HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

ANNOUNCEMENT: HMA IS PLEASED TO ANNOUNCE IT IS A GLG COUNCIL PARTNER

IN FOCUS: PENNSYLVANIA MEDICAID MANAGED CARE RFP

HMA ROUNDUP: GEORGIA SELECTS NON-EMERGENCY TRANSPORTATION VENDORS; NEW YORK HEALTH SYSTEM REDESIGN PROPOSALS RELEASED; PENNSYLVANIA DOI ANNOUNCES INTENTION TO OPERATE INSURANCE EXCHANGE; INDIANA RBM RFI RELEASED

OTHER HEADLINES: ARIZONA PROVIDERS SUE TO BLOCK RATE CUTS; MEDICAID ELIGIBILITY FOR PRISONERS IN IOWA, PENNSYLVANIA, MAINE; 14 STATES RECEIVE CMS EXCHANGE GRANTS; NASBO HIGHLIGHTS ONGOING STATE BUDGET PRESSURES

RFP CALENDAR: PENNSYLVANIA RFP ADDED, HAWAII DELAYED

NOVEMBER 30, 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 MEDICAID MCO RFP RELEASED

This week, our *In Focus* section reviews the Medicaid managed care expansion RFP released by the Commonwealth of Pennsylvania on November 16. The Department of Public Welfare previously released a public Discussion Paper on the statewide expansion of the HealthChoices managed care program on August 23. HMA's September 7th Weekly Roundup included a summary and analysis of that paper.

Pennsylvania HealthChoices Overview

HealthChoices currently serves approximately 1.2 million Medicaid lives through contracts with managed care organizations (MCOs) 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 RFP expands the HealthChoices program to the remaining 42 counties in the state. Currently, 25 of the 42 expansion counties offer the Voluntary Managed Care program, under which individuals may choose to enroll in either the ACCESS Plus enhanced primary care case management (PCCM) plan or in an MCO plan.

The Department froze MCO plan expansions into new counties under the Voluntary Managed Care Program when it implemented ACCESS Plus. Since then, the only MCO plan enrollment increases in the Voluntary Managed Care program have come from new eligibles: if an MCO already operated in the county, additional consumers could opt to enroll with the MCO. Also, one MCO (Gateway) withdrew from 17 Voluntary Managed Care Program counties, remaining in only two voluntary counties by the end of 2010.[1]

Key Changes in Final RFP

The key change in the final RFP (compared to the earlier Discussion Paper) is the exclusion of seven counties from the expansion procurement process. Instead, these seven counties will be carved into the existing HealthChoices contracts (which are not being re-bid) for the Southwest Zone (Bedford, Blair, Cambria, and Somerset Counties) and the Lehigh-Capital Zone (Franklin, Fulton and Huntington Counties). As a result of this change, only 35 instead of 42 counties will be bid under this RFP reducing the lives covered by roughly 100,000. We estimate this change decreases the market opportunity under the RFP by close to 20 percent.

Another significant change is the wording that "the Department will award agreements to no more than three offerors per zone." This is a change from the Discussion Paper which limited awards to two plans per zone. The Department may ultimately only select two plans, but has the option to select three. It is likely that MCO responses to the Discussion Paper prompted this change.

[1] December 2010 Medicaid Statistical Report.

Current Market

Table 1 details June 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 – June 2011 Enrollment Snapshot of HealthChoices Counties

	HealthChoices	%
AmeriHealth Mercy (incl. Keystone)	423,691	35%
Gateway Health Plan	238,795	20%
UnitedHealthcare	176,515	15%
Health Partners of Philadelphia	167,830	14%
UPMC Health Plan	142,467	12%
Aetna	46,183	4%
Coventry	13,167	1%
Total	**1,208,648**	

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

In the 35 counties slated for expansion, 20 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. Currently, more than 63,000 Medicaid beneficiaries across these 20 counties have voluntarily enrolled in a MCO plan. Table 2 details March 2011 MCO plan enrollment in the 25 voluntary counties.

Table 2 – June 2011 Enrollment Snapshot of Voluntary Program Counties

	RFP Counties	%	Non-RFP Counties	%
AmeriHealth Mercy (incl. Keystone)	4,963	8%	0	0%
Gateway Health Plan	6,059	10%	4,869	8%
UnitedHealthcare	43,911	69%	7,742	12%
UPMC Health Plan	8,350	13%	944	1%
Total	**63,283**		**13,555**	

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

Planned Expansion

Under the proposed statewide expansion, HealthChoices will enter the remaining 42 counties not currently served by the HealthChoices program. However, as noted above, only 35 of these counties are included in the RFP. The remaining seven counties will be carved into the existing Southwest Zone HealthChoices contracts (four counties) and the existing Lehigh/Capital Zone contracts (three counties). The 35 counties will be divided into two zones – New West and New East – increasing 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	93,084	53%	183,819	64%
Voluntary MCO	31,903	18%	25,084	9%
FFS/Other	49,147	28%	80,480	28%
Total	**174,134**		**289,383**	

Source: PA Department of Public Welfare. RFP #20-11, HealthChoices Physical Health Services for the New West and New East Zones. November 16, 2011

The New West zone comprises 13 counties and roughly 174,000 Medicaid lives, the majority of which are currently enrolled in the ACCESS Plus program. The New East zone comprises 22 counties and roughly 290,000 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 one or both of the new 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. Over 275,000 of the almost 465,000 Medicaid lives in the New West and New East zones are currently enrolled in ACCESS Plus.

Market Opportunity

Between the New West and New East zones, there are roughly 465,000 TANF and ABD Medicaid lives that will be bid under the HealthChoices expansion. Assuming a PMPM capitation rate of $320, these two zones represent an annual market opportunity of nearly $1.8 billion. This is down from an estimated $2.2 billion market opportunity under the original RFP Discussion Paper. However, given the continuation of the ACCESS Plus program 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 percent of the time. Under this very conservative MCO

enrollment scenario, we estimate a combined market opportunity of more than $400 million in annualized revenue.

Scoring Criteria and Timeline

As noted above, plans will have the opportunity to bid on one or both of the two HealthChoices expansion zones. We note that the scoring criteria put forth in the RFP does not include a price component.

Evaluation Criteria	
Technical Proposal includes: • Work Statement Questionnaire/Soundness of Approach • Financial Condition • Personnel Qualifications • Prior Experience • Statement of the Problem	80%
Disadvantaged Business Participation	20%
Bonuses available for: • Enterprise Zone Small Business Participation • Contractor Partnership Program • Mentor Protégé Program • Domestic Workforce Utilization	16%

Despite the month delay in anticipated RFP release, the implementation dates for the New West and New East Zones have not changed from the state's discussion paper released in late August.

Schedule	Date
Pre-Proposal Conference	December 5, 2011
Proposals Due	January 18, 2012
Implementation - New West Zone	September 1, 2012
Implementation - New East Zone	March 1, 2013

HMA Medicaid Roundup

Georgia

HMA Roundup – Mark Trail

On November 23, Georgia's Department of Community Health announced contract awards in the non-emergency transportation broker procurement. Winning bidders were Access2Care (Atlanta), Logisticare (East, Southwest, Central) and Southeasttrans (North). We estimate that each region represents between $13 and $16 million in annualized revenue to the winning awardee. Logisticare is a subsidiary of publicly-traded Providence Service Corporation.

Indiana

HMA Roundup – Catherine Rudd

Indiana's Office of Medicaid Policy and Planning issued a Request for Information (RFI) related to its contemplated adoption of a radiology benefits management (RBM) program. The RFI essentially seeks to screen potential applicants based on their experience, capabilities and ability to hit financial targets. The state has not committed to procuring and implementing an RBM program but if it does, only those that respond satisfactorily to the RFI will be notified of the RFP and allowed to bid.

New York

HMA Roundup – Denise Soffel

The Brooklyn Health Systems Redesign Work Group released its final report. The Work Group is an off-shoot of Governor Cuomo's Medicaid Redesign Team. The Work Group is headed by Steven Berger, who also led the NYS Commission on Health Care Facilities in the 21st Century (commonly called the Berger Commission), which in 2006 issued a set of sweeping and controversial recommendations to restructure the hospital and nursing home systems in New York State and reduce excess capacity. While the current report is focused on Brooklyn hospitals, many of which are in significant financial distress, it also articulates a series of restructuring principles to drive health industry restructuring across the state. These principles include the need to create integrated delivery systems; to focus on patient-centered primary care; to institute collaborative, community-based health planning; and to strengthen governance and leadership of health care institutions. In a striking departure for New York State, the report recommends exploring innovative options for capital formation, including private investment. New York currently does not allow publicly traded companies to operate hospitals or physician practices.

The report also recommends a series of tools for change, the most controversial of which is to provide the Commissioner of Health with the authority to replace hospital board members for failure to meet their fiduciary responsibilities, and to appoint a temporary operator for health care facilities that "present a danger to the health or safety of their patients" or have operators who have failed in their obligations.

The report can be found at:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report

Additionally, the Department of Health has revised the scheduled roll-out of its health homes initiative. Phase 1 applications were due November 1, with a planned start date of January 1, 2012. Phase 2 applications are now due on February 1, 2012, with an estimated April 1 start date; Phase 3 applications are due April 21, 2012, with an estimated start date of July 1. More information at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

In the news

- **State pulls procurement for replacing flawed Medicaid payment system**

  In February 2010, DOH issued a notice to firms about its plans to replace eMedNY and required bids by Nov. 19, 2010. Three companies spent hundreds of thousands of dollars competing, including CSC, which was disqualified for failing to comply with bid requirements, according to a DOH spokesman. The two finalists prepared for an answer they had awaited for months on a contract expected to be good for $150 million to $200 million a year for the winner. Instead, they received a three-sentence letter Nov. 9 from state Medicaid Director Jason Helgerson, saying the DOH was pulling the procurement. A DOH spokesman, said CSC, whose most recent contract extension expires in June, will get another extension. That could jeopardize millions of government dollars. The federal Centers for Medicare and Medicaid Services approved CSC's last extension in 2008 and warned DOH the state could face the loss of enhanced federal reimbursement if a new system didn't seem to be on track for operation by July 1, 2012. The federal government is giving DOH time to redo its plans, which were first studied by a consultant, whose October report supported terminating the bids. (Times Union)

New Jersey

HMA Roundup – Eliot Fishman

Earlier this month, we highlighted an article discussing New Jersey's intent to implement a carve-out behavioral health managed care program as part of its broader 1115 waiver proposal. The RFP for adults is likely to be developed in early 2012 even if the waiver is still in process. Given the projected January 1 2013 implementation date with a four month readiness review preceding implementation, the RFP is likely to be released in the first quarter of 2012. The RFP will call for an ASO contract in 2013 and then phase in of risk in 2014 and beyond. Children will remain in the existing ASO contract, which is going to be modified as of July 2012 to incorporate all children's behavioral health services and substance abuse services.

Pennsylvania

HMA Roundup – Izanne Leonard–Haak

Earlier this month, the Pennsylvania Department of Insurance announced that the state will be running its own health insurance exchange once federal law allows for their creation in 2014. In announcing the decision on its website, the DOI stated "After considerable evaluation and citizen input, we are taking steps to establish a state based and state run health insurance exchange. A state run exchange will provide the most flexibility for the Commonwealth."

Earlier this year, Pennsylvania passed Act 22, which added two new eligibility groups to its Medicaid and General Assistance programs: state and county prisoners. The changes went into effect on August 22 for state prisoners and October 10 for the county correctional system. According to recent news reports, the state may generate up to $12 million in savings by implementing this change which enables it to receive federal matching funds for services that had been fully funded by the state.

Finally, Pennsylvania's seasonally adjusted unemployment rate was 8.1 percent in October, down from 8.3 percent in September. Pennsylvania's unemployment rate was below the U.S. rate of 9.0 percent, and has been below the U.S. rate for 42 consecutive months, and at or below the U.S. rate for 60 consecutive months.

OTHER HEADLINES

Alabama

- **Gov. Robert Bentley releases plan for health insurance exchange**

  A quasi-government agency would be created to operate the Alabama Health Insurance Marketplace under a proposal released today by Gov. Robert Bentley. The marketplace, if approved by the Alabama Legislature next year, would allow individuals and small business owners to comparison shop among various health insurance plans. The state exchanges are required to be running by 2014 under the Affordable Care Act, approved by Congress in 2010. Bentley and the commission he appointed agreed that it was best for Alabama to create its own plan, as opposed to the federal government-run option. (AL.com)

Arizona

- **Arizona hospitals sue to stop Medicaid cuts to health care providers**

  Arizona hospitals filed suit Tuesday to void efforts by the state to further cut what it pays health care providers for care provided to Medicaid patients. In legal papers filed in federal court here, attorneys for the hospitals contend the latest 5 percent cut, on top of an identical reduction in April and a three-year freeze in reimbursements "results in rates that are so low that they violate the mandate of federal law." That law, the lawyers said, requires that rates for Medicaid services "be consistent with quality and assure that Medicaid beneficiaries have equal access to services." Peter Wertheim, the association's vice president, said the net effect of all those moves means that the Arizona Health Care Cost Containment System, the state's Medicaid program, would be paying hospitals just two-thirds of what it actually costs them to provide care. The hospitals want a federal judge to void not only the state's actions but last week's approval of the cuts by Kathleen Sebelius, director of the U.S. Department of Health and Human Services. (East Valley Tribune)

- **Arizona Medicaid cut approved by feds**

  Federal health officials have approved an additional 5 percent reduction in the rates hospitals and other health-care providers are reimbursed for Medicaid patients, part of Gov. Jan Brewer's budget-balancing package. The rate cut, retroactive to Oct. 1, follows another 5 percent reduction in April and a rate freeze imposed in 2007. It will save the state an estimated $95 million this year, savings hospitals say comes at the expense of health-care facilities and privately insured patients. Arizona hospitals will now be paid 70 percent of what it costs to care for a Medicaid patient, said Pete Wertheim, a vice president with the Arizona Hospital and Healthcare Association. (Tucson Citizen)

California

- **Three Meetings To Address Duals Conversion**

  This week, the state begins a series of stakeholder meetings across California, all looking at different aspects of the ambitious task of converting more than one million dual eligibles to a more comprehensive model of care. The three meetings start with this week's stakeholder discussion of mental and behavioral health coverage Friday in Sacramento. The mid-December meeting in San Francisco will focus on consumer protection, and the third meeting at the end of the month in Los Angeles will deal with long-term care. The Department of Mental Health hosts a preliminary meeting examining community mental health services tomorrow in Sacramento. All meetings are open to the public and will be webcast. (California Healthline)

- **Rural medical providers say Medi-Cal cuts will slash skilled-nursing care**

  Hospital officials in California's rural counties say the latest round of cuts to Medi-Cal could leave thousands of the state's neediest people without access to medical care. At particular risk, they say, are elderly and long-term patients who need skilled-nursing care. The cuts are intended to save the budget-strapped state up to $623 million. Reimbursement rates will be trimmed as much as 10 percent, but earlier cuts blocked by legal action could also take effect, making the effective reductions 20 percent or more. (Sacramento Bee)

- **Ruling To Prompt New ADHC Transition**

  The final settlement of a lawsuit challenging the state's first Adult Day Health Care transition plan will be released tomorrow, and the federal judge in the case will issue a ruling on the settlement in two weeks. Of the approximately 35,000 frail and elderly patients who have been getting ADHC care, about 9,300 will be presumptively or categorically eligible for CBAS care. The rest of the people currently in the state's ADHC program -- about 25,700 -- will need a face-to-face evaluation to determine whether or not they qualify for CBAS. Presumably, those assessments would be completed either by the time the judge's final sign-off is due on Jan. 24, or by the end of the current ADHC benefit extension, which will run out by Mar. 1. The state has estimated about half the 35,000 beneficiaries will qualify for the new program. A federal judge is expected to issue preliminary approval of the settlement Dec. 13. (California Healthline)

- **Health benefits: Governments can't break promises, court rules**

  Health benefits for government retirees may not be eliminated if state and local governments had clearly promised workers those benefits, the California Supreme Court ruled Monday. In a unanimous decision, that state high court said retired Orange County employees may be able to show they had an implied contract that prevented the county from changing a healthcare plan in a way that caused the premiums of many retirees to skyrocket. Retirees sued the county in 2007 after it revamped the health benefit program to save money. A federal trial court sided with the county. An appeals court, which is now considering the case, asked the California Supreme Court to clarify state law in the case. The California high court sided with employees in its ruling, but said there must be clear evidence that the county promised lifetime health benefits. (Los Angeles Times)

Florida

- **Study: Florida Leads Nation In Getting More Kids Insured**

  Florida leads the nation in reducing the number and rate of uninsured children, according to a study released Tuesday. From 2008 to 2010, the number of uninsured children in Florida fell by more than 160,000 to 506,934, says the report by researchers at the Georgetown University Center for Children and Families. The state's rate of uninsured kids dropped from 16.7 percent to 12.7 percent. Florida was one of 34 states and the District of Columbia to reduce its rate of uninsured children since 2008. But there remain wide differences between states. Nevada has the highest rate of uninsured children — 17.4 percent — while Massachusetts has the lowest at 1.5 percent, according to the study which was based on an analysis of Census data. Texas leads the nation in number of uninsured kids with nearly 1 million although it was able to lower its uninsured rate to 14.5 percent from 17 percent. Nationally, the uninsured rate for children fell from 9 percent to 8 percent from 2008 to 2010, as the number of uninsured children fell by 960,000, the study said. (Kaiser Health News)

Illinois

- **State may put non-profit hospitals on tax rolls, with incentives**

  Officials of the Illinois Department of Revenue are floating a proposal that would put non-profit hospitals on the property tax rolls but minimize the burden by offering credits for free care, an about-face from the get-tough attitude of just three months ago. The department ignited a firestorm in August when it stripped charitable status from properties owned by Northwestern Memorial Hospital in downtown Chicago, Edward Hospital in Naperville and Decatur Memorial Hospital Downstate in part because they provided less than 2% of net patient revenue on free care. But a month later, Gov. Pat Quinn called a halt to any more decisions, saying the law was unclear. He has asked for recommendations on new legislation, due this spring. The tax credits could mean that non-profit hospitals wouldn't pay the same amount in tax as comparable commercial properties, according to people with knowledge of the revenue department's plan. To sweeten the deal for hospitals, a portion of the tax money could be used to increase Medicaid funding, which now provides rock-bottom reimbursement rates, those sources say. Another portion could fund primary care clinics for the poor, sources say. How the tax credits would be allocated and how much tax revenue would be directed toward Medicaid or community clinics, among other ideas, could not be determined. But the department's proposal would mean that non-profit hospitals would start paying property taxes, if at a reduced rate, providing badly needed revenue to municipalities and school districts. (Crain's Chicago)

Iowa

- **DHS wants to preserve Medicaid eligibility for jailed Iowans**

  Officials in the Iowa Department of Human Services are working to prevent some of the folks who're on Medicaid from losing their benefits if they're sent to jail. Right now, when someone on Medicaid goes to jail, their benefits are terminated. The county covers their medical bills during lock up, but when they get out they have to reapply for Medicaid benefits. Ann Weibers of the Iowa Department of Human Services says

mental health advocates say it's a dangerous cycle for some people who are taking medications. Last spring, the governor and state legislators agreed to suspend some Medicaid eligibility for up to a year while a person was incarcerated, so they don't have to reapply when released from jail. Weibers says the legislation only covered the elderly and the disabled, but federal authorities require the state to provide the same benefit to pregnant women and minors. (Radio Iowa)

Maine

- **State considers putting prisoners on Medicaid**

Medical care for inmates in the state's correctional system is expensive and the state foots the bill, although a 1997 ruling by the federal government would allow some inmates that are hospitalized to get the mostly federally funded Medicaid program. The state has not taken advantage of this opportunity until now. Current efforts are aimed at reducing state health costs for inmates until 2014, when the federal health care reform act will cover all inmates with incomes less than 133 percent of the federal poverty level. (Bangor Daily News)

Michigan

- **Health Exchange Update:**

While the Senate passed SB 693 creating the MIHealth Marketplace, which would act as a clearinghouse for insurance plans, the House is not as anxious as the governor to get that into law, as Gongwer has previously reported. The House Health Policy Committee has taken weeks of testimony on the issue and another hearing is scheduled for Thursday. But they are not debating the Senate bill, rather continuing discussion on the issue. The House may wait until after the U.S. Supreme Court rules in June on the constitutionality of the federal Patient Protection and Affordable Care Act. (Gongwer News)

Tennessee

- **BlueCross Hires Pierce As President, CEO Of TennCare MCO**

Scott C. Pierce has been named president and CEO of Volunteer State Health Plan, BlueCross BlueShield of Tennessee's Medicaid managed care organization. In this position, Mr. Pierce oversees administration of VSHP's Medicaid operations, which manages care for nearly half a million Tennesseans. Since 2006, Mr. Pierce has served as the chief financial officer and assistant commissioner of the Bureau of TennCare. (The Chattanoogan)

United States

- **States receive more flexibility, resources to implement Affordable Insurance Exchanges**

The Department of Health and Human Services (HHS) Tuesday awarded nearly $220 million in Affordable Insurance Exchange grants to 13 states to help them create Exchanges, giving these states more flexibility and resources to implement the Affordable Care Act. The health care reform law gives states the freedom to design Affordable Insurance Exchanges – one-stop marketplaces where consumers can choose a private

health insurance plan that fits their health needs and have the same kinds of insurance choices as members of Congress. The Department also released several Frequently Asked Questions providing answers to key questions states need to know as they work to set up these new marketplaces. Critical among these are that states that run Exchanges have more options than originally proposed when it comes to determining eligibility for tax credits and Medicaid. And states have more time to apply for "Level One" Exchange grants. Tuesday's awards bring to 29 the number of states that are making significant progress in creating Affordable Insurance Exchanges. States receiving funding today include: Alabama, Arizona, Delaware, Hawaii, Idaho, Iowa, Maine, Michigan, Nebraska, New Mexico, Rhode Island, Tennessee, and Vermont. (HHS.gov press release)

- **Thinking Through Health Exchanges**

  Governing.com interviews Darin Gordon, director of Tennessee's Medicaid program TennCare and vice president of the National Association of Medicaid Directors (NAMD), regarding exchange development and the issues and challenges facing states. Gordon believes many states are just beginning to understand the full range of the impact the ACA could have. (Governing)

- **States face bleak economic forecast, report says**

  Things have improved since the worst of the recession, but states still face a dire fiscal situation, according to a report to be released Tuesday by the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO). The Fiscal Survey of States says that even as states struggle with tepid revenue growth, they will be called on to spend more because of the economic distress caused by continued high unemployment. The report says that Medicaid will place the biggest budgetary burden on states. Because of increasing caseloads, declining federal help and spiraling health-care costs, state Medicaid spending is growing much faster than state revenue, crowding out funding for other priorities. Many states have streamlined their Medicaid programs in an effort to control costs. Still, officials in more than half of the states said in a recent survey that there is an even chance that their Medicaid programs will face a budget shortfall as enrollment continues to increase. (Washington Post)

- **Nominee to head Medicare viewed as a pragmatist**

  On Wednesday, the White House nominated Marilyn Tavenner to run the Center for Medicare and Medicaid Services. The announcement was made at nearly the same time that the center's current head, Donald M. Berwick, submitted his resignation. Republican senators had pledged to block Berwick's confirmation, and his recess appointment was to expire at the end of the year. Tavenner joined the Obama administration in February 2010 as Medicare's principle deputy administrator. In health policy circles, her nomination to head the agency was widely expected. It is unclear what reception she will get in confirmation hearings. Republicans have reacted cautiously to her nomination. (Washington Post)

PRIVATE CO. NEWS

- **MAXIMUS Signs Three-year Medicaid Contract with Louisiana**

  MAXIMUS announced this week that it has signed a new contract with the Louisiana Department of Health and Hospitals (DHH) to provide enrollment broker services under the state's BAYOU HEALTH Medicaid managed care program. The three-year, $11.9 million program is expected to launch in December 2011. Nearly 900,000 of Louisiana's 1.2 million Medicaid and LaCHIP recipients will transfer to BAYOU HEALTH, the state's Medicaid managed care program. Under the new contract, MAXIMUS will provide choice counseling and enrollment services to members on the state's five health managed care plans, as well as general information for current and potential members through a state-of-the-art enrollment center. Through a "no wrong door" approach to enrollment, the Company will also provide members with self-service options via Web portal and interactive voice response system. (MAXIMUS news release)

- **Centene Corporation's Wellness Subsidiary Wins Disease Management Contract for State of Louisiana**

  Centene announced this week that Nurtur, its subsidiary which provides life, health and wellness programs, has been awarded a contract to provide disease management services for state employees in Louisiana. More than 180,000 beneficiaries are eligible under the contract, including employees their spouses, dependents and retirees. (Centene News Release)

- **Acadia Healthcare** a Franklin, Tenn.–based operator of behavioral healthcare facilities, has filed for a secondary public offering of 8.33 million common shares. Jefferies and Citigroup are serving as co-lead underwriters. Acadia closed trading Wednesday at $9.19 per share. It was a privately-held company until earlier this month, when it went public via a reverse merger with PHC Inc. **Waud Capital Partners** is Acadia's majority shareholder, with a 78.3% ownership position.

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 revised Pennsylvania RFP timeline. Additionally, we have included the delayed dates in the Hawaii RFP. Finally, we note that the Kentucky RBM RFP was pulled after the state decided to carve that benefit into its recently awarded MCO contract.

Date	State	Event	Beneficiaries
November 16, 2011	Pennsylvania	RFP Released	465,000
December 2, 2011	Hawaii	Proposals due	225,000
December 2, 2011	Washington	Proposals due	800,000
December 6, 2011	Nebraska	Proposals due	75,000
December 13, 2011	Missouri	Proposals due	425,000
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 17, 2011	Hawaii	Contract awards	225,000
January 17, 2012	Washington	Contract awards	800,000
January 18, 2011	Pennsylvania	Proposals due	465,000
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
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
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	175,000
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	290,000
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
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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

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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