HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: KANSAS MEDICAID MCO RFP

HMA ROUNDUP: CALIFORNIA ADHC SETTLEMENT NEGOTIATIONS CONTINUE; IMPOSITION OF PROVIDER RATE CUTS IN CALIFORNIA DELAYED; PENNSYLVANIA BEHAVIORAL HEALTH RFP RELEASED; ILLINOIS LEGISLATIVE SESSION ENDS WITHOUT MOVEMENT ON EXCHANGE LEGISLATION OR PROVIDER TAX

OTHER HEADLINES: NEW JERSEY CONSIDERS MANAGED BEHAVIORAL HEALTH PROGRAM; STATES MONITOR SUPER COMMITTEE NEGOTIATIONS; WASHINGTON ENDS LIMITS ON ER VISITS

HMA WELCOMES: LINDA FOLLENWEIDER – CHICAGO, IL

RFP CALENDAR: PENNSYLVANIA NEW EAST AND NEW WEST REGIONS COMING SOON

NOVEMBER 16, 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: KANSAS MEDICAID MCO RFP REVIEWED

This week, our *In Focus* section reviews the Kansas Medicaid managed care RFP, released last week. On the heels of Missouri's announcement to rebid its Medicaid managed care population, Kansas announced a rebid of the roughly 210,000 current Medicaid lives served under a capitated managed care structure. In addition to these lives, Kansas announced the intention to carve-in benefits for non-dual eligible aged, blind, and disabled Medicaid lives and behavioral health Medicaid lives previously excluded from managed care plan enrollment. Further, the State announced its intention to seek a waiver from the Centers for Medicare and Medicaid Services (CMS) to mandatorily enroll dual-eligible Medicaid and Medicare lives, children in foster care, and disabled children into managed care plans. Assuming full approval of this waiver, this would essentially place all Kansas Medicaid lives into a managed care plan.

Below, we review the key provisions of the proposal and provide estimates of potential enrollment and spending on both the rebid and expansion populations. One particular aspect of the RFP to note is in the scoring criteria; 100 percent of the scoring is devoted to price.

Current Market

Kansas Medicaid currently serves approximately 210,000 children, families, and pregnant women through two managed care plans under the Kansas HealthWave program. The two plans are UniCare (WellPoint) and Children's Mercy Family Partners (acquisition by Coventry pending). Additionally, the Medicaid program serves 36,000 aged and 57,000 disabled beneficiaries outside of the managed care structure. In total, the Medicaid program spends roughly $2.3 billion on services for just over 300,000 covered lives.

MCO Expansion Populations

Under the RFP, the aged, blind and disabled (ABD) populations will be transitioned from fee-for-service to capitated managed care. This population of 93,000 lives (36,000 aged, 57,000 disabled) accounts for approximately $1.7 billion in current Medicaid spending, nearly 74 percent of total Medicaid spending.

Kansas ABD Population	$	%
HCBS	$ 599,794,030	35%
Nursing Facilities	$ 422,921,599	25%
Inpatient Hospital	$ 173,277,006	10%
Pharmacy	$ 123,741,193	7%
Behavioral Health	$ 113,643,641	7%
Other	$ 97,394,252	6%
Medicare Buy-In	$ 75,314,463	4%
Physician Services	$ 56,745,663	3%
Outpatient Hospital	$ 29,978,662	2%
Substance Abuse	$ 7,595,904	0%
Total	**$ 1,700,406,413**	**100%**

Source: Kansas Department of Health and Environment, FY 2010. Available here.

Based on estimates by the Kansas Health Institute, 62,000 of these ABD lives are dual-eligible for Medicaid and Medicare and consume more than $900 million in annual Medicaid spending.[1] As noted above, the enrollment of dual-eligible ABD beneficiaries in managed care plans is subject to CMS approval of a state waiver. Even without the dual-eligibles, this expansion would add 31,000 lives to managed care rolls, with estimated annual spending of $800 million.

Additionally, the State is planning to submit a waiver to enroll children in foster care in managed care plans. In FY 2009, the State provided Medicaid services to approximately 15,000 foster care children, with annual spending of more than $110 million.[2]

Price-Based Award / Market Opportunity

The State has not yet released the detailed databook with an actuarially determined statewide low cost estimate (LCE) per member per month (PMPM) rate. Plans are invited to propose discounts to this rate, and the three lowest actuarially sound rates will be awarded contracts, provided they meet all technical requirements of the proposal. With this RFP, the new KanCare program expects to slow the rate of Medicaid spending growth by one-third annually.

We estimate the market opportunity of this RFP at more than $2.3 billion, based on a blended PMPM of $650 and 303,000 enrolled lives. If CMS does not approve a waiver to enroll dual-eligibles and foster children, we would estimate the market opportunity of this RFP at close to $1.3 billion, based on a blended PMPM of $470 and 226,000 enrolled lives.

RFP Timeline

Procurement Timeline	Date
RFP Released	Nov. 8, 2011
Optional Pre-Bid Vendor Conference	Nov. 17, 2011
Written Question Deadline	Nov. 23, 2011
Mandatory Pre-Bid Vendor Conference	Late Nov./Early Dec.
State Post Question Responses	Dec. 5, 2011
Follow-Up Written Question Deadline	Dec. 19, 2011
State Post Follow-Up Question Responses	Dec. 30, 2011
Proposals Due	Jan. 13, 2012
Contract Awards	TBD
Implementation	Jan. 1, 2013

[1] "States to gain access to Medicare data." Kansas Health Institute New Service. May 11, 2011. Available at: http://www.khi.org/news/2011/may/11/states-gain-access-medicare-data/

[2] Medicaid Statistical Information System (MSIS) State Summary Datamart. FY 2009. Accessed on November 15, 2011. http://msis.cms.hhs.gov

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Discussions continue regarding a potential settlement between the State and an advocacy organization called Disability Rights California over the State's decision to reduce funding for adult day health centers (ADHCs). At this point, it is unclear what the settlement will entail, but it's possible that a subset of high-acuity ADHC beneficiaries will be allowed to continue accessing the benefit.

Also of note, The Brown Administration announced on Monday that it will not implement the 10 percent Medi-Cal provider rate reductions as authorized in the 2011-2012 State Budget and modified through the federal approval process, until after the December 19th federal court hearing on a lawsuit that is seeking to stop the reductions. That federal district court in Los Angeles could issue an order that could further delay implementation beyond that date or it could take other action that would allow the cuts to be implemented. Pursuant to state law and the approved state plan amendment, the rate reductions would continue to be retroactive to June 1, 2011, and it is expected that the Department of Health Care Services will retroactively implement the rate reduction for services provided on or after that date, unless barred from doing so by the courts. Importantly, the delay in implementing the cuts does not specifically impact Medi-Cal managed health care plans. The Department published managed care rates that implement these rate reductions retroactively to July 1, 2011. The provider rate reductions reduce two-plan and geographical managed care rates by 2.2 percent on an annualized basis. The announcement does not appear to delay implementation of the managed care reductions, as the lawsuit does not include managed care plans or rates.

In the news

- **Red tape hampers care for patients who are poor and disabled**

  In a trial effort set to begin in 2013, California plans to begin shifting several hundred thousand dual eligibles into managed care plans to serve all their healthcare needs. Currently, the vast majority of the state's dual eligibles are in health plans in which doctors and hospitals bill patients on the basis of services provided, meaning costs often soar quickly, healthcare experts say. Managed care plans would reduce spending, state officials say, and make it easier for patients with complex health needs to get required care without receiving duplicate treatments or unnecessarily landing in nursing homes or hospitals. Dual eligibles and advocates for seniors and the disabled have mixed views about managed care's ability to make things better. Some say having one place to go for medical care would be a huge improvement. Others worry that it could become harder to choose doctors. (Los Angeles Times)

Georgia

HMA Roundup – Mark Trail

In an unexpected move, the State released an RFQC (request for qualified contractors) related to the State's eligibility system redesign. The RFQC is meant to "screen" potential bidders that are qualified to respond to the RFP when it is issued next year. The eligibility system redesign contract is expected to encompass the Medicaid, TANF and SNAP programs and is estimated to be in the $50 to $100 million range. Potential bidders may include Maximus, PSI, Deloitte, Accenture, HP and others.

Illinois

HMA Roundup – Matt Powers / Jane Longo

The fall legislative session ended last week, with the legislature failing to move on enabling legislation for the state health insurance exchange. The legislature also did not bring up a proposed hospital provider tax bill. The legislature will meet for one day at the end of November but is not expected to act on either of these issues.

The Illinois Medicaid Advisory Committee (MAC) Care Coordination Subcommittee held a public meeting on Tuesday, November 15 to discuss performance and quality measure development for Coordinated Care Entities (CCEs) that will operate under the State's care coordination initiative. The State will issue an RFP for CCEs in January, 2012, with a follow-up RFP for managed care plans later in the year. The State is required to have 50 percent of the Medicaid population in some form of care coordination by 2015.

After a major kickoff to a Medicaid payment reform initiative this summer, there has been little significant news out of the state or the provider community on the progress of this effort and the state has yet to release draft payment rates to hospitals. Legislation will likely be introduced this coming spring with a goal of a redesigned payment system by the end of 2012. There is a meeting of the Technical Advisory Group scheduled for after the Thanksgiving holiday, which could provide significant detail on the structure of rate reform moving forward.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The Pennsylvania Department of Public Welfare (DPW) is soliciting proposals from licensed, risk-assuming private sector behavioral health managed care organizations (BH-MCOs) to become a Primary Contractor to manage the purchase and provision of behavioral health services in the Commonwealth's mandatory managed care program, HealthChoices. The RFP covers Medicaid beneficiaries residing in the 23-county North/Central State Option zone where Community Care Behavioral Health (CCBHO), a subsidiary of UPMC, is the incumbent MBHO. In addition, two counties (Lycoming and Clinton), which are currently served by CBHNP, a subsidiary of AmeriHealth Mercy, may be added to the scope of the RFP.

The term of the Agreement is anticipated to be July 1, 2012 through June 30, 2017. At its option, DPW may extend the Agreement on the same terms and conditions for one additional three-year period. The pre-proposal conference is on November 21, 2011, and proposals are due January 4, 2012.

Regarding the budget, Pennsylvania collected $1.8 billion in General Fund revenue in October, which was $67.1 million, or 3.6 percent, less than anticipated. Fiscal year-to-date General Fund collections total $7.7 billion, which is $282.1 million, or 3.6 percent, below estimates. Revenue spokeswoman Elizabeth Brassell said that the level of collections was more than the $1.76 billion collected in October 2010, showing some signs of economic growth. Of the State's three major revenue-raisers, only sales tax collections ran higher than expected, while personal income and corporate taxes combined fell nearly $91 million below what was estimated. Brassell attributed the sales tax boost to an uptick in motor vehicle sales last month.

OTHER HEADLINES

Arkansas

- **DHS hires new state Medicaid director**

  Andy Allison, a top official in the Kansas Department of Health and Environment, has been named director of the Arkansas Department of Human Services Division of Medicaid Services. Allison takes over as work groups are hammering out details of a plan to change the way the state Medicaid program and private insurers pay for health care services in Arkansas. In a statement released by DHS, Allison said the culture of the Medicaid program and all of health care must change for states to contain Medicaid spending and improve health outcomes for patients who rely on the program. (Arkansas News)

Colorado

- **Uninsured grow: Survey shows 16 percent of Coloradans lack health insurance**

  The number of Coloradans without health insurance jumped 151,000 from two years ago as the eroding economy undermined state efforts to expand coverage, according to a comprehensive survey on health care access. The portion who are uninsured jumped from 14 percent of the population to 16 percent since 2008-09, according to the Colorado Health Access Survey by the Colorado Trust and Colorado Health Institute. Adding in those who are "underinsured," or paying more than 10 percent of their income for out-of-pocket health services above and beyond insurance premiums, the combined number reaches 1.5 million Coloradans, survey officials said. Anticipating arguments that the sample exaggerates the problem by counting people who only lose insurance for a few weeks, the survey said 60 percent of the uninsured lacked a policy for a whole year or more. (Denver Post)

Florida

- **Move Medipass recipients to full managed care, high-ranking Florida Senate Republican says**

  As Florida waits for a federal decision about overhauling the state's Medicaid program, a top Senate Republican said Tuesday he supports moving more than 400,000 beneficiaries into HMOs or another type of managed-care plan. The proposal, backed by Senate Health and Human Services Appropriations Chairman Joe Negron, would be an interim step and would affect people in 31 counties who are enrolled in what is known as the "MediPass" portion of Medicaid. The state Agency for Health Care Administration estimated that shifting those beneficiaries into HMOs or another type of managed-care plan, known as provider-service networks, could save as much as $87 million a year. (The News-Press)

- **Florida's push for specific waiver in health-care law could have big implications**

  Florida is taking issue with a regulation requiring insurance companies to spend at least 80 percent of premiums on medical costs. The state wants the Obama administration to waive the spending requirement for Florida insurers, a move that critics say would roll back a crucial consumer protection in the health-reform law. Officials in Florida say the waiver is essential to keep insurers from packing up and moving their business out of state. (Washington Post)

Kansas

- **Kansas moves ahead on health insurance exchange**

  Members of the Special Committee on Financial Institutions and Insurance recommended that the Legislature approve continuing to build a state-run exchange when it reconvenes in January. The committee's recommendation followed a day-long hearing during which business groups and others argued that the federal law would drive up costs for many consumers and cause many employers to stop offering health coverage to the nearly 45 percent of Americans who are covered by plans at work. (Kansas Reporter)

Louisiana

- **LSU signs with 4 Medicaid health providers**

  LSU's health division has signed on with four private health plans that would provide the care for some 900,000 of the state's Medicaid recipients beginning next year. SU signed agreements with AmeriGROUP Louisiana Inc., Amerihealth Mercy of Louisiana Inc., Community Health Solutions of America, Inc., and UnitedHealthcare of Louisiana, Inc. (NOLA.com)

Maryland

- **New Maryland health program promotes care for the whole patient**

  Maryland has selected 52 primary care practices from about 200 applications to take part in a care coordination program, which began in May and will run for three years. About 245,000 patients are in the program. All five of the state's largest commercial health insurance plans — CareFirst, Cigna, Aetna, Coventry and United Healthcare —

as well as the state Medicaid program are joining to provide about $6 million a year to practices for additional staff, training and technology upgrades. Despite tight budgets and cost pressures, the state and the insurance companies are betting that these upfront investments will save money and improve care in the long run. The new payments to the practices are in addition to fees doctors currently receive from insurers or Medicaid for office visits and other services. Practices also will receive 50 percent of any savings in total patient costs resulting from, for example, fewer avoidable hospital admissions and emergency room visits. (Washington Post)

New Jersey

- **Medicaid Seeks to Bring Managed Care to Behavioral Services**

New Jersey is seeking federal approval to redesign its system for providing behavioral health services to Medicaid members -- one of the many changes the state Department of Health (DHS) proposed in the Comprehensive Medicaid Waiver it submitted in September. If the plan is approved, it would mark the first time that adult Medicaid beneficiaries with mental illnesses and addictions would be administered by a behavioral health managed care provider. The DHS has long used managed care to deliver physical health services to most of the Medicaid population. Advocates for the behavioral health community said they welcome many of the proposed changes, but caveats and concerns remain. Some question the program's aggressive timetable. (NJ Spotlight)

South Carolina

- **South Carolina's Waiting Game On Health Insurance Exchange**

South Carolina's top health official will recommend this week that the state decline creating its own health insurance exchange. Instead, the state should let the federal government build the insurance marketplace in the state for now. That recommendation is expected to go to a committee appointed by the governor to study the issue on Friday. If a state does nothing, Washington is required to step in and build an exchange by 2014. That thinking — as well as a list of technical and logistical problems — is swaying decision-makers in other states too, industry analysts say. (Kaiser Health News)

Virginia

- **State could face new budget cuts**

Virginia could face a budget shortfall of as much as $1.5 billion in the next two-year budget cycle that would require more state spending cuts, members of a key House of Delegates committee learned Tuesday. Revenue growth won't be strong enough to meet expected cost increases in Medicaid, public education and pension obligations during the two-year budget cycle that begins July 1, the House Appropriations Committee was told at its retreat in Staunton. The state could face a general fund budget shortfall ranging from $885 million to $1.5 billion for the two-year period that begins July 1, according to a briefing provided to committee. (Roanoke Times)

Washington

- **State ending limits on Medicaid ER visits**

  A court ruling Thursday is forcing Washington to temporarily repeal rules that seek to limit Medicaid coverage of emergency-room visits for nonemergency care. A Thurston County judge said the state did not follow proper procedures when it established a three-visit annual limit. Officials with the state's Health Care Authority said they are going to rework the proposal and that the ruling did not address whether the larger effort is legal. State officials implemented the rule a month ago, hoping to deter people who overuse the emergency room. About 3 percent of patients exceed the three-visit threshold in an average year, with a small group of clients exceeding 100 visits in what state officials characterize as a quest for drugs. The state projected that it would save more than $30 million over two years. (Seattle Times)

Wisconsin

- **Medicaid changes to hit community centers first**

  Community health centers, which provided care to 271,000 patients statewide and almost 78,000 in Milwaukee last year, would be among the first to see the effects of the proposed changes to BadgerCare Plus and other state health programs. The changes - approved Thursday by the legislative committee that oversees the state budget - could result in an estimated 65,000 people dropping or losing their coverage, according the Legislative Fiscal Bureau. The Department of Health Services proposed changes in the program to close a more than $500 million gap in the state budget. They include moving an estimated 263,000 people to a health plan with reduced benefits, adding copayments and increasing premiums for tens of thousands of people. The Wisconsin Primary Health Care Association supports people paying at least part of the cost of their care, said Lisa Davidson, a spokeswoman for the group. But it is worried that the increase in premiums will force some families to drop their coverage. (Journal-Sentinel Online)

United States

- **Federal Medicaid funding at risk**

  Congressman Edward Markey and 23 other representatives and senators sent a letter to the deficit reduction supercommittee Wednesday in hopes of protecting Medicaid from potential cuts. A federal match for the 12 states that expanded their health insurance programs for the poor prior to the passage of health care reform is one of many items being considered for cutbacks as the bipartisan congressional super committee tries to come up with $1.2 trillion in savings over 10 years. Such a cut could result in a $660 million hit to Massachusetts in federal Medicaid funding between 2016 and 2020 if the committee adopts the portion of President Obama's deficit reduction proposal that called for cutting Medicaid by $15 billion, according to an estimate provided by Markey's office. The other states that would be affected are: Arizona, Delaware, Hawaii, Maine, Minnesota, New York, Pennsylvania, Vermont, Washington, Wisconsin, and Washington, DC. (Boston Globe)

- **Mental health funding decreases in many states**

  A new study was released November 11 by the National Alliance on Mental Illness, showing how general fund spending on mental health programs has changed after the recession. Twenty-eight states cut funding for those with serious mental illnesses, with total cuts amounting to $1.6 billion between fiscal year 2009 and fiscal year 2012. Nine states cut funding by 10 percent or more during that time: South Carolina (39%), Alabama (36%), Alaska (33%), Illinois (32%), Nevada (28%), California (21%), Idaho (18%), Kansas (12%) and Mississippi (10%). The District of Columbia also imposed a substantial decrease, reducing its appropriations by 24 percent. Besides North Dakota, five other states increased funding by more than 10 percent: Georgia (22%), Oregon (21%), Maine (15%), West Virginia (12%) and Rhode Island (11%). The analysis does not count money spent on mental health programs through Medicaid, the state-federal health insurance program for the poor, or through specific state agencies, such as child and family authorities. It examines only general funds. (Stateline)

- **Medicaid directors to feds: Give states flexibility**

  State Medicaid directors are asking the federal government to fast-track state Medicaid improvements by emphasizing health over bureaucratic process and rapidly disseminating best practices so that states can benefit from the success of others. Under the existing Medicaid approval system, states are simultaneously asked to seek permission for and report on health care systems that other states have already found successful. The process typically takes more than a year and involves layers of duplicative reports. Often, approval is granted for a pilot study in only a few counties, requiring a whole new process for a statewide rollout. (Stateline)

PRIVATE CO. NEWS

- **Clearview's Senior Care Centers Wraps Active Day Deal**

  Connecticut private equity firm Clearview Capital completed a merger between its portfolio company, Senior Care Centers of America, and Active Day Inc., that provides a network of care centers for adults in 11 states. Specifics on the deal were not publicized. The PE firm is currently investing through its second fund. (Press release)

HMA WELCOMES…

Linda Follenweider – Chicago, IL

Linda Follenweider joins HMA's Chicago office as a Senior Consultant. Linda comes to HMA from The Advocate Health System in Chicago where she has most recently worked in care coordination in one of the busiest Emergency Departments in the state. Prior to her time at The Advocate Health System, Linda served for several years as a Nurse Practitioner and the Illinois Clinical Services Manager for Evercare and implemented best practices for vulnerable patient populations in nursing homes and chronic disease management in the community. Linda also served as the Asthma Clinical Director for the

Ambulatory and Community Health Network of Cook County and as Clinic Manager at the Chicago Family Health Center (FQHC). Linda is a certified Advanced Practice Nurse with many years of clinical experience, including serving as Family Nurse Practitioner at the Addus Healthcare-Stateville Penitentiary.

Linda earned her Bachelor of Science degree in Nursing and Master of Science degree at St. Xavier University, and her doctorate in Epidemiology at the University of Illinois – Chicago.

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 last 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)

Upcoming HMA Appearances

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

Vernon K. Smith, Speaker

December 13, 2011

Washington, DC