HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup: Trends in State Health Policy

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IN FOCUS: PART ONE OF A TWO-PART SERIES ON MEDICAID MANAGED CARE RFPS

HMA ROUNDUP: UPDATES FROM CALIFORNIA, FLORIDA, GEORGIA, NEW YORK, NEW JERSEY, TEXAS, AND WASHINGTON DC

ALSO MAKING HEADLINES: WHITE HOUSE ENDORSES EARLY OPT-OUT OF KEY ACA PROVISIONS; GOVERNORS AND WHITE HOUSE SPAR OVER MEDICAID COSTS; PENNSYLVANIA ELIMINATES ADULTBASIC PLAN; WISCONSIN GOVERNOR SEEKS TO LIMIT LEGISLATURE'S INPUT INTO MEDICAID PROGRAM CHANGES;

UPCOMING APPEARANCES:

BARCLAYS CAPITAL 2011 GLOBAL HEALTHCARE CONFERENCE (MARCH 15, 2011)

MARCH 2, 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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INTRODUCTION

We hope you enjoy our second issue of the Health Management Associates *Weekly Roundup*. Our goal is to provide you with in-depth research and analysis on the latest issues in state health policy, leveraging the experience and insights of Health Management Associates' 62 Principals and Senior Consultants, most of whom joined the firm after long and successful careers leading state-sponsored healthcare programs. Our *In Focus* topic this week is part one of a two-part series reviewing states' plans to expand their Medicaid managed care programs. In this issue, we review near-term expansion opportunities in states that have either already issued a request for proposals (RFP) or where new categories of beneficiaries are being transitioned into incumbent plans. After the *In Focus* section, we provide updates on the latest developments in state Medicaid programs through a roundup of news from HMA's 11 offices. We hope you find the content informative and useful. In order for you to get a sense for the type of material the *Weekly Roundup* will cover, this issue is complementary. Beginning with the March 9th issue, access to the *Weekly Roundup* will be on a subscription basis.

Thank you for your interest,

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IN FOCUS: MEDICAID MANAGED CARE RFPS

This week, our *In Focus* section looks at how Medicaid managed care RFP activity is shaping up in 2011. As states grapple with gaping budget deficits and federal requirements that restrict their ability to reduce Medicaid expenditures through traditional means, many are contemplating mandatory Medicaid managed care programs for the first time or considering expansions of existing programs. This is certainly not a new phenomenon for those that have followed the Medicaid managed care sector the last ten years, though the pace of expansions and the willingness on states' parts to include the aged, blind and disabled (ABD) is unprecedented in our experience. Based on our analysis of current and pending Medicaid managed care expansions/reprocurements, we estimate the total pipeline represents approximately $40 billion in annualized expenditures including 11 states considering transitioning ABD beneficiaries into managed care. Given the current pace of activity emerging from the states, this figure could rise even higher by the end of the current legislative sessions.

The Medicaid managed care companies have supported this view in providing projections of the magnitude of potential activity. In recent investor communications by the publicly-traded managed care organizations (including UnitedHealth, Amerigroup and Centene) the pipeline of activity is estimated to be $33 billion to $40 billion. We note that in 2010, states spent a total of $80 billion on Medicaid managed care, or 21% of program spending, suggesting a pipeline opportunity equivalent to roughly half of the current market. Even after accounting for the pipeline, we estimate that less than a third of total Medicaid spending would be conducted through managed care organizations.

	FY 2010 ($B)
Medicaid - MCO	$80
% of total	*21.0%*
Estimated pipeline	$40
% of total	*10.5%*
MCO + Estimated Pipeline	**$120**
Total Medicaid spending	$382
MCO+pipeline % of total	*31.5%*

Source: CMS-64 Medicaid Financial Management Report

The opportunities captured in the pipeline figure referred to above include states rebidding current contracts, introducing Medicaid managed care programs for the first time, expanding existing Medicaid managed care programs to new eligibility categories/geographies, and/or carving additional services into existing managed care contracts. Some of the expansions quantified above represent more visible, near-term opportunities while others may evolve over time and in markets that may be known to the Medicaid managed care organizations (MCOs) themselves but haven't been disclosed publicly at this time.

With that, we are providing a two-part review of Medicaid managed care expansion opportunities underway or in development. Part one focuses on the near-term (2011) opportunities around which there is the greatest level of visibility. These include situations where state have issued an RFP or are transitioning additional eligibility categories into existing programs with incumbent vendors. As the table below indicates, we identity 7 such opportunities totaling 925K lives and $5.2 billion in annualized expenditures.

Near-term Medicaid Managed Care Expansion Opportunities[1]

	Populations covered	Status	Members	Market Opportunity ($M)
South Carolina	TANF	Member transition pending	80,000	$200
California SPD	ABD	Member transition pending	380,000	$2,100
Illinois	ABD	Member transition pending	35,000	$290
West Virginia	ABD	Member transition pending	55,000	$290
Pennsylvania SW	TANF	Contract awards pending	300,000	$1,100
California - Stanislaus	TANF	Contract awards pending	50,000	$120
Arizona (ALTCS)	LTC	RFP	25,000	$1,100
Total			**925,000**	**$5,200**

In the following discussion, we provide additional detail on these opportunities where we consider the visibility of structure and timing to be greatest. Next week, our *In Focus* section will look at emerging opportunities including large scale expansions under consideration in Texas, Louisiana and Kentucky.

Near Term Expansion Opportunities

South Carolina

Status: Contracts awarded, member transition pending (April 2011)

On January 11, 2011, the South Carolina Department of Health and Human Services announced that 80,000 additional Medicaid beneficiaries will be required to select a health plan or Medical Homes Network (MHN) beginning in April. This expansion of the state's Healthy Connections Choices program increases the total enrollment base from current 529K to over 600K. We estimate the additional membership will increase total Medicaid managed care spending in the state by approximately $200 million. The new members will choose from the existing options, including four health plans and one MHN, or one of the two new MHNs that the state is recommending for approval, Carolina Medical Homes and Palmetto Physician Connections. The table below lists the membership and market share of the current plans in the state.

[1] TANF refers to groups that are related to the Temporary Assistance for Needy Families (TANF) cash assistance program, which includes parents, children and pregnant women. LTC is long term care.

South Carolina Medicaid Managed Care Enrollment, February 2011

	Feb-11	% of Total
First Choice/Select Health	206,373	50.5%
Absolute Total Care (Centene)	87,920	21.5%
Unison Health Plans	73,513	18.0%
BlueChoice Health Plan	40,736	10.0%
Medically Complex Children's Waiver	79	0.0%
Total	**408,621**	

Source: South Carolina Department of Health and Human Services

California: Seniors and Persons with Disabilities (SPD)

Status: Member transition pending (June 2011)

Beginning June 1, 2011 approximately 380,000 Seniors and Persons with Disabilities (SPD) that are not also enrolled in Medicare will transition from the Medi-Cal fee for service (FFS) program to managed care plans on a mandatory basis. The beneficiaries will shift into one of the full-risk managed care plans that already operate in their county of residence. The mandate will be implemented by county on a rolling basis beginning June 1, 2011. Beneficiaries will choose from at least two plan options in every county and will be assigned to a plan if they do not make a choice. Potential enrollees may request a medical exception from enrollment if they have a major health issue being treated by a provider that is not part of the contracted network of the managed care plans. Enrollees may also request up to one year of "continuity of care" with a primary care provider not in the plan's network. In this case, the plan must pay the provider at either plan contract rates or Medi-Cal fee for service rates. As all of the existing plans will be required to assume the SPD enrollees who have selected that plan, no RFP is being conducted as part of this expansion of the existing managed care program.

In the table below, we estimate the number of enrollees that will transition into the existing plans based on current market share in the relevant counties. Assuming an enrollment distribution consistent with current market share, LA Care health plan would add 100K SPD beneficiaries, or 26% of the total, followed by Health Net (86K), WellPoint (48K), Inland (48K) and Molina (22K).

Medi-Cal Managed Care Enrollment, January 2011

Plan Name	Enrollment Jan-11	% of total
L.A. Care Health Plan	854,928	26.3%
Health Net	737,407	22.6%
Total Anthem	409,094	12.6%
Total Inland	409,657	12.6%
Total Molina	189,561	5.8%
Alameda Alliance For Health	102,147	3.1%
Community Hlth Grp Partner	103,563	3.2%
San Francisco Health Plan	39,952	1.2%
Santa Clara Family H.P.	101,905	3.1%
Kern Family Health Care	108,192	3.3%
Health Plan of San Joaquin	79,645	2.4%
Contra Costa Health Plan	62,210	1.9%
Total Kaiser	41,254	1.3%
Care1st Partner Plan, LLC	16,160	0.5%
	3,255,675	

Source: California Department of Health Care Services, HMA estimates

Based on an approximate Medi-Cal payment rate of $450 to $500 per member per month (consistent with estimated FFS costs according to a Mercer rate analysis), we estimate the total market opportunity to be $2.0 to $2.3 billion on an annualized basis. We note that there has been discussion recently among the plans and the actuaries over the adequacy of the rates. HMA Principal and former Medi-Cal Director Stan Rosenstein notes that the 10 percent year one cost savings assumed in the rate development analysis is the largest such target the state has ever incorporated into its managed care rates. Earlier the state responded to concerns by the plans and made some upward adjustment to the rates, arriving at the 10 percent savings amount. Since that time, objections to the current rate forecasts appear to have quieted down.

Illinois – Aged, Blind and Disabled (ABD)

Status: Contracts awarded, member transition pending (TBD)

On September 9, 2010, the Illinois Department of Healthcare and Family Services selected IlliniCare Health Plan (Centene) and Aetna Better Health to serve 35,000 ABD beneficiaries in the state, mostly in counties surrounding Chicago. The agreement was part of a pilot program to expand Medicaid Managed Care Services to the ABD and LTC populations. The expansion was originally intended to go live on January 1, 2011; however the program is not yet operational and a revised start date has not been disclosed. HMA's understanding is that contracting efforts between the health plans and hospitals are moving more slowly than anticipated. Based on rate data made available by the state, we estimate the market opportunity associated wth this program to be approximately $290 million. We note that there is a second phase of the implementation that would transition an additional 2,000 institutionalized LTC beneficiaries into the

capitated managed care program beginning at a later date. To the extent this stage actually materializes, we estimates it would represent an additional $120 million opportunity to the selected plans.

Illinois Medicaid Managed Care Enrollment, January 2011

	Jan-11	% of Total
Current program		
Harmony Health Plan (WellCare)	140,270	60.6%
Family Health Network	54,717	23.6%
Meridian Health Plan	1,467	0.6%
Chicago Reach	285	0.1%
New program (estimated enrollment)		
IlliniCare Health Plan (Centene)	17,423	7.5%
Aetna Better Health	17,423	7.5%
Total	**231,584**	

Source: Illinois Department of Healthcare and Family Services

California – Stanislaus County

Status : Awaiting contract awards

On February 14th, 2011, RFP responses were received by Stanislaus County from health plans interested in serving as the Local Initiative Medi-Cal Managed Care health plan. Stanislaus County utilizes the "two-plan" managed care model in which beneficiaries have a choice of enrolling in either a "local plan" or a "commercial plan". The Stanislaus RFP is only for the Local Initiative piece of the plan which currently covers 50,000 members with only one incumbent, Anthem Blue Cross. The contract duration is 5 years with potential one year extensions for up to three additional years. We estimate total spending associated with this contract to be roughly $120 million per year.

According to the RFP documents, an RFP was released in 2008 by Stanislaus County to identify a potential new health plan to serve as the local initiative. This effort occurred while Anthem Blue Cross had issued a termination notice to DHCS. No policy decision resulted from the RFP process. Anthem Blue Cross rescinded the termination notice and continues as the Local Initiative.

Health Net was named Stanislaus County's Commercial Plan in August, 2005 and will be unaffected by this RFP.

Pennsylvania

Status : Awaiting contract awards

On October 29, 2010, Pennsylvania issued an RFP to procure the services of MCOs to operate the HealthChoices Physical Health program in the SW Zone. The SW Zone includes the counties of Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland. The RFP is a re-bid of existing business with an estimated contract size of $1.1 billion, approximately $500 million of which is attributable to Alleghany County and $600 million of which is attributable to the remaining 9 counties.

The Department will enter into agreement negotiations with no more than five MCOs. Participation in the HealthChoices SW program will be limited to HMOs that have been licensed by the Commonwealth of Pennsylvania. The SW Zone is currently served by three incumbents: Gateway Health Plan, Unison Health (UNH), and UPMC for You. Other operators of the HealthChoices program in the state are Aetna, AmeriHealth, Coventry Cares, Health Partners, and Keystone Mercy. Current membership and market share information for the SW Zone is as follows:

SW Pennyslvania Medicaid Managed Care Enrollment, January 2011

Incumbent	Membership	Market Share
Gateway Health Plan	116,211	39%
Unison Health Plan (UNH)	59,777	20%
UPMC for You	123,110	41%
Total	**299,098**	

Source: Pennsylvania Department of Public Welfare, RFP 11-10

Contract Details

The agreement will commence on January 1, 2012 and will end after 5 years with an optional extension period of 3 years. The contract is for a full risk capitated agreement. There is an estimated 91% Medical Loss Ratio (MLR) minimum for the contract.

Arizona Long Term Care System (ALTCS)

Status: RFP released, bids due 4/1/2011

On January 31, 2011, the Arizona Health Care Cost Containment System (AHCCCS) issued an RFP for a rebid of its existing Arizona Long Term Care System (ALTCS) program. AHCCCS is the nation's oldest Medicaid managed care program, in place since 1982, and the ALTCS program serves the state's elderly, physically disabled and developmentally disabled populations. The RFP pertains only to the managed care organizations that provide LTC services for the elderly and physicially disabled beneficiaries of which there are just over 25K enrolled currently. The table below lists the organizations currently participating in the ALTCS program and their enrollment as of the beginning of this year.

ALTCS Medicaid Managed Care Enrollment, January 2011

Incumbent	Membership (1/11)	Market Share
Mercy Care LTC	8,633	34.1%
Pima County LTC	4,337	17.1%
Bridgeway Health Solutions (Centene)	3,059	12.1%
EverCare Select (UnitedHealth)	2,996	11.8%
SCAN-LTC	2,910	11.5%
Pinal County LTC	1,498	5.9%
Yavapai County LTC	987	3.9%
Cochise HealthSystems	871	3.4%
Total	**25,291**	

Source: Arizona Health Care Cost Containment System (AHCCCS)

The RFP does not contemplate a service area expansion or eligibility category expansion. As such, using the FY 2010 average per member per month (PMPM) rate of $3,300, we estimate the contract size to be in the $1.0-$1.2 billion range with awards currently scheduled to be announced May 9th for an operational start date of October 1.

There are seven geographical service areas (GSA). The state will select one plan in each region other than Maricopa where it will select three. We note that there are currently four plans operating in Maricopa so one organization will be eliminated.

ALTCS Enrollment by County

Counties	GSA	Enrollment	% of total	Incumbent	# of Awards
Maricopa	52	15,296	60.5%	Mercy Care LTC, Bridgeway Health Solutions (Centene), EverCare Select (UnitedHealth), SCAN-LTC	3
Pima, Santa Cruz	50	4,337	17.1%	Pima County LTC	1
Pinal, Gila	40	1,498	5.9%	Pinal County LTC	1
Apache, Coconino, Mohave, Navajo	44	1,492	5.9%	EverCare Select (UnitedHealth)	1
Yavapai	48	987	3.9%	Yavapai County LTC	1
Cochise, Graham, Greenlee	46	871	3.4%	Cochise HealthSystems	1
La Paz, Yuma	42	810	3.2%	Bridgeway Health Solutions (Centene)	1

Source: Arizona Health Care Cost Containment System (AHCCCS)

There is a price component of the bid. AHCCCS will publish a capitation rate range for each GSA. The ranges to be used for this RFP will be in the lower half of the actuarially sound rate range determined by GSA as developed by the AHCCCS actuary. AHCCCS will only evaluate the Offeror's full long term care capitation rates. In order for the bid to be considered, it must be within the published range.

Services Covered

- Acute Care
- Nursing facility
- ICF/MR
- Hospice
- Behavioral Health
- Home and community based (HCBS)

Timeline

Procurement Schedule*	
1/31/2011	RFP Issued
2/9/2011	Vendor conference
4/1/2011	Proposals due
5/9/2011	Tentative award announcement
10/1/2011	Operational start date

Source: Arizona Health Care Cost Containment System (AHCCCS)

West Virginia

Status: Member transition pending (TBD)

West Virginia planned to transition 55,000 ABD beneficiaries to it is Medicaid managed care program in early 2011, equaling a total market opportunity of approximately $270

million. The additional lives were to be awarded via a no-bid contract to the three incumbent MCOs in the state, Unicare (Wellpoint) , Carelink (Coventry), and the Health Plan of Upper Ohio. The three incumbents currently service over 160,000 members in the state TANF program that is currently valued at $290 million. The plan is temporarily on hold as the initial arrangement to move forward with no-bid contracts met heavy opposition from state lawmakers. Nevertheless, the state anticipates completing the transition by the end of the year.

West Virginia Medicaid Managed Care Enrollment, February 2011

Plan Name	Members As of 2/11	Market Share
Unicare	83,154	49.3%
Carelink	57,751	34.2%
Health Plan of Upper Ohio	27,758	16.5%
Total MCO	**168,663**	

Source: West Virginia Bureau for Medical Services

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

A judge is reviewing whether or not to extend a restraining order that prevents the state from freezing Medicaid hospital rates for non-contract hospitals. If the order isn't extended, the freeze will go into effect immediately. Since non-contract hospitals' rates are set at 90% of costs, as costs go up, so do rates.

Budget Update: This week, the conference committee will begin to meet and reconcile differences. It is expected that the 10% provider rate reductions will be included in the final budget, subject to a federal judge's ruling on the state's appeal of the 9th Circuit Court's decision that rate reductions are impermissible due to the impact on beneficiary access. Additionally, the final budget is expected to include the adoption of beneficiary co-payment increases (subject to federal waiver), and the adoption of some benefit limits, such as over-the-counter cold medicine. The proposals to limit the number of prescription drugs or doctors visits will not be in the final budget. Finally, at this time, negotiations continue on whether or not to put the $12 billion in tax extensions on the ballot in June. Republican votes in the Assembly will be required to do so.

In the news

- Ruling on Medi-Cal reimbursement rates next week, federal judge says (Sacramento Bee)
- Despite medical parole law, hospitalized prisoners are costing taxpayers millions (LA Times)

Florida

HMA Roundup – Gary Crayton

Budget Update: There are no committee meetings this week, but the session starts Wednesday, March 8th, with additional workshops beginning next week as well. The Senate budget bill has not been formally filed and does not yet have a bill number, but should be filed sometime this week. The lack of a bill number means that changes can still be made to the Senate bill. The House Bill should also be out by the second week of the session at the latest, but our expectations is that it will resemble the Medicaid reform bill that passed in the House last year. In terms of budget savings, there have been talks of cutting benefits to the medically needy eligibility group which could result in savings of up to $1billion.

In the news

- One of the biggest private investment firms in the U.S. is behind bid to buy Jackson Health (Miami Herald)

Georgia

HMA Roundup – Mark Trail

With the legislature halfway finished, the key Medicaid issue focuses on the 1% rate cut to providers. Since the state has to pay back a $500million loan for unemployment benefits, the a large rate cut may be needed in order to repay the loan. Given that the initial legislative hearing on the issue just took place, Georgia has not requested a waiver yet, but this is not a static position.

As was disclosed last week, the Georgia Medicaid managed care RFP has been delayed. The state plans to hire an external consultant to evaluate and make recommendations regarding key elements of the program including the potential inclusion of ABD beneficiaries.

In the news

- Snapshots of health care legislation (Georgia Health News)
- Hudgens said Georgia should create its own insurance exchange (ajc.com)

New York

HMA Roundup – Deborah Zahn

On February 24, 2011, the Medicaid Redesign Team presented Governor Cuomo its report outlining short-term recommendations to meet the Governor's Medicaid spending target of $52.8 billion in the fiscal year that begins April 1. That is a decrease of $982 million or 2 percent from current year authorized spending. The report introduces a global cap on State Medicaid expenditures of $15.109 billion and includes 79 recommendations aimed at reducing Medicaid spending and making the program more efficient and effective. The recommendations and estimated savings include:

- Transition long-term Certified Home Health Agency Services patients to Managed Long-Term Care - $100 million
- Reduce the profit component included in the calculation of plan rates from 3% to 1% for the Medicaid and Family Health Plus managed care programs. - $94 million
- Move the New York State Medicaid Pharmacy program under the management of Medicaid Managed Care - $50 million
- Eliminate funding included in Medicaid and Family Health Plus premiums for direct marketing of Medicaid recipients for Managed Care – $22.5 million
- Implement a uniform surcharge on surgery and radiology services provided by physicians in office-based settings, including non-licensed urgent care centers – $57.8 million
- Eliminate the "return on" and "return of" equity and residual reimbursement provided in the capital nursing home rate for proprietary nursing homes – $43.5 million
- Consolidate all pharmacy fee-for-service proposals into one reform package that includes several initiatives that optimize rebate opportunities, reduce waste, rationalize coverage and reimbursement, or remove statutory limits that drive cost – $89.4 million
- Enhance and improve the State's Medicaid program integrity efforts through coordination of audit and other fraud, waste and abuse activities, and collaboration with other State and Federal entities – $80.3 million
- Reform personal care services program in New York City – $57 million
- Reduce fee-for-service dental payments to match rates paid by managed care providers on high volume dental procedures – $27.7 million
- Implement patient management/care coordination for high cost, high need patients and secure a 90% federal match through the ACA – $33.2 million

The report also recommends an additional $17.41 million spending to expand the State's current Patient-Centered Medical Home Program.

Although Governor Cuomo has accepted the recommendations, there are still some changes expected due to opposition from different industry groups to specific recommendations, alternative savings proposals being negotiated, and negotiations during the legislative budget process. Many of the recommendations also will require a federal waiver.

The Medicaid Redesign Team's next task is to develop long-term recommendations for greater savings and quality improvement. This will include developing recommendations for reducing the nearly $1.5 billion in preventable admissions and readmissions and a Voluntary Health Care Industry Cost Containment Initiative, which will enable each sector to substitute a new initiative for all or a portion of across-the-board reductions related to the global cap. The recommendations are due in November.

Link to the Medicaid Redesign Team recommendations and other information:

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

In the news

- Cuomo's budget strategy, getting adversaries to suggest cuts, is paying off (NY Times)
- New York Medicaid Panel Cuts Back (NY Times)
- State proposal would limit annual Medicaid rise (NY Times)

New Jersey

HMA Roundup – Eliot Fishman

New Jersey's Governor Chris Christie has announced four major Medicaid managed care initiatives as part of the Executive Budget. First, New Jersey's long-term care benefits for seniors and people with physical disabilities would be moved into a managed long-term care program, for projected savings of $27 million. Second, Aged, Blind and Disabled beneficiaries would be enrolled in managed care on a mandatory basis, for projected savings of $11 million. Third, New Jersey's sizable Adult Day and Personal Care benefits would be carved into the acute care managed care benefit for individuals enrolled in mainframe managed care, for projected savings of $30 million. The fourth and largest item is the proposed negotiation of a global 1115 waiver with CMS involving unspecified Medicaid benefit and cost restructuring, with projected savings of $300 million.

In the news

- Medicaid cuts crucial part of NJ budget (app.com)

Texas

HMA Roundup – Linda Wertz

The Texas legislature is still in the midst of budget negotiations with no decisions having been made yet and no deviation to date with the proposed 10% rate cut. At this point, everything is still on the table including the use of rainy day funds. There has also been little movement in terms of the Medicaid managed care RFP, but it is increasingly likely that the announcement will be delayed perhaps by a month or more. The key issues surrounding the RFP will be the pharmacy carve-out, inpatient carve-in, and the scope of geographical expansion.

In the news

- Medicaid cuts mean dim future for rural hospitals (AP Texas News)
- Experts urge Texas legislators to spare mental health care for children from budget cuts (dallasnews.com)
- Mental Health Cuts Would Strain Local Texas Jails (Texas Tribune)

Washington, D.C.

HMA Roundup - Lillian Spuria

The National Governors Association meetings are taking center stage in DC this week as governors will be using this opportunity to lobby the federal government and present position papers on health reform. Most governors will likely object to provider tax changes in the president's budget and some may even express concern regarding Medicaid savings in the budget given the fiscal pressures facing the states.

In other DC news, The Medicaid and CHIP Payment and Access Commission (MACPAC) will be issuing their first report which will be released shortly. The focus of the report will be on Medicaid financial sustainability, access to services, eligibility, and issues surrounding the integration of care for dual-eligible beneficiaries. The MACPAC report must be delivered to Congress by March 15th.

In the news

- Obama Backs Easing State Health Law Mandates (NY Times)
- States get off revenue roller coaster (stateline.org)
- Republican governors to government: Give us Medicaid grants (The Hill)
- When care is split between Medicare and Medicaid (Kaiser Health News)
- HHS to Governors: You have flexibility on health reform implementation (Kaiser Health News)
- Vague on details, health official rejects GOP govs' Medicaid pitch (The Hill)
- State Medicaid Director Letter on ACA MOE requirement (CMS)

OTHER STATE HEADLINES

Arizona

- Brewer Aims to Cut Fewer People from Medicaid (Arizona Republic)
- Arizona aide: Ending Medicaid would cripple state (azcentral.com)
- Ariz. Medicaid cuts spur debate over impact on Providers (Kaiser Health News)

Connecticut

- Malloy embraces health reform, but cautious about SustiNet (CT Mirror)

Delaware

- Delaware Government: Medicaid care heads home (delawareonline.com)

Denver

- Dems, GOP differ on health plan (denverpost.com)

Illinois

- Advocate confirms talks with Sherman Hospital (Chicago Breaking News)

Kentucky

- Kentucky Senate prepares to take on Medicaid issue (Bloomberg Businessweek)
- Senate committee rejects Beshear's Medicaid fix (bgdailynews.com)

Massachusetts

- Gov. Patrick to pitch Mass. health care cost plans (boston.com)
- Massachusetts tackles health care costs (Stateline)
- Advocates say proposed cuts would force many into nursing homes (boston.com)
- Caritas owner widens its aims (boston.com)

Michigan

- Michigan counties face big health costs (Detroit News)
- Blues, HMOs urge regulation changes (Gongwer News)

Minnesota

- GOP proposal for health fund 'overhaul' under discussion (minnpost.com)

New Mexico

- Senators grill behavioral health managing firm (SanteFeNewMexican.com)
- Lawmakers still mulling health care exchange (SanteFeNewMexican.com)

Ohio

- Hospitals offer to help ease Ohio budget deficit (Dayton Daily News)
- Ohio's new health chief focuses on doctor-patient link (Columbus Dispatch)
- Report: Medicaid Patients With Schizophrenia, Psychosis Account For Most Spending (Gongwer News)
- Insurers tout plan to cut Medicaid costs (Columbus Dispatch)

Pennsylvania

- PA's adultBasic health insurance runs out of funds, shuts down (Philly.com)
- Facing budget pinch, states cut insurance (NY Times)

North Carolina

- Blue Cross denies ill intent on health reform (newsobserver.com)

South Carolina

- Critics: Impact of Medicaid cuts would be huge (thestate.com)
- Budget plan cuts education, health care (thestate.com)

West Virginia

- CCMH and SJH merger finalized (newsandsentinel.com)

Wisconsin

- Wisconsin Union Battle Masks Medicaid Tensions (Kaiser Health News)
- Budget aims to end growth of Medicaid programs in state (Wisconsin State Journal)

HMA Recently Published Research

Medicaid Enrollment: June 2010 Data Snapshot – Kaiser Commision on Medicaid Facts

Medicaid enrollment increased nationwide by 7.2 percent, or 3.37 million, between June 2009 and June 2010, exceeding 50 million enrollees for the first time in the program's history. Medicaid enrollment has grown by 7.6 million (17.8 percent) since the start of the recession in December 2007.

Link to report

New Opportunities for Addressing Behavioral Health Needs and Other Options in the ACA

The Patient Protection and Affordable Care Act (ACA) offers an important opportunity for states to improve health care for people with chronic conditions and behavioral health needs, and potentially contain long-term costs. In the December 2010/January 2011 issue of the Commonwealth Fund's *States in Action* newsletter, HMA's Sharon Silow-Carroll, Principal, and Diana Rodin, Consultant, define health homes, discuss the ACA provision and the latest federal guidance to states, and present opportunities and options for states to pursue.

Link to report

Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports

This report is a comprehensive analysis of the impact of the recession for both Medicaid and non-Medicaid funded long-term services and supports (LTSS) in each state. Based on

a survey of 50 states, territories, and the District of Columbia, this report explores how the recession affects state services and supports for the aged and disabled populations as states adjust policies to deal with difficult budget constraints. It also illustrates state-by-state how LTSS are financed and provides a very early snapshot of the likelihood of states pursuing some of the LTSS provisions within the Affordable Care Act (ACA).

Link to report

Making the Investments Work: Important Benefits and Key Challenges in Implementing Health Reform in Florida

This report presents key features of the new national health reform law and explores the important potential benefits to Florida along with the main challenges. The report highlights the Medicaid expansion, health insurance exchange, and insurance market reform features of the Affordable Care Act. It also explains how the new benefits are funded and how that will affect Florida taxpayers. A few other important features of the law are briefly explained, such as the requirements placed on individuals to obtain insurance and larger employers to offer it or pay an assessment, and new grant opportunities related to improving health care delivery and financing.

Link to report

HMA WELCOMES…

Jaimie Hammerling Bern - Principal

Boston, MA

Jaimie Hammerling Bern comes to HMA from the Massachusetts Office of Medicaid, where most recently she has served as the Project Manager of the Patient-Centered Medical Home Initiative (PCMHI). In this role, Jaimie was responsible for the development and implementation of the statewide PCMHI, including contract management, developing a procurement to select primary care practices for participation, engaging public and private payers in program design and payment reform, overseeing a statewide advisory Council of diverse stakeholders, and working with providers to transform their practices and align activities with the PCMHI. Prior to this, Jaimie was the Assistant Director of Commonwealth Care, under the Commonwealth Health Insurance Connector Authority. Commonweath Care provides subsidized insurance to eligible individuals through a blend of Medicaid and commercial health plan program elements, much as the Health Insurance Exchanges will do beginning in 2014.

Earlier in her career, working in the Massachusetts Office of Medicaid, Jaimie was the Program Development Coordinator for the Office of Acute and Ambulatory Care, a consultant to the MCO Program, Acting Director/Deputy Director of the MCO Program, and a Contract Manager providing technical assistance and oversight of two start-up MCOs. She also worked as a consultant at the University of Massachusetts Medical School, and in the New York City Mayor's Office of Medicaid Managed Care.

Jaimie earned her Bachelor of Arts degree at the University of Michigan, her Masters degree in Public Health at Columbia University, and her Masters of Science in Nursing at Massachusetts General Hospital Institute of Health Professions.

UPCOMING APPEARANCES

Barclays Capital 2011 Global Healthcare Conference

On March 15, 2011, HMA Principal Dianne Longley will be presenting at the Barclays Capital 2011 Global Healthcare Conference in Miami, Florida. Topics to be addressed include an update on the Texas Medicaid managed care RFP and the potential impact on managed care organizations and providers operating in the state, the outlook for provider rate changes in the FY 12/13 biennial budget, and a status report on the implementation of key programmatic changes required by the ACA, including the creation of a Health Benefits Exchange. In addition to a presentation and break-out, Ms. Longley will be available for one-on-one meetings on Tuesday, March 15th. Please contact your Barclay's salesperson for more details.

CBI Health Exchange Summit, Medicaid and Health Insurance Exchanges

Vernon Smith and Stan Rosenstein

March 7, 2011

Alexandria , VA

IMS's Data Niche Drug Rebate Conference 2011

Vernon Smith, Keynote Speaker

March 9, 2011

Orlando, FL

2011 Michigan Developmental Disabilities Conference: "Planning for Health Care Reform - A Michigan Update"

Eileen Ellis, Keynote Speaker

April 20, 2011

East Lansing, Michigan