HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN THIS ISSUE:

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

HMA ROUNDUP: UPDATES FROM CALIFORNIA, FLORIDA, GEORGIA, INDIANA, ILLINOIS, TEXAS AND WASHINGTON DC

ALSO MAKING HEADLINES: MAINE MLR WAIVER GRANTED, GOP GOVERNORS PROMOTE MEDICAID BLOCK GRANTS; HEALTH INSURANCE EXCHANGE LEGISLATION DEBATED IN NORTH CAROLINA, TENNESSEE, WEST VIRGINIA; VERMONT CONSIDERS SINGLE PAYER MODEL

UPCOMING APPEARANCES:

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

MARCH 9, 2011

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

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IN FOCUS: MEDICAID MANAGED CARE RFPS/RFIS

This week, we provide the second installment of our two-part review of Medicaid managed care expansion activity. One *Weekly Roundup* simply could not contain the amount of Medicaid managed care business potentially out to bid over the next two years, so we decided to spread the wealth over two issues. As we discussed last week, based on our analysis of current and pending Medicaid managed care expansions/reprocurements, we estimate the total pipeline represents between $40 billion and $50 billion in annualized expenditures, or 50% of current year spending on Medicaid managed care.

Last week we reviewed seven opportunities for business expansion totaling roughly $5 billion in annualized expenditures. Since that time, an eighth opportunity in Virginia has come to our attention. Each of these represents a near-term business opportunity that we believe is likely to develop in 2011/early 2012. It includes five states moving beneficiaries from fee for service (FFS) or primary care case management (PCCM) programs into managed care for the first time and three states re-bidding existing contracts.

Near-term Medicaid Managed Care Expansion Opportunities[1]

	Populations covered	Status	Expansion enrollment	Enrollment re-bid	Members	Market opportunity ($M)
California SPD	ABD	Member transition pending	380,000	0	380,000	$2,100
Pennsylvania SW	TANF	Contract awards pending	0	300,000	300,000	$1,100
Arizona (ALTCS)	LTC	RFP	0	25,000	25,000	$1,100
Illinois	ABD	Member transition pending	35,000	0	35,000	$290
West Virginia	ABD	Member transition pending	55,000	0	55,000	$290
South Carolina	TANF	Member transition pending	80,000	0	80,000	$200
California - Stanislaus	TANF	Contract awards pending	0	50,000	50,000	$120
Virginia	TANF	Member transition pending	30,000	0	30,000	$80
Total			**580,000**	**375,000**	**955,000**	**$5,280**

Source: HMA estimates

This week, the *In Focus* section looks at Medicaid managed care program expansions that are in earlier stages of development but which will provide potential growth in 2012 and beyond. Among the opportunities evaluated are large scale reprocurements/program expansions in Texas, Florida, Louisiana and Georgia that we would characterize as high visibility future events. These four states alone represent over $30 billion in annualized spending. We also identify a number of earlier stage concepts under discussion in Illinois, Kentucky, Maine, Hawaii and Montana. In aggregate, the opportunities described below represent a 10.6 million increase in Medicaid beneficiaries covered under managed care delivery systems (including full-risk and PCCM models) and annualized expenditures of roughly $41 billion.

[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. ABD refers to the aged, blind and disabled population.

Intermediate-term Medicaid Managed Care Expansion Opportunities

	Populations covered	Status	Expansion enrollment	Enrollment re-bid	Total members	Market Opportunity ($M)
Texas	TANF, ABD	RFP Pending	1,200,000	2,070,000	3,270,000	$12,800
Florida	TANF, ABD, LTC	Legisilature	1,700,000	1,100,000	2,800,000	$12,000
Georgia	TANF, ABD	RFP Delayed	100,000	1,100,000	1,200,000	$4,000
Illinois	TANF, ABD	Legisilature	1,100,000	0	1,100,000	$4,000
Maine	TANF, ABD	RFP Delayed	270,000	0	270,000	$1,700
Louisiana	TANF, ABD	RFP Pending	875,000	0	875,000	$4,000
Washington	TANF, ABD	RFP Pending	0	700,000	700,000	$1,500
Kentucky	TANF	RFI	0	165,000	165,000	$750
Hawaii QUEST	TANF	RFI	0	215,000	215,000	$500
Montana	TANF, ABD, LTC	Legislature	20,000	0	20,000	$100
Total			**5,265,000**	**5,350,000**	**10,615,000**	**$41,350**

Source: HMA estimates

Combining the near and intermediate term opportunities, we arrive at a total market opportunity of roughly 12 million lives and $46billion in annualized spending. In the following discussion, we provide additional detail on these emerging opportunities.

In terms of visibility into the opportunities described, our current view is that the Texas and Florida reprocurements/expansions are the most likely catalysts over the next 18 months, with Louisiana pushing forward as well (RFP due out on April 11, 2011). Less clear at this point is the extent to which the ABD population will be included as part of the Georgia rebid and whether or not Maine will move forward with planned changes (the RFP was scheduled for release in May but has been delayed indefinitely). Potential opportunities in Illinois, Kentucky and Montana are in earlier stages of development with the specific delivery system changes less clearly defined (as is the case in another recently disclosed opportunity not listed above, Idaho). We have not included discussions underway in states such as New Jersey, Wisconsin and Ohio to implement or expand their managed long term care programs. Our list will be updated to include those opportunities once details emerge as to the nature of the programmatic changes to be implemented.

Finally, it is worth noting that in some cases the opportunity for risk-based managed care organizations may be mitigated somewhat by the coexistence of PCCM programs or integrated "medical home" models. For example, Louisiana will offer an enhanced, shared-savings "coordinated care" model alongside its risk-based health plans, and Florida is doing something similar with its Provider Service Networks (PSNs). We would also be surprised if Illinois were to replace its PCCM model with full-risk MCOs. To the extent PCCM options are offered side by side with Medicaid MCOs, they may absorb a material percentage of the market opportunity. For example, in South Carolina, PCCM organizations are offered alongside Medicaid MCOs and cover 23% of the market. That said, we still consider the current pipeline to be the largest we have ever seen (and growing) and note that both Texas and Florida are moving to eliminate their traditional PCCM options after running them alongside risk-based managed care plans for many years.

Texas

Status: Draft RFP released, official RFP delayed

On November 5, 2010, the Texas Health and Human Services Commission (HHSC) released a draft RFP for its Medicaid managed care program. The official RFP was original-

ly scheduled to be released on December 21, 2010, but as of March 8, it had yet to be released. The most recent official development is that a vendor conference scheduled for February 7th was cancelled. Our Texas team expects the RFP will be released after state officials have the opportunity to review vendor responses to the draft RFP and, most likely, once related issues such as coordinating continued payment under the upper payment limit (UPL) arrangement are secured. At the latest, we expect the RFP to be released by the end of the legislative session in May.

With that, we expect the official RFP to build off of the draft version. We have reviewed that document and summarize the key elements in the discussion below. Specifically, the Medicaid managed care programs that are affected by the RFP include the following:

- **STAR:** Covers acute care services primarily for women and children;
- **STAR+Plus:** Provides integrated delivery of acute care services and community-based long-term services and supports to aged, blind, and disabled (ABD) Medicaid recipients;
- **CHIP:** Provides primary and preventative health care to low-income, uninsured children; and
- **Primary Care Case Management:** This program is not included in the RFP, but is scheduled to be converted to a full-risk arrangement and individuals moved to the Medicaid "Rural Service Area" served by STAR.

The RFP contemplates a reprocurement of all existing STAR, STAR+PLUS and CHIP contracts, except for the CHIP rural service area (RSA) contracts (managed by Centene and Molina) and the Dallas/Tarrant STAR+PLUS contracts (managed by AMERIGROUP, Molina, Centene and Bravo Health), both of which were rebid last year. STARHealth, Texas' coordinated care model for children in the foster care program (managed by Centene) is also not affected by the current RFP.

In addition to reprocuring the existing contracts, the RFP contemplates four major changes to the current program structure, which we describe below.

1. *Expansion of STAR into two (2) new regions, the Hidalgo Service Area and Medicaid Rural Service Area (MRSA)*

   According to data provided on the HHSC web site, this change would shift 350,000 Hidalgo service area Medicaid beneficiaries into the STAR program, representing $900 to $950 million in annualized spending. This change would also shift 530,000 MRSA members from PCCM to the STAR program, representing $1.3 to $1.5 billion in annualized spending. As such, the combined impact of this expansion would be almost 900,000 new Medicaid managed care members representing roughly $2.3 billion in expenditures running through managed care organizations.

   While minimal public resistance to the MRSA roll-out has occurred to date, we note that the legislature is not permitted to expand managed care to three counties (Hidalgo, Cameron, and Maverick) in the Hidalgo region without changing current law. As such, this element of the expansion will not move forward unless the legislature votes to allow it, though we currently expect that to happen by the end of the current legislative session in May.

2. *Expansion of STAR+PLUS into the El Paso, Jefferson, and Lubbock Service Areas, as well as the new Hidalgo Service Area*

   In aggregate, we estimate that expanding STAR+PLUS into these regions will add 53,000 new members to the program, representing a market opportunity of approximately $500 million (including inpatient costs). We note the same restriction on extending coverage into the Hidalgo area will have to be resolved by the legislature.

3. *The addition of prescription drug benefits to the managed care structure. The prescription drug benefit will no longer be carved out of managed care.*

   In order to maximize manufacturer rebates, Texas has historically carved out the prescription drug benefit from its managed care contracts. With the Drug Rebate Equalization (DRE) provisions of the Affordable Care Act, the state can now access those rebate dollars regardless of whether the members are enrolled in managed care organizations or not. We estimate the incremental increase in per member per month (PMPM) revenue to be approximately $60 for Medicaid (STAR and STAR+PLUS) members and $25 for CHIP beneficiaries, resulting in an aggregate increase in the annual market opportunity across all regions and programs of approximately $2.4 billion. It is important to note that, as stipulated by the ACA, the full amount of the state share of federal drug rebates will flow through to the state, not the managed care organization.

   Estimated FY2013 Drug Costs by Region

Region	Medicaid	CHIP	Total
Bexar	$206,058,306	$13,297,855	$219,356,162
Dallas	$263,446,684	$25,828,383	$289,275,067
El Paso	$87,327,917	$7,121,726	$94,449,643
Harris	$460,589,338	$54,617,828	$515,207,166
Hidalgo	$273,064,086	N/A	$273,064,086
Jefferson	$71,842,789	N/A	$71,842,789
Lubbock	$58,407,970	$3,935,222	$62,343,192
Nueces	$79,988,695	$4,228,403	$84,217,098
Tarrant	$152,517,530	$18,309,281	$170,826,811
Travis	$111,700,427	$10,277,487	$121,977,913
RSA	$419,371,972	$38,741,087	$458,113,060
Total	**$2,184,315,714**	**$176,357,273**	**$2,360,672,987**

   Source: Texas Health and Human Services Commission

4. *The addition of inpatient facility services to the managed care structure for STAR+PLUS.*

   In 2005, Texas' HHSC attempted to expand STAR+PLUS to all of the regions in which STAR was already in place. In order to do so, however, the legislature would have had to sacrifice significant federal matching dollars through its inpatient upper payment limit (UPL) arrangement, a source of federal financing that is only available in a FFS reimbursement structure. The legislature opted to protect the UPL funds by carving the inpatient component out of managed care capitation rates and scuttling the planned expansion of STAR+PLUS in Dallas and Fort Worth altogether. Recog-

nizing the benefit that putting managed care companies at risk for inpatient costs would have on total spending, HHSC is once again evaluating whether or not to include those costs in the capitation rate in all counties where STAR+PLUS is in place (including Dallas and Fort Worth, where STAR+PLUS was ultimately implemented in February 2011).

Texas hospitals have already begun to resist this change, highlighting that the UPL generates $900 million of incremental federal financing to hospitals that would be lost if STAR+PLUS were expanded. On the other hand, since 2005 a number of states, including Georgia, Michigan, Florida and California, have designed work-around solutions to the UPL issue, typically by creating a Safety Net Care Pool (SNCP) from which a mixture of federal and state dollars would be appropriated in order to keep the most UPL-reliant hospitals whole. Recent news articles have suggested a compromise arrangement is in development that would enable the state to continue accessing the UPL funds.

With that, we estimate that across all of the programs, the number of beneficiaries covered by a managed care company is expected to increase by 51.6% by March 2012, from 2.3 million to 3.5 million. Of this total, 91% is attributable to service area expansions with the rest coming from organic caseload growth. The new and expansion regions are highlighted in gray in the table below.

Medicaid Managed Care Enrollment, February 2011 and March 2012 (est.)

	Current Enrollment (2/11)						Post RFP Enrollment (3/12)						
	STAR	STAR PLUS	CHIP	STAR HEALTH	RSA	Total	STAR	STAR PLUS	CHIP	STAR HEALTH	RSA	Total	% growth
Bexar	193,282	46,140	40,537	4,065	0	284,024	203,240	48,306	41,893	4,323	0	297,762	4.8%
Dallas	301,938	51,808	78,735	3,112	0	435,593	314,041	53,958	81,368	3,285	0	452,652	3.9%
El Paso	114,807	0	21,710	556	0	137,073	113,846	22,691	22,436	592	0	159,565	16.4%
Harris	485,444	90,987	166,496	7,488	0	750,415	516,130	97,170	172,064	8,052	0	793,416	5.7%
Hidalgo	0	0	N/A	0	0	0	350,852	65,434	N/A	1,603	0	417,889	N/A
Jefferson	0	0	N/A	565	0	565	66,593	17,635	N/A	1,100	0	85,328	N/A
Lubbock	38,249	0	11,966	906	0	51,121	66,204	12,839	12,397	1,470	0	92,910	81.7%
Nueces	70,235	18,632	12,890	1,145	0	102,902	78,279	20,926	13,321	1,318	0	113,844	10.6%
Tarrant	180,944	28,490	55,814	2,311	0	267,559	188,738	29,669	57,680	2,440	0	278,527	4.1%
Travis	122,866	16,966	31,330	2,294	0	173,456	129,397	17,787	32,378	2,488	0	182,050	5.0%
RSA	0	0	118,099	8,953	0	127,052	0	0	122,045	6,474	529,602	658,121	N/A
Total	**1,507,765**	**253,023**	**537,577**	**31,395**	**0**	**2,329,760**	**2,027,320**	**386,415**	**555,582**	**33,145**	**529,602**	**3,532,064**	**51.6%**

Source: Texas Health and Human Services Commission

In terms of spending, we estimate that the added enrollees, in addition to the inpatient and pharmacy carve-ins, will expand the program from $6.2 billion in annualized spending to $12.8 billion.

Estimated Medicaid Managed Care Spending Upon Full Implementation

	New Members	Increase in State HMO Spending ($M)
STAR Expansion (Hidalgo, MRSA)	880,000	$2,329
STAR+PLUS (Jefferson, El Paso, Lubbock, Hidalgo)	53,000	$496
Rx Carve-in	N/A	$2,400
Inpatient carve-in	N/A	$947
Total	**933,000**	**$6,172**
FY 11E State Spending ($M)*		$6,635
Estimated Total Spending (Upon full implementation)		**$12,807**
% Increase		*93.0%*

**Includes STAR, STAR+PLUS, STARHealth and CHIP*

Source: HMA analysis of data provided by the Texas Health and Human Services Commission

Timeline

The timeline in the draft RFP contemplated an operational start date of March 1, 2012 which, to our understanding, the state continues to target despite having missed earlier milestones.

Procurement Schedule*

11/5/2010	Draft RFP released
TBD	RFP release date
TBD	Vendor conference
TBD	Proposals due
TBD	Tentative award announcement
3/1/2012	Operational start date

**As of 1/27/11, procurement timeline has been removed while state reviews public comments to draft RFP*

Evaluation Criteria

According to the draft RFP, price is not a component of the evaluation criteria. Instead, the RFP will evaluate a plan's bid based in part on:

- Indicators of probable performance under the contract, including past performance in Texas or comparable experience, financial resources and solvency.
- The level of effort and resources required to monitor the plan's performance and maintain a good working relationship with the plan.

Based upon the criteria enumerated in the draft RFP, it appears that incumbent plans are well positioned in the bidding process based on their established track records and experience.

Key Features

Several important features are detailed in the draft RFP:

- The contract runs through August 31, 2015 with options that can extend the contract for a total of eight years, or through 2020.

- The state is considering expanding the threshold at which point the experience rebate provision requires health plans to share savings back with the state from 3.0% to 3.5%, though not until year two of the contract.
- Up to 5% of the capitation rate is at risk based upon the health plan's ability to meet certain performance benchmarks. The system is designed such that all plans have the opportunity to meet the benchmarks.
- Excluded population groups include:
    - Persons in institutional settings:
        - Persons residing in a nursing facility;
        - Residents of Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
        - Residents of Institutions of Mental Diseases or State Hospitals.
    - Persons enrolled in a waiver program other than a 1915(c) STAR+PLUS Waiver program:
        - Community Living Assistance and Support Services;
        - Medically Dependent Children's Waiver;
        - Home and Community Services Waiver;
        - Deaf Blind Multiple Disability Waiver;
    - Individuals not eligible for full Medicaid benefits (e.g., Frail Elderly program, Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), undocumented aliens);
    - Individuals enrolled in the STAR Health Program.

Florida

Status: Senate and House bills introduced, conference committee most likely in April, RFP expected in the summer

In our February 23rd issue of the *Weekly Roundup*, we described the key elements of the Florida Senate's Medicaid Reform bill, which would expand the current Medicaid managed care program state-wide. On Friday, March 4, the House submitted its reform proposal, the key elements of which we summarize in the discussion below. The next step will be for the branches to iron out the differences in a conference committee, which will likely take place in April. Assuming legislation is passed by the end of the session, we would expect an RFP to be released by the summer.

Key Elements of PCB HHSC 11-01 and 11-02 (March 4, 2011)

PCB HHSC 11-01 establishes the Florida Medicaid program as a statewide integrated managed care program for all covered services, including long-term care services. All populations would be required to enroll in a qualified plan except for women only eligible for family planning services and women who are only eligible for breast and cervical

cancer services. Unlike the recently released Senate bill, the developmentally disabled population would become a mandatory enrollment category. In other words, virtually all of the 2.8 million Medicaid beneficiaries in the state would be folded into the program. There are currently 1.1 million Floridians enrolled in Medicaid managed care plans.

Qualified Plans:

Qualified plans under both bills include the following:

- Provider service networks (PSN)
- Exclusive provider organizations
- Health maintenance organizations
- Specialty health plans

The state would select a limited number of plans through a competitive selection process in seven regions. The minimum and maximum number of plans varies per region and is listed in the table below. Specialty plans, which target distinct populations based on age, medical condition or diagnosis are not subject to the plan limits (unless they exceed more than 10% of the region's enrollees). All managed care contracts would be five years in length with no renewal periods. All "carve-out" plans would be eliminated.

PCB HHSC 11-01 **Proposed Enrollment and Plans by Region**

	Region							
	Panhandle	North Central/Northeast	West Central	Central	Southwest	Southeast	South	Total
Total enrollees	209,392	398,583	528,116	457,797	244,295	458,655	544,244	**2,841,082**
Minimum plans	3	3	4	4	3	4	5	**26**
PSN plans if responsive	1	1	2	2	1	2	2	**11**
Maximum plans	3	6	8	7	3	7	9	**43**
DD plans	2-3 (1 PSN)		2-3 (1 PSN)			2-4 (1 PSN)		**6-10 (3 PSN)**

Source: Florida House of Representatives

As a reminder, the Senate bill would carve the state into 19 regions. We view fewer regions as preferable for managed care organizations, as they increase the available beneficiary pool and mitigate the strength of local provider groups.

Medical Loss Ratio Requirements

Payment rates would be negotiated in an actuarially sound manner as part of the selection process but will be based on historical utilization patterns and risk-adjusted based on clinical mix. Unlike the Senate bill, the House bill would not implement a minimum medical loss ratio (MLR) requirement for health plans but instead utilize a "savings rebate" model, similar to what is employed in Texas. The savings rebate will be established by determining pre- tax income as a percentage of revenues and applying the following income sharing ratios:

- 100%of income up to and including 5%of revenue will be retained by the plan.
- 50% of income above 5% and up to 9% will be retained by the plan, with the other 50% refunded to the state.
- 100% of income above 9% of revenue will be refunded to the state.

For any plan that meets or exceeds agency-defined quality measures, the following income sharing ratios would apply:

- 100% of income up to and including 6% of revenue will be retained by the plan.
- 50% of income above 6% and up to 10% will be retained by the plan, with the other 50% refunded to the state.
- 100% of income above 10% of revenue will be refunded to the state.

We view the savings rebate parameters described above as more favorable to managed care organizations than the Senate bill's proposed 90% minimum MLR.

Selection Criteria

Responses to the invitation to negotiate (ITN) will be evaluated on the following criteria.

- Plan accreditation;
- Experience with similar populations;
- Availability and accessibility of primary care providers;
- Community partnerships that create re-investment opportunities;
- Commitment to quality improvement;
- Additional benefits, particularly dental care, disease management and other enhanced services;
- Pre-bid agreements with providers to meet network requirements. The Agency for Health Care Administration (AHCA) will give weight to signed contracts;
- Pre-bid agreements with select providers of essential services such as children's hospitals, medical school faculties, and trauma centers; and
- Comments submitted by providers related to a specific plan.

Implementation for the TANF and ABD programs is slated to begin January 1, 2013 with the roll-out complete by October 1, 2014. While the criteria listed above should benefit incumbent plans, the extended timeline for implementation might mitigate that bias.

Long Term Care Managed Care Programs

The House bill requires the agency to begin implementation of a statewide LTC program, including Home and Community Based (HCB) services, using a managed care model. Implementation is scheduled to begin July 1, 2012 with the roll-out completed by October 1, 2013. Mandatory enrollment groups include:

- Medicaid beneficiaries 65+ or disabled and meet level of care standards,
- All recipients in a nursing facility or enrolled in a waiver on the day managed care plans become available in their region.

The MLTC program would conform to the same seven geographic regions discussed above, and preference will be given to acute care plans that also participate in the LTC program. Payment rates would include incentives to keep individuals out of nursing homes as long as possible with a goal of 65% of enrollees receiving home and community

based care. All nursing homes and hospice providers would be included in each plan's network, and payments would take the form of "pass through" FFS rates.

Developmentally Disabled Long-Term Care Managed Care Programs

The House bill requires the Agency to begin implementation of a statewide long-term care managed care program for persons with developmental disabilities. Qualified plans include comprehensive plans that combine medical and HCB services, and long-term care plans that only provide HCB services. Implementation is scheduled to begin January 1, 2015 with the roll-out completed by October 1, 2016.

Summary

As we discussed in the earlier report, we estimate this year's Senate bill would add 900,000 to 1.2 million Medicaid beneficiaries to the mandatory managed care program and increase state expenditures through managed care by $8 to $12 billion. Based on our evaluation of the House bill, we believe the opportunity is even larger, with total enrollment equal to 2.8 million in the state, or 1.7 million incremental enrollees. In terms of spending, no rate data was provided, but we estimate the total market opportunity implied by the House bill is toward the high end of the range we previously estimated if not higher. For a summary of the House and Senate bill timelines please contact us.

Louisiana

Status: Stakeholder engagement, RFP scheduled for release 4/11/2011

For the past year, Louisiana has been developing a model for expanding its current Medicaid managed care program to include both PCCM options and risk-based managed care organizations. The program has had a number of fits and starts and is now under the direction of new Medicaid Director, Bruce Greenstein, who strongly supports the managed care model. In February, Louisiana issued a Notice of Intent draft to replace its existing CommunityCARE PCCM program with a Coordinated Care Network (CCN) program that will include both PCCM options and a limited number of risk-based managed care plans (versus a prior "all-comers" model that met with resistance).

According to the Notice of Intent, the new CCN program will offer beneficiaries the choice of delivery system models between:

- FFS/PCCM with shared savings; or
- Prepaid risk-bearing managed care organizations

Enrollment in the state will be divided into nine regions covering just under 875,000 lives. There will be a minimum of two plan options in each region, though the state has not yet specified how many plans it intends to award contracts. Plans do not have to bid in all regions. We note that, unlike some other states, the regions are fairly equally distributed from an enrollment standpoint, with no region representing more than 18% or less than 6% of the total.

Louisiana Proposed Regional Managed Care Structure

Region	Parishes	Projected Enrollment	% of total
1. New Orleans Area	Jefferson, Orleans, Plaquemines, St. Bernard parishes	161,527	18%
2. Capital Area	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana parishes	119,471	14%
3. South Central Louisiana	Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, Terrebonne parishes	78,940	9%
4. Acadiana Area	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion	118,388	14%
5. Southwest Louisiana	Allen, Beauregard, Calcasieu, Cameron, Jefferson-Davis	54,016	6%
6. Central Louisiana	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn	62,827	7%
7. Northwest Louisiana	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster	105,492	12%
8. Northeast Louisiana	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll	80,090	9%
9. Northshore Area	Livingston, St. Helena, St. Tammany, Tangipahoa, Washington	93,163	11%
Total		**873,914**	

Source: Louisiana Coordinated Care Networks Proposal Notice of Intent Draft

While the state has not disclosed any rate setting data, using industry-wide benchmarks, we estimate the annualized market opportunity in Louisiana to be approximately $4 billion when fully operational in 2012 (assuming the current timeline is achieved). Pharmacy services would be carved out of the managed care benefit package, though mental health services would be included. The Notice of Intent mandates a minimum 85% MLR, a common requirement in current state procurements.

Populations Covered:

Mandatory eligibility categories include:

- Children < 19 yrs old and their parents ;
- Qualified pregnant women and children;
- ABD adults > 19 yrs old (excluding LTC facility residents, dual eligibles, hospice recipients);
- Uninsured women < 65 yrs old with breast/cervical cancer or eligible through the CHIP prenatal option; and
- Medically needy

Prospective Vendors

As the state has no existing risk-based managed care program, there are no incumbents already doing business with the state. However, a number of managed care organizations have already submitted a Letter of Intent (LOI) to participate in some or all regions of the program including the following 10:

Letter of Intent to Participate	Regions
Amerigroup Corporation	1, 2, 3 and 9
Louisiana Healthcare Connections (Centene)	All
Aetna	All
Healthcare USA of Louisiana (Coventry)	All
UnitedHealthcare Community Plan	All
WellCare of Louisiana	All
AmeriHealth Mercy of Louisiana	All
Vantage Health Plan	Ouachita Parish
Community Health Network	All
Meridian Health Plan	All

Source: Louisiana Coordinated Care Networks Proposal Notice of Intent Draft

We note that, among the plans pursuing Medicaid managed care business in other states, WellPoint did not appear on this LOI list. As the Medicaid Management Information Systems (MMIS) vendor in the state, Molina is prohibited from bidding on the CCN contract. Among private plans, we highlight that both AmeriHealth Mercy and Meridian appear to be pursuing multiple state opportunities. Only two PCCM options have signed Letters of Intent to Participate, UniHealth and Louisiana Independent Physician's Association.

Procurement Timeline

The current CCN procurement timeline is as follows:

Procurement Schedule	
3/30/2011	Public hearing on NOI
4/11/2011	Target date for RFP issuance
4/18/2011	Vendor conference
6/24/2011	Proposals due
8/1/2011	Tentative award announcement
1/1/2012	Operational start date

Source: Louisiana Coordinated Care Networks Proposal Notice of Intent Draft

Georgia

Status: RFP delayed, now expected spring 2012

The Georgia managed care contracts were recently extended by one year, through June 30, 2013, with a one year renewal option beyond that. As such, the eagerly awaited RFP will likely not be issued until the spring of 2012 at the earliest. Based on discussions with HMA Principal and former Georgia Medicaid Director Mark Trail, the GA RFP was delayed to give the new administration time to study the current program, its successes, challenges, and opportunities for improvement and/or expansion. He expects the state will engage a consultant to conduct an evaluation of the current program. Mark notes that the current Department of Community Health (DCH) Commissioner, David Cook, previously served as the Executive Director of the Medical Association of Georgia and as such, may not be as favorably inclined to move the ABD into managed care as the previous administration.

As a reminder, the Georgia Medicaid managed care program is currently divided between three publicly traded organizations: Centene, Amerigroup and WellCare. In aggregate, we estimate the current market size to be approximately $2.9 billion in annualized spending. There are approximately 500,000 ABD beneficiaries in the state, though a waiver would be required to move most of them into a managed care plan. Using only a state plan amendment, the state can migrate approximately 100,000 ABD beneficiaries (SSI adults) into managed care. If we assume just this subset of the ABD population were included as part of an expanded program, total managed care spending would increase to approximately $4 billion.

Georgia Medicaid Managed Care Enrollment, July 2010

	Jul-10	% of Total
WellCare	547,458	49.1%
Centene	300,018	26.9%
AMERIGROUP	266,704	23.9%
Total	**1,114,180**	

Source: Georgia Department of Community Health

Illinois

Status: Bill passed General Assembly

On January 6, 2011, HB 5420 passed both houses of the Illinois General Assembly and was sent to the Governor. The bill introduces a number of changes to the Illinois Medicaid, CHIP and AllKids programs including the creation of "coordinated care" organizations that the bill envisions will account for 50% of Medicaid enrollment by January 1, 2015. Whether a "coordinated care" organization refers to an enhanced PCCM program, a full-risk managed care program or some combination of the two is unclear at this time, but the legislation does establish that the participating entities be prepared to assume greater financial risk than do the current PCCM program participants.

There are approximately 2.3 million Medicaid beneficiaries in Illinois of which 1.8 million are in the Illinois Health Connect PCCM program. There is a very small voluntary managed care program in the state that is dominated by WellCare. As we mentioned in last week's *Roundup*, Aetna and Centene have been selected to cover approximately 40,000 ABD lives in the counties surrounding Cook County (Chicago) with roll-out anticipated later this year. To the extent that the state can migrate 50% of beneficiaries into a full risk-managed care program, we conservatively estimate the potential market opportunity to be in the $4 billion range, though that is a very preliminary forecast.

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**	

Key Features

The new "coordinated care" program has several important features:

- It requires at least 50% of recipients eligible for comprehensive medical benefits to be enrolled in a care coordination program by January 1, 2015.
- Coordinated care is defined as "delivery systems where recipients receive care from providers participating under contract in integrated delivery systems that are responsible for providing for or arranging for the majority of care."
- Payment for coordinated care will be pay for performance (health care outcomes, evidence-based practices, use of primary care, EMRs, electronic health info exchange) on a capitated basis with full financial risk or through other risk-based payment arrangements.
- To achieve the 50% goal, enrollment must include individuals from each medical assistance enrollment category (parents, children, seniors, people with disabilities).
- Services must be more comprehensively defined and more risk shall be assumed than in the current PCCM program.
- The legislation requires the Department of Health and Family Services (HFS) to submit an annual report to the General Assembly, beginning in April 2012, which discusses the progress and implementation of the care coordination program.
- The legislation also requires HRS to submit a report by April 2011 that includes a full analysis of federal requirements regarding upper payment limits to providers and changes needed to implement full financial risk coordinated care.

Maine

Status: Stakeholder engagement, RFP delayed

Since 2010, Maine has been developing plans to implement a statewide managed care program called the Managed MaineCare Initiative (MMI). The plan is to move all of the state's Medicaid beneficiaries into a managed care program in a phased roll-out beginning in April 2012. The state has no risk-based managed care program today, instead utilizing a Primary Care Case Management (PCCM) approach including a fee-based care management program that, under the proposed structure, will be eliminated (incum-

bents Schaller Anderson/Aetna and APS Healthcare). The state has been undergoing an extensive and deliberative stakeholder engagement process for the last nine months and originally expected to release an RFP by May 1, 2011. However, the state recently announced that it will no longer be working under its original procurement timeline and has ceased holding monthly stakeholder meetings. Delays of this nature are common, and we would not consider Maine's decision as a departure from its plan, but we will monitor the situation and identify any future developments.

As of December 2009, there were just under 270,000 Medicaid beneficiaries in Maine of which 70% were parents and children and 30% were elderly and disabled. While the state has not disclosed any rate development data, using industry-wide benchmarks, we estimate the annualized market opportunity in Maine to be approximately $1.7 billion when fully operational in 2014. As originally contemplated, the state intends to limit choice to only two HMOs, each of which would have to operate state-wide. The managed care contracts would have a three-year initial term with one, two-year renewal option.

Maine Medicaid Enrollment by Category

Eligibilty Category	Enrollment (12/09)
Children & Adults	186,870
ABD	81,700
Total	**268,570**

Source: Health Management Associates

Populations covered

The plan proposed by the state would phase all MaineCare populations into an MCO model over three years according to the following transition timeline:

- Year 1 (April 2012): Parents, children and adults (excl. LTC adults)
- Year 2 (April 2013): Children with special needs
- Year 3 (April 2014): Dual eligibles, waiver enrollees

Evaluation Criteria

Bidders will be evaluated on a series of criteria at the heart of which is flexibility in provider payment relationships. These include innovative contracting methodologies and state-sponsored demonstrations, particularly around higher cost populations. Specifically, the state listed the following criteria:

- Strategies to develop partnerships and new payment relationships with providers that promote accountability, quality improvement, and provider capacity;
- Strategies to improve care coordination and outcomes for special needs populations;
- Strategies for improving the delivery of long-term care services to encourage less use of nursing home services; and
- Strategies to fully utilize and engage community resources to support member needs.

Finally, and perhaps most interestingly, MCOs will be expected to also sell individual insurance policies on Maine's Health Insurance Exchange in 2014. The state intends to use an enrollment broker to assist members in selecting a plan until 2014, at which time it expects to transition this functionality to the Exchange. This is the first example we have encountered of a state combining its Medicaid RFP process with Exchange plan selection. Over time, we expect the contracting efforts for Medicaid and the Exchange to be aligned in many states.

Prospective Vendors:

Among the organizations attending a December 10, 2010 prospective vendors meeting were:

Vendor's Conference Attendees
Aetna Medicaid
Amerigroup Corporation
AmeriHealth Mercy
Anthem
APS Healthcare
Arcadian Helath Plan
Centene Corporation
Magellan Health
Meridian Health Plan
Network Health, Commonwealth Care
ValueOptions

Source: MaineCare Managed Care Project

Washington

Status: RFP Expected in the fall

Washington is expected to rebid its existing Healthy Options Medicaid managed care program in the fall. At this time, no RFP has been issued and public discussion has been limited. It has been speculated that the state will consider moving the remaining ABD population into the program on a mandatory basis. In 2010, Washington spent $1.5 billion on its Medicaid managed care program (state and federal share), in which approximately 700,000 state residents were covered in full -risk managed care organizations.

Washington Medicaid Managed Care Enrollment, February 2011

	Feb-11	% of Total
Molina Healthcare of Washington	329,567	47.4%
Community Health Plan of Washington	235,740	33.9%
Columbia United Providers	56,137	8.1%
Regence Blue Shield	39,296	5.7%
Group Health Cooperative	23,253	3.3%
King County Care Partners	7,242	1.0%
Asuris Northwest Health	3,238	0.5%
Kaiser Foundation Health Plan	433	0.1%
Total Washington	**694,906**	

Source: Washington State Department of Social and Health Services

Kentucky

Status: RFI seeks comment on delivery system reforms

Kentucky is evaluating delivery system changes across its Medicaid program and recently issued an RFI seeking ideas for innovative care delivery models. Historically, Kentucky has operated a capitated Medicaid managed care program in the 16 counties that encompass and surround Louisville. The managed care vendor is a local non-profit entity, Passport Health Plan, which covers approximately 165,000 lives. In addition, the state operates a PCCM program covering an additional 350,000 lives, with the remaining approximately 300,000 lives in FFS Medicaid. Recently, the management team of Passport has been criticized by the legislature for inappropriate spending on administrative functions including lobbying, public relations, travel and salaries. In fact, Passport's founder and CEO, Dr. Larry Cook, was forced to step down in the wake of the scrutiny, and an RFP was recently released seeking organizations to conduct an assessment of "the efficiency and appropriateness of expenditures as necessary to provide quality health care services to Medicaid eligible individuals in Kentucky Region 3" (where Passport operates). As such, it appears that the state is contemplating changes to the program's structure that might create opportunities among its 165,000 Medicaid beneficiaries (~$750 million in total spending) in the existing plan as well as the roughly 650,000 lives that are in the PCCM/FFS programs.

In reviewing the RFI, to which responses were due February 7, 2011, the state focused on three key features for prospective responders to consider:

- Models can be statewide or on a county basis;
- Models are encouraged to include all Medicaid eligibility categories; and
- Models are encouraged to include all services, including behavioral health.

No additional detail was provided in the RFI, but the Governor's FY 2012 budget assumes savings realized through Medicaid managed care programs, suggesting additional detail will be forthcoming.

Kentucky Medicaid Enrollment by Category

Eligibilty Category	Enrollment (12/09)
Children & Adults	471,796
Elderly	93,765
Disabled	198,002
Total	**763,563**

Source: CMS

Hawaii

Status: RFI seeks comment on delivery system reforms

On January 21, 2011 Hawaii released an RFI for managed care vendors for its QUEST program. Quest is Hawaii's Medicaid managed care program for low-income children and adults. ABD beneficiaries are covered through a separate program (QExA), which is not part of this RFI. The RFI is comprised of questions to which the state wants health plans to respond including:

- Given the enrollment distribution in the state, what is the appropriate number of plans/island?
- Would plans be encouraged/discouraged from bidding if:
  - All plans that met the technical scoring criteria were allowed to participate; and
  - Capitation rates were the same to all participating plans?
- How should continuity of care be maintained for beneficiaries that transition from QUEST to QExA?
- What care delivery models should health plans pilot to improve quality and efficiency of care?
- Should NCQA accreditation be a requirement for participation in the program?

RFI Responses were due on February 11, 2011. Given the nature of the questions, our sense is that the state's intentions are to rebid the program with some potential modifications to the requirements that may create opportunities for plans not yet in the markets. WellCare suggested on its most recent earnings call that a formal RFP could be released later this year. We estimate the market size of the QUEST program, based on annual managed care spending by the state to be approximately $500 million.

The table below identifies the plans currently participating in the QUEST program and their market share.

Hawaii Medicaid Managed Care (QUEST) Enrollment (December 2010)

Incumbent	Membership	Market Share
HMSA	115,552	53.0%
AlohaCare	76,733	35.2%
Kaiser	25,855	11.9%
Total	**218,140**	

Source: State of Hawaii Dept. of Human Services

Montana

Status: Demonstration project submitted to CMS

In November 2010, Montana Medicaid Director Mary Dalton submitted a concept paper to CMS that would create a pilot risk-based Medicaid managed care program in five counties. The proposed program would include all eligibility categories totaling just under 20,000 beneficiaries (17,000 Medicaid, 2,000 CHIP). This compares to a total Medicaid population in the state of approximately 100,000. No spending projections are available, but we estimate the total market opportunity to be in the $100 million range. Given the small population size, only one managed care organization would be selected to participate in the demonstration program and, given its locally operated call center in Great Falls, MT, local press reports have noted that Centene has been actively engaged with the state in the past.[2] That said, plan selection would be subject to a competitive bidding process.

Interestingly, the document references the potential increase in Medicaid eligible residents attributable to the Affordable Care Act, which it estimates to be between 55,000 and 84,000. In that light, the demonstration program is viewed as a way to evaluate the feasibility of a statewide managed care program at some point in the future. The press report referenced above suggested the original plan was to release an RFP in January of 2011, though that has not happened. To the extent more details are made available, we will track them.

HMA Medicaid RoundUp

California

HMA Roundup – Stan Rosenstein

Budget update: The conference committee met on Friday and, somewhat surprisingly, many of the cuts that the legislature had dismissed have been brought back to the floor. Among the cuts is a cap on physician visits at seven, unless certified medically necessary. The biggest budget saver remains the 10% reduction in rates, which has been adopted by the legislature but still needs to be approved by both federal courts and CMS. Further changes include the cutting of adult day care by $85 million (50%) and a prescription

[2] "*State considers testing private Medicaid management.*" Mike Dennison, missoulian.com, October 13, 2010.

drug limit that will be capped at five scripts per month unless prior authorization is given. With the changes approved by the conference committee, it is unlikely that these cuts will be revisited by the legislature prior to final passage of the budget.

In the news

- Judge orders halt to planned freeze of Medi-cal reimbursements (Sacramento Bee)
- New health cuts plus old cuts equal a budget (CA Healthline)

Florida

HMA Roundup – Gary Crayton

The big news in Florida this week was the release of the House Medicaid reform bill, which we describe above. The House bill was released two weeks after the Senate introduced its plans to reform the $17 billion program. The key differences between the House and Senate bills are in the timeframes for implementation (Senate more aggressive), number of regions (House – 7, Senate – 19), managed care profitability (Senate 90% MLR, House uses a savings rebate methodology), and the transition of the developmentally disabled population to managed care (House includes it, Senate does not). Additionally, the House has a major provision on the low income pool (LIP), which the Senate doesn't address. These are the key issues that need to be ironed out over the course of the legislative session. For a summary of the House and Senate bill timelines please contact us.

While it's too early to call which way the legislature will ultimately lean on most of these items, our sense is that the timeframe articulated by the Senate (RFP issued by July1, 2012) is overly aggressive and will likely get pushed back. In terms of next steps, the respective committees in the House and Senate will begin to meet over the next week, at which point amendments will be offered by members of the committees. Once all of the amendments are heard, the respective bills will have to pass in each chamber after which there will likely be a conference committee (sometime in April) before a merged bill could be passed by each chamber.

In the news

- Sides gird up for Medicaid fight in Florida (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The Governor's bill to establish the Georgia Health Exchange Authority (HB 476) was introduced on Friday, March 4. The bill will put the Governor largely in control of the Exchange process. Notably, the Exchange would be run by a nine-member governing board consisting of seven members that will be appointed by the Governor. The bill also sets up an Advisory Council whose role it will be to advise the Governor, not the governing body. Further, the Exchange gives the state the authority to sell the policies, collect the premiums, and then fund the health plans based on enrollment. The bill includes the following provisions:

- Establishes an Authority to run the Exchange
    - Functions for both the individual and small business markets
- The Exchange is governed by a nine-member board including: the Commissioner of DCH (or designee); the Insurance Commissioner; and seven other members from the general public appointed by the Governor.
    - There will be three ex officio members to include the Director of the Office of Planning and Budget (OPB), the Governor's Executive Counsel, and the Director of the Georgia Technology Authority (GTA).
    - The Governor will appoint the Chairperson.
- The Authority would be administratively attached to the DCH.
- The Executive Director would be appointed by the Governor.
- The Authority will have the power to:
    - Solicit, receive and review proposals from technology vendors to support the Exchange;
    - Execute contracts;
    - Adopt rules and bylaws;
    - Sell qualified health insurance plans ;
    - Coordinate with other agencies, including DCH for Medicaid and CHIP; and
    - Administer the newly created "GA Health Care Exchange Trust Fund".
- Creates a separate trust fund to receive and disburse funds related to the business of the Exchange; and
- Creates an Exchange Advisory Committee:
    - To advise the Governor; and
    - To provide for input from the health care industry, business leaders, and other stakeholders.

Obviously the Legislature could modify the bill as it progresses.

In the news

- Georgia takes first steps toward healthcare reform (Journal Constitution)

Illinois

HMA Roundup – Matt Powers

The implementation date of the ABD expansion in the collar counties is still running behind schedule, but the administration remains committed to the program, and we expect to see members assigned to plans within the next couple of months. Also in Illinois news, McKesson currently has a $30+ million disease management contract, which is scheduled to expire on June 30. There has been no indication of a pending RFP, and it is unclear

whether the lack of progress indicates an extension or expiration of the contract at this time.

In the news

- Republicans propose welfare reform as Illinois budget fix (Post Dispatch)

Indiana

HMA Roundup – Cathy Rudd

Last week, Indiana selected First Data to enter contract negotiations for its eligibility system and health insurance exchange planning effort. First Data is also the vendor in Indiana for MMIS planning. This is an important step in the state's efforts to comply with and implement the provisions of the ACA.

Additionally, on March 2, the state provided an update to senate and house insurance committees on health care reform. The presentation focused on Senate Bill 461, which makes some changes in current insurance laws to bring them into compliance with the ACA. The bill also makes changes to the current Healthy Indiana Plan (HIP) in an effort to use it as the transitional vehicle for the benchmark benefit plan in 2014.

In the news

- Senate Bill 461(Indiana General Assembly)
- House & Senate Health & Insurance Committees presentation (IN.gov)

Texas

HMA Roundup – Linda Wertz

The timing of the managed care RFP's release remains uncertain with no updates since early February. It is possible that the RFP's release is being delayed until negotiations between the state, hospitals and CMS are completed regarding UPL funding. According to recent news accounts, negotiations between CMS and Texas are progressing, and it appears that there may be a viable work-around.

In the news

- Mapping where federal hospital dollars go in Texas (Texas Tribune)
- Texas nursing homes concerned over Medicaid cuts (Houston Chronicle)

Washington, D.C.

HMA Roundup - Lillian Spuria

There has been ongoing discussion in Washington this week on the issue of block grants to states for Medicaid. We note that Democrats have long been opposed to block grants for Medicaid when they have come up before, and there is no support for block grants from the administration. As such, we see very small chance of any block grant legislation emerging from the legislature.

Looking ahead, we expect the Congressional Budget Office's (CBO) analysis of the President's budget to be released in the next week and also highlight that the Medicaid and CHIP Payment and Access Commission (MACPAC) is scheduled to release its report to Congress by March 15th.

In the news

- Senate confirmation for Senate's Berwick looks tough (Wall Street Journal)
- State budget cuts decimate mental health services (Yahoo News)

Other State Headlines

Alabama

- In the Alabama Medicaid budget there's not much to cut (Birmingham News)

Arizona

- Brewer considers Medicaid enrollment freeze (Arizona Republic)

Idaho

- Medicaid reform bill clears first House hurdle (Idaho Statesman)
- Medicaid reform focuses on reigning in services (Times-news)

Kentucky

- Deadlock on Medicaid budget fix in Kentucky legislature (Courier Journal)
- Proposals, but no agreement on Medicaid budget solution (Courier Journal)

Maine

- Maine gets break in federal health care overhaul (Yahoo News)

Missouri

- Prison health care providers to merge (Modern Healthcare)

North Carolina

- Gov. Perdue vetoes GOP bill challenging health care law (Fay Observer)

Ohio

- Gov. John Kasich targets nursing home lobby in speech (Plain Dealer)

South Carolina

- Long-term care could get a closer look (Greenville Online)
- South Carolina doctors to see 3% cut in Medicaid rates (ABC News 4)

Tennessee

- State House passes Health Freedom Act (Chattanoogan)

Vermont

- Single-payer health legislation on the move in Vermont (Burlington Free Press)

Virginia

- Seeking new options for Medicaid (Roanoke Times)

Washington

- Kriedler accuses Premera of 'stonewalling' on transparency bill (Seattle Times)

West Virginia

- Health insurance exchange bill advances (WV Gazette)

Wisconsin

- Recall drives could make history (Journal Sentinel)
- Opinion polls show sharp divisions on Walker (Journal Sentinel)
- State official wants to keep Medicaid drug coverage, shift patients to managed care (State Journal)

HMA Recently Published Research

Medicaid Enrollment: June 2010 Data Snapshot – Kaiser Commission 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

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.

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