67 million or 5.4 percent compared to October 2010. Through four months of FY2012, net revenue collections totaled $5.36 billion, an increase of $339 million or 6.8 percent over the prior year through October. The Governor notes that while growth has continued it has softened which supports his cautious optimism regarding the state's economic outlook.

An amendment was approved to allow Amerigroup and Centene Medicaid managed care plans to go statewide effective January 2012. No official pronouncement has been made from the MCOs as to their plans. As far as we know, there is no change to the auto assignment algorithm, which will continue to be based on a combination of quality factors and price.

Illinois

HMA Roundup – Matt Powers / Jane Longo

During this final week of the fall legislative session, or Veto Session, the Illinois Hospital Association will advocate for legislation to modify and enhance the Illinois Hospital Assessment Program within the Medicaid program. This modification, developed by the IHA, would bring the state substantial new Medicaid funding – including a net annual benefit to hospitals of $200 million. About two-thirds of the new program payments would be for outpatient services including a substantial increase for physicians. The State of Illinois would also benefit by receiving $20 million in unrestricted funds. This proposal would sunset in June 2014.

As we noted last week, the next meeting of the Medicaid Advisory Committee's (MAC's) Care Coordination Subcommittee will be Tuesday, November 15, from 10 a.m. to noon in both Springfield and Chicago. The committee will consider the HEDIS and HEDIS-like performance measures that will be included in the Innovations Project solicitation. To the extent similar populations are being covered, the State will utilize uniform measures to make comparisons across differing care coordination models.

In the news

- **Rate negotiation hangs up health-benefits exchange bill**

  Negotiations that so far have failed to produce legislation creating a statewide health-benefits exchange apparently are hung up on the issue of whether the exchange's board should have the power to negotiate rates with insurers. Officials from Gov. Pat Quinn's administration have said the General Assembly needs to pass a bill this week setting up an exchange, preferably by three-fifths majorities so the proposal can take effect immediately. If there's no action, Illinois will risk losing more than $90 million in federal startup funds. A key issue in negotiations, Harris said, is whether the state-level exchange — an essential part of the federal Affordable Care Act — would have bargaining power under the "active purchaser model." Insurance industry officials oppose the exchange having bargaining power because they say the situation could prompt insurers to offer fewer products to consumers on the exchange. (Olney Daily Mail)

Indiana

HMA Roundup – Catherine Rudd

Indiana submitted comments on the proposed Federal rules on Exchanges, Medicaid and Eligibility, and the proposed rule on Reinsurance and Risk Adjustment (Link to the press release). The general response of the state echoes the concern voiced by other states that the rules provide too much federal oversight and adopt an ambitious timeline. Additionally, the state has not made public its decision about whether or not to develop a state-based exchange.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The reprocurement for the Medical Assistance Transportation Program (MATP) broker in the Philadelphia area has been finalized. The vendor will continue to be Logisticare and contract negotiations are ongoing. The state hopes to have a contract in place by December 1, 2011. The Philadelphia MATP budget for FY 11-12 is estimated to be $44.7 M for 40,962 clients, up from the FY 10-11 budget of $40.9M for 39,041 clients.

In the news

- **Highmark, WPAHS sign pact to bail out hospitals**

  Highmark Inc. on Tuesday announced it had reached an affiliation agreement with the West Penn Allegheny Health System that immediately infuses the ailing health system with an additional $100 million. The insurer also floated the possibility of further acquisitions, saying that WPAHS may not be the only hospital system that ultimately ends up in its provider portfolio. The $100 million is in addition to $50 million Highmark gave to WPAHS in June, when the two parties first announced plans to join forces, and is part of a total $475 million Highmark has committed to stabilize the West Penn Allegheny system. (Pittsburgh Post-Gazette)

OTHER HEADLINES

District of Columbia

- **Coventry still weighing D.C. Medicaid contract bid**

  Like most companies that run public sector health insurance plans, Bethesda, Maryland-based Coventry Health Care Inc. is scouring the marketplace for chances to increase its Medicaid business as governments expand eligibility for the joint state-federal program. But when it comes to an opportunity just five miles away from its corporate headquarters — in the District — Coventry and others are circumspect. D.C. is searching for a third Medicaid contractor, but Coventry hasn't yet decided whether it will bid later this month. (Washington Business Journal)

Florida

- **Florida works out deal to preserve $1 billion for health care**

  The lone obstacle between the state and federal government in Medicaid 1115 waiver negotiations appears to have been settled as state officials announced on Tuesday that Florida will continue to receive $1 billion to fund health care for the poor, uninsured and underinsured. Medicaid Deputy Director of Finance Phil Williams told a hospital panel on Tuesday that the state will continue to receive $1 billion in Low Income Pool money for three years. Three LIP Council members expressed concern about a requirement that the state spend $50 million on "new" or "significantly" enhanced existing programs. They worried that the state already is financing $34 million in primary-care programs but that it wouldn't count toward the requirement. There also are con-

cerns that the hospitals receiving the most LIP dollars will be required to meet certain "milestones." Failing to meet the requirements could put at risk 3.5 percent of the LIP dollars they receive. (The Florida Current)

- **Privatizing of Florida prisons' health care hits snag**

  The outsourcing of physical and mental health care, dentistry and prescription drugs to more than 100,000 inmates was a campaign pledge of Gov. Rick Scott, who called for competitively bid health care contracts. Born as a cost-saving measure, it has been controversial from the start. Lately the project has run into so much resistance from private vendors, who have bombarded the state with more than 600 questions, that the Department of Corrections has pushed back its schedule to implement the project by several weeks. The health care bid is actually five proposals in one, because the huge Florida prison system is divided into four regions. Companies can apply for a contract in Regions 1, 2, or 3 or in all three. Separately, prisons in South Florida's Region 4 were ordered privatized in another part of the budget now under attack in court by the union for prison guards, the Police Benevolent Association. The prison system says it will answer vendors' questions by Nov. 18. Bid proposals are due Dec. 12 and will be opened the next day. The choice of vendors is subject to approval by a 14-member panel of state lawmakers, and the state hopes to start a transition to privately run care by April 2012. (St. Petersburg Times)

- **Governor's task force to shape future of assisted living facilities**

  When the state's assisted living facilities (ALF) Workgroup meets for the final time in Miami this week, it's expected to vote on crucial recommendations that are expected to shape the future of the state's ALFs — now home to more elders and people with mental illness than any other institutions in Florida. The group has generated considerable heat as industry leaders have clashed with a Tampa Bay-area lawmaker and advocates for elders and people with disabilities for weeks over the direction of one of the fastest-growing industries in Florida. (Miami Herald)

Kansas

- **Kansas Announces Sweeping Medicaid Restructuring**

  Kansas Gov. Sam Brownback announced a major overhaul of the state's Medicaid program today, which would put nearly all Medicaid recipients into private, managed-care plans. While low-income families are currently in such plans, elderly and disabled Kansans receive care through a fee-for-service system. The state has drafted a request for proposals from private contractors willing to provide comprehensive health, mental health and long-term health care services at a fixed rate per person. State officials say they expect to select three vendors, who will compete for clients. At a news conference today, Lt. Gov. Jeff Colyer, predicted the changes could slow the growth in Medicaid spending by nearly one percent a year. That would save the state more than $350 million over the next five years and would save the federal government $500 million at the same time. (Kaiser Health News)

Louisiana

- **State launches online medical records exchange**

  Buoyed by a $10 million federal grant, state health officials and industry leaders on Friday celebrated the launch of a Web-based medical records exchange. Authorities tout the Louisiana Health Information Exchange as a way to link disparate health care providers, from primary care doctors to hospitals and pharmacists, so they can collectively provide better and cheaper patient care. The build-out and launch is financed by federal money included in the 2009 economic stimulus package, which included money for every state to develop and expand their capacity for electronic medical records. Gov. Bobby Jindal tapped the Louisiana Health Care Quality Forum, an independent not-for-profit agency, to get the network online. (NOLA.com)

- **Medicaid transition to private networks to begin Dec. 15, state health chief says**

  The Louisiana health department will begin Dec. 15 enrolling almost 900,000 current Medicaid and LaCHIP insurance holders in new coordinated care networks run by private insurers and health care providers. Gov. Bobby Jindal's top health-care initiative will launch first in southeast Louisiana on Feb. 1, with enrollments and launches to follow elsewhere across the state. The system, which will be known as Bayou Health, will comprise $2.2 billion of the $6.7 billion in annual Medicaid insurance spending. (NOLA.com)

New Jersey

- **Horizon offshoot expands its patient-centered care model to Medicaid beneficiaries**

  Horizon Healthcare Innovations and Horizon New Jersey Healthcare, subsidiaries of the state's largest insurer, Horizon Blue Cross Blue Shield of New Jersey, announced Wednesday its patient-centered medical home program — already installed at the Forest Hills Family Health Associates practice — will now include 1,800 Medicaid beneficiaries. Under the PCMH initiative, doctors are paid fees for coordinating comprehensive care for Horizon members, and have the opportunity to earn more money if the program demonstrates better patient outcomes and more efficient care. That's a departure from the current fee-for-service model. Eight primary care centers in New Jersey have adopted the PCMH model, which supports 24,000 Horizon-insured patients. (NJBIZ.com)

New Mexico

- **Nearly 60 percent of New Mexico voters oppose cuts to Medicaid**

  59 percent of New Mexico voters say the federal budget deficit reduction should not involve cutting Medicaid, according to a new poll commissioned by advocacy groups in the state. The Research and Polling, Inc. poll also found that 83 percent of surveyed New Mexico voters believe Medicaid, which provides government-funded health insurance for lower-income Americans, is an important program. (New Mexico Independent)

New York

- **In State Care, 1,200 Deaths and Few Answers**

  In New York, it is unusually common for developmentally disabled people in state care to die for reasons other than natural causes. One in six of all deaths in state and privately run homes, or more than 1,200 in the past decade, have been attributed to either unnatural or unknown causes, according to data obtained by The New York Times that has never been released. The figure is more like one in 25 in Connecticut and Massachusetts, which are among the few states that release such data. (New York Times)

South Carolina

- **18 hospitals to see 8% cuts**

  About a third of hospitals serving South Carolinians collected a combined $110 million in state and federal taxpayer money last year through a program designed to reward medical centers that provide high levels of uncompensated care. But those 18 hospitals, which include three in the Charleston area, actually do not provide a disproportionate amount of care to uninsured South Carolinians and those enrolled in government-sponsored insurance programs. Now the state is cutting payments to those hospitals by about 8 percent, saving taxpayers nearly $9 million annually. (The Post and Courier)

United States

- **States worried they'll bear the brunt of anger over health law's shortcomings**

  State officials are pushing back hard against what they view as shortcomings in the healthcare reform law for fear they'll be barraged with complaints when people have trouble affording insurance. Federal regulators are writing the rules governing key aspects of the law, including the guidelines to determine who's eligible for subsidies to buy private insurance. Those benefits will be delivered through state-based exchanges, however, leaving state officials on the receiving end of complaints if glitches in the law aren't ironed out by 2014. (The Hill)

- **Venture capitalists, trying to curb health-care costs**

  Over the past two decades, venture capitalists helped make possible striking advances in health care, including robotic surgery, cancer vaccines and genomics. But such innovations also fuel higher health-care spending, and now private investors see new opportunities in betting on companies that could curb those costs. Some of that money is increasingly going to information technology, business services and other health-focused companies. For instance, software companies that cater to the health-care industry received $407 million in investments in the first three quarters of this year, compared with $311 million for the full year in 2007 before the recession. Though the increase so far remains modest, investors say interest in the sector is heating up. (Washington Post)

- **Low-income state workers begin to gain access to Children's Health Insurance Program**

  At least six states have opened their Children's Health Insurance Program to the kids of low-income state employees, an option that was prohibited until the passage of the 2010 health-care law. This relatively small step has as its backdrop years of debate over the program, known as CHIP, including concerns that it encourages states — and consumers — to replace private insurance with taxpayer-subsidized coverage. States must show that they have not cut their share of employee health insurance costs in an effort to push their workers' children to CHIP and that the cost of the coverage available to employees is a financial hardship for families. (Washington Post)

PRIVATE COMPANY NEWS

- **TA Associates Completes Senior Whole Health Deal**

  Private equity firm TA Associates has completed its investment in Senior Whole Health, a Cambridge, Mass.-based health plan provider. Terms of the deal were not released. Formed in 2004, Senior Whole Health focuses on individuals who qualify for both Medicare and Medicaid. (Press release)

- **CareSouth Acquires Family Care**

  CareSouth Health System, a privately-held healthcare company has acquired home health provider Family Care. Investment bank The Lenox Group advised on the transaction. (Press release)

- **RegionalCare Merges with Essent**

  RegionalCare Hospital Partners has completed its merger with Essent Healthcare. Terms of the deal were not released. The combined company, which operates under the RegionalCare name, now owns seven hospitals across six states. Essent is backed by Vestar Capital Partners and Cressey & Co. (Press release)

- **Blackstone Completes Acquisition of Emdeon**

  The Blackstone Group has completed its take-private acquisition of Emdeon Inc., a Nashville, Tenn.-based provider of healthcare revenue and payment cycle management solutions. The deal was valued at approximately $3 billion, with existing Emdeon shareholder Hellman & Friedman retaining a "significant minority equity interest." Fellow Emdeon backer General Atlantic sold its entire position. Emdeon stockholders received $19 per share, which represents a 44% premium to its July 26 closing price (the final trading day before news of a possible deal broke). (Press release)

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. We have updated the calendar to include the Missouri and Kansas RFPs released this week.

Date	State	Event	Beneficiaries
Imminent	Pennsylvania	RFP Released	565,000
November 18, 2011	Hawaii	Proposals due	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Kentucky RBM	Implementation	N/A
December 2, 2011	Washington	Proposals due	800,000
December 6, 2011	Nebraska	Proposals due	75,000
December 13, 2011	Missouri	Proposals due	425,000
December 23, 2011	Hawaii	Contract awards	225,000
January, 2012	California (Central Valley)	Evaluation (delayed)	N/A
January 1, 2012	Virginia	Implementation	68,000
January 13, 2012	Kansas	Proposals due	313,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 16, 2011	Hawaii	Implementation	225,000
January 17, 2012	Washington	Contract awards	800,000
January 31, 2012	Ohio	RFP Released	1,650,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
February 28, 2012	Nebraska	Contract awards	75,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
May 1, 2012	Hawaii	Implementation	225,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 15, 2012	California (Central Valley)	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	270,000
January 1, 2013	Kansas	Implementation	313,000
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 Recently Published Research

Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

Vernon K. Smith, Managing Principal
Eileen Ellis, Managing Principal
Kathleen Gifford, Principal

For the 11th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) present their budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. (Link to report)

Managing Medicaid Pharmacy Benefits: Current Issues and Options

Vernon K. Smith, Managing Principal
Sandy Kramer, Senior Consultant

This report examines reimbursement, benefit management and cost sharing issues in Medicaid pharmacy programs. The analysis, conducted by researchers from the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, focuses on the potential of several measures recently highlighted by HHS Secretary Kathleen Sebelius to reduce Medicaid pharmacy costs. The findings were informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011. (Link to report)

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Vernon K. Smith, Managing Principal
Kathleen Gifford, Principal
Dyke Snipes, Principal

This 50-state survey, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, provides a comprehensive look at state Medicaid managed care programs, documenting their diversity, examining how states monitor access and quality, and exploring emerging efforts to improve care, including managed long-term care and initiatives targeted toward dual eligibles. The survey was released September 13, 2011, at a public briefing at the Kaiser Family Foundation's Washington, D.C. office.

Links to the report and presentations below:

Link to report: (PDF)
Link to presentations: (.WMV Video); (.MP3 Audio)

UPCOMING HMA APPEARANCES

American Medical Association Council on Medical Service Innovation

Vernon K. Smith, Speaker

November 11, 2011

New Orleans, Louisiana

PhRMA Annual Meeting for State Government Affairs and State Policy

Vernon K. Smith, Speaker

November 15, 2011

Reston, Virginia

NGA National Summit on Government Redesign: "Opportunities for Medicaid Redesign"

Vernon K. Smith, Speaker

December 13, 2011

Washington, DC