HMA

Health Management Associates

HMA Investment Services Weekly Roundup
Trends in State Health Policy

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In Focus: Kentucky, Texas and Louisiana RFP Updates

Introduction

Medicaid managed care RFP season went into high gear this past week with the official release of procurements in Kentucky, Louisiana and Texas. All three of these RFPs were expected (as discussed in our weekly Roundup from March 9th) and constitute three of the largest near-term opportunities for Medicaid managed care companies. Specifically, we estimate the total contract size of these three opportunities to be roughly $18 billion in annual expenditures. This brings the total amount of Medicaid managed care business currently out to bid or in the process of rolling out to over $23 billion in annual spending, according to our estimates.

Active Managed Care Procurements:

	Populations covered	Status	Expansion enrollment	Enrollment re-bid	Members	Size ($M)	Plans
Texas	TANF, ABD	RFP	1,200,000	2,070,000	3,270,000	$12,800	
Louisiana	TANF, ABD	RFP	875,000	0	875,000	$3,400	
California SPD	ABD	Member transition pending	380,000	0	380,000	$2,100	LA Care, Health Net, WellPpoint, Molina, others
Kentucky	TANF, ABD	RFP	295,000	165,000	460,000	$1,700	
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	Centene, Aetna
West Virginia	ABD	Member transition pending	55,000	0	55,000	$290	WellPoint, Carelink, HP of the Upper Ohio Valley
South Carolina	TANF	Member transition underway	80,000	0	80,000	$200	Centene, UnitedHealth, BlueChoice, Select Health
California - Stanislaus	TANF	Contract awards pending	0	50,000	50,000	$120	
Virginia	TANF	Member transition pending	30,000	0	30,000	$80	Amerigroup, WellPoint, Sentara, Coventry, VA Premier
Total			**875,000**	**540,000**	**1,415,000**	**$23,180**	

Sources available upon request

Of course, the frenzy is far from over. The Florida legislature is moving decisively to expand Medicaid managed care to all beneficiaries in the state in what we estimate will be a $12 billion annual opportunity (at least), with smaller expansions contemplated in Washington, Montana and Hawaii—all expected to be released later this year. In aggregate, we expect that by the end of 2011, close to $40 billion worth of annual Medicaid managed care business will have been awarded or in some stage of procurement. Moreover, we continue to track new opportunities in earlier stages of development, including recent discussions in New Hampshire and Kansas. Finally, a number of states are contemplating expanding their current programs to include long-term care services and supports, including New Jersey, New York, Ohio and Washington.

If there is a common theme among the newly issued RFPs it's that they all set very aggressive timelines for vendor responses. As the table below indicates, the Texas and Kentucky proposals are due within six weeks of the RFP's release (and two days of each other), with the Louisiana response due only a month later.

Given the size of the contracts, we would argue that the timelines for implementation are very aggressive in all three cases. The Kentucky roll-out timeline is least realistic in our opinion, particularly since it is a state without Medicaid managed care today. Our experience in tracking these events is that procurement timelines are rarely met. Of course, the urgency to implement these programs is driven by budget constraints in each of the states, where savings derived from the implementation of Medicaid managed care are being counted on in the fiscal year (FY) 2012 budgets.

Kentucky, Texas and Louisiana Medicaid Managed Care Procurement Timelines

	KY	TX	LA
RFP Published	4/7/2011	4/8/2011	4/11/2011
Vendor conference	5/11/2011	4/18/2011	4/18/2011
Proposal due	5/25/2011	5/23/2011	6/24/2011
Contract award	N/A	8/31/2011	7/25/2011
Implementation	7/1/2011	3/1/2012	1/1/2012

Source: RFP documents

As mentioned above, we provided details on each of these opportunities, in a Roundup published March 9th. For a copy of that report, please contact me at gnersessian@healthmanagement.com. Much of the information that was released with the RFPs last week in Texas, Louisiana and Kentucky is consistent with the documents upon which we based that report, but in the discussion below, we provide brief updates on each. We also provide a detailed, region by region breakdown of the opportunity in Texas

Kentucky

Link: https://emars.ky.gov/online/vss/Advantage

Status: RFP released 4/7/2011

Last Thursday, the Kentucky Cabinet for Health and Family Services released a RFP for capitated Medicaid managed care plans to begin enrolling members as early as July 1, 2011. The RFP contemplates covering 460,000 Medicaid beneficiaries in a mandatory managed care program, including 165,000 current managed care enrollees. Upon the receipt of a Medicaid waiver from CMS, Kentucky intends to shift an additional 90,000 Medicaid beneficiaries into the managed care program. We estimate the market opportunity available to managed care plans associated with the first phase of this roll-out to be approximately $1.7 billion in annual spending.

Target Population

According to the RFP, the Kentucky Medicaid program is comprised of roughly 64% (510,000) families and children, including children, pregnant women and caretaker relatives. The remaining 36% (290,000) is aged, blind and disabled (ABD). Of this total, roughly 460,000 beneficiaries are covered under the terms of the RFP. Specifically, all low-income families, children and pregnant women will transition to one of the selected managed care plans in the state on a mandatory basis, as will the aged, blind, and disabled eligibility groups (Medicaid services only). An additional 90,000 beneficiaries

will become eligible for mandatory enrollment if the state is granted a waiver to enroll dual eligibles, children in foster care, and disabled children. The state is in the process of applying for this waiver. Additional data on the eligible population and their distribution across the eight regions will be released with the Data Book on April 20.

Timeline

The state has laid out an aggressive timeline, with proposals due in six weeks and implementation to start by July 1, 2011. We would not be surprised to see this timeline pushed back.

Procurement Schedule	
April 20, 2011	1st set of vendor questions due
April 20, 2011	State issues Data Book
May 11, 2011	Vendor Conference – 10:00 AM CT
May 25, 2011	Proposals due
July 1, 2011	Phase-in of enrollment (subject to change)

Evaluation Criteria

Vendors are asked to submit cost proposals, which account for nearly half of the evaluation score. The lowest cost proposal for each scenario will receive the maximum points, and remaining proposals will be scored relative to the lowest cost. Plans can bid statewide or on a regional basis.

Under the technical section, the state's proposal evaluation will be based on the following:

- Experience in providing capitated Medicaid managed care services.
- Demonstrated ability to achieve quality goals, as laid out by the Kentucky Medicaid program.
- Demonstrated ability to integrate improved health outcomes and cost-effectiveness.

Scoring Criteria	
Cost Proposal	1,200
Provider Network	400
Experience	400
Quality Programs and Care Coordination	400
Innovative Programs	100
Oral Presentations (if necessary)	250
Total Technical	**2,750**

Prospective Vendors

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. 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). While incumbents tend to be difficult to unseat, particularly in RFPs with very tight timetables, given the circumstances, Passport may be in a vulnerable position with respect to its contract defense. Importantly, the state did not quantify how many plans it will select.

Prior to the vendor conference on April 18th, we are reluctant to speculate which plans might be interested in bidding on the Kentucky RFP. Given the tight timetable, however, it makes sense to us that any plan with an existing provider network in the state, even if it is a largely commercial network, will be well positioned relative to new market entrants. Thus, we would expect both WellPoint (Blue Cross Blue Shield of Kentucky) and UnitedHealth to express interest in, and likely pursue, the opportunity. Given that such a large percentage of the scoring is price-based, however, it will be very difficult to anticipate which plans will be awarded contracts.

Texas

Link: http://www.hhsc.state.tx.us/contract/529120002/announcements.shtml

Status: RFP released 4/8/2011

Last week, the Texas Health and Human Services Commission (HHSC) released an RFP for its Medicaid managed care program. The RFP seeks to reprocure existing STAR, STAR+PLUS, and CHIP contracts and to expand the program to new areas, mostly in South Texas. Excluded from the re-procurement are the CHIP rural service area contracts currently managed by Centene and Molina and the Dallas/Tarrant STAR+PLUS contracts rebid last year, managed by AMERIGROUP, Molina, Centene and Bravo Health. In aggregate, we estimate that 3.3 million Texans will participate in the Medicaid managed care program upon full implementation, compared to 2.1 million today. Moreover, the RFP also carves pharmacy benefits into the STAR and STAR+PLUS contracts, and inpatient services into the STAR+PLUS contracts. In aggregate, we estimate the total market opportunity associated with all of the proposed changes to be $12.8 billion in annualized spending.

Estimated Annual Medicaid Managed Care Expenditures Post-expansion

	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: Texas Health and Human Services Commission, HMA estimates

HHSC released a draft RFP in November. Changes between the draft and final RFPs are fairly minor, so for a detailed description of the RFP, we refer investors to our March 9th Roundup in which we summarized the opportunity.

With that, we make a few observations:

- Historically, Texas has exhibited a willingness to add new plans to the program. In the 2005 RFP, the state added Molina, WellPoint and Aetna. In last year's RFP for the Dallas/Tarrant STAR+PLUS contracts, the state added Bravo Health, a company with no existing Medicaid experience in any state. In other words, we expect the RFP will attract new bidders and would not be surprised if one or more were awarded contracts.
- That said, we see little risk to incumbent plans. All of the existing managed care organizations have participated in the program for many years and are viewed favorably by the state. We don't expect any of the existing plans to be unseated, given their incumbency advantage.
- In fact, incumbents should fare well from a business expansion standpoint.
    - First, we note that according to our estimates, approximately $3 billion, or 25%, of the annual revenue opportunity is associated with the pharmacy and inpatient carve-ins. In other words, as long as the incumbent plans hold on to their current contracts, their capitation rates will adjust higher to reflect the cost of pharmacy and inpatient services, increasing the revenue pool available to them substantially.
    - Second, there are a number of large provider-sponsored plans in the state that are not likely to bid in the expansion areas, reducing the pool of potential competitors in those areas.
    - Third, in the past when new plans have been added to existing regions, they have struggled to "catch up" in terms of enrollment distribution. For example, WellPoint was added to the Dallas STAR service area in 2006 alongside Amerigroup and Parkland. Five years later, WellPoint still maintains less than 5% of the market share in that region.

- In the discussion below, we summarize the new business opportunity in each of the 11 regions out to bid. As the tables indicate, there is wide variation in the number of beneficiaries covered in each region. For example, we estimate that the largest service area, Harris, represents a $2.2 billion market opportunity, while the smallest, Lubbock, represents "only" $0.3 billion. Accordingly, it will be important to monitor how many plans are selected in each region in order to quantify the membership opportunity.

Regional Breakdown

Below we have estimated the impact on state MCO expenditures by region, taking into account the re-procurement and expansion of managed care contracts, the impact of the prescription drug benefit carve-in, and the carve-in of inpatient hospital benefits into STAR+PLUS contracts. We have ranked the county-regions according to post-RFP enrollment size, excluding the Medicaid rural service area. In regions impacted significantly only by carve-ins of the prescription drug benefit and inpatient services, the major driver of estimated spending increases is the prescription drug carve-in.

Harris

Harris Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	485,444	516,130	Amerigroup, Community First, Molina, TX Childrens, United
STAR PLUS	90,987	97,170	Amerigroup, Evercare, Molina
CHIP	166,496	172,064	Amerigroup, Community Health Choice, Molina, TX Children's, United
STAR HEALTH	7,488	8,052	
RSA	0	0	
Total	**750,415**	**793,416**	
Estimated expenditures	*$2,108,136*	*$2,239,209*	
Rx carve-in	*$0*	*$515,207*	
S+P inpatient carve-in	*$0*	*$137,717*	
Estimated total expenditures	***$2,108,136***	***$2,892,133***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Harris region, the largest in the state, is projected to increase by roughly 43,000 enrollees, entirely attributable to caseload expansion. Harris county contracts are being re-procured, but there are no new territories or eligibility groups being added to the contract service area. That said, including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $900 million upon implementation.

Dallas

Dallas Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	301,938	314,041	Amerigroup, Parkland, UNICARE
STAR PLUS	51,808	53,958	Molina, Centene
CHIP	78,735	81,368	Amerigroup, Parkland, UNICARE
STAR HEALTH	3,112	3,285	
RSA	0	0	
Total	**435,593**	**452,652**	
Estimated expenditures	*$1,248,335*	*$1,298,406*	
Rx carve-in	*$0*	*$289,275*	
S+P inpatient carve-in	*$0*	*$62,289*	
Estimated total expenditures	***$1,248,335***	***$1,649,970***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Dallas region is projected to increase by roughly 17,000 enrollees, entirely attributable to caseload expansion. As a reminder, the STAR+PLUS contracts in Dallas are not included as part of the re-procurement, as they were just awarded last year. That said, including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $400 million upon implementation.

Hidalgo

Hidalgo Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	0	350,852	
STAR PLUS	0	65,434	
CHIP	N/A	N/A	
STAR HEALTH	0	1,603	
RSA	0	0	
Total	**0**	**417,889**	
Estimated expenditures	*$0*	*$1,292,499*	
Rx carve-in	*$0*	*$273,064*	
S+P inpatient carve-in	*$0*	*$64,908*	
Estimated total expenditures	***$0***	***$1,630,471***	

Source: Texas Health and Human Services Commission, HMA Estimates

The Hidalgo region represents a significant opportunity for growth, presuming that the legislature votes to allow managed care expansion into three of the region's counties. Post-RFP enrollment is projected at just under 420,000 enrollees, almost entirely in STAR and STAR+PLUS. We estimate annual regional expenditures will exceed $1.6 billion.

Bexar

Bexar Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	193,282	203,240	Aetna, Community First, Centene
STAR PLUS	46,140	48,306	Amerigroup, Centene, Molina
CHIP	40,537	41,893	Aetna, Community First, Centene
STAR HEALTH	4,065	4,323	Centene
RSA	0	0	
Total	**284,024**	**297,762**	
Estimated expenditures	*$882,496*	*$925,789*	
Rx carve-in	*$0*	*$219,356*	
S+P inpatient carve-in	*$0*	*$50,320*	
Estimated total expenditures	***$882,496***	***$1,195,465***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Bexar region is projected to increase by roughly 13,000 enrollees, entirely attributable to caseload expansion. Including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $300 million, upon implementation.

Tarrant

Tarrant Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	180,944	188,738	Aetna, Amerigroup, Cook Children's
STAR PLUS	28,490	29,669	Amerigroup, Bravo
CHIP	55,814	57,680	Aetna, Amerigroup, Cook Children's
STAR HEALTH	2,311	2,440	
RSA	0	0	
Total	**267,559**	**278,527**	
Estimated expenditures	*$694,916*	*$723,978*	
Rx carve-in	*$0*	*$170,827*	
S+P inpatient carve-in	*$0*	*$38,844*	
Estimated total expenditures	***$694,916***	***$933,649***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Dallas region is projected to increase by roughly 11,000 enrollees, entirely attributable to caseload expansion. As a reminder, the STAR+PLUS contracts in Tarrant are not included as part of the re-procurement, as they were just awarded last year. That said, including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $240 million, upon implementation.

Travis

Travis Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	122,866	129,397	Amerigroup, Centene
STAR PLUS	16,966	17,787	Amerigroup, Evercare
CHIP	31,330	32,378	Seton, Centene
STAR HEALTH	2,294	2,488	
RSA	0	0	
Total	**173,456**	**182,050**	
Estimated expenditures	*$449,643*	*$472,440*	
Rx carve-in	*$0*	*$121,978*	
S+P inpatient carve-in	*$0*	*$15,335*	
Estimated total expenditures	***$449,643***	***$609,752***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Travis region is projected to increase by roughly 9,000 enrollees, entirely attributable to caseload expansion. Including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $150 million upon implementation.

El Paso

El Paso Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	114,807	113,846	El Paso First Premier, Centene
STAR PLUS	0	22,691	
CHIP	21,710	22,436	El Paso First Premier, Centene
STAR HEALTH	556	592	
RSA	0	0	
Total	**137,073**	**159,565**	
Estimated expenditures	*$327,538*	*$483,779*	
Rx carve-in	*$0*	*$94,450*	
S+P inpatient carve-in	*$0*	*$16,377*	
Estimated total expenditures	***$327,538***	***$594,606***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the El Paso region is projected to increase by roughly 22,000 enrollees, as the state expands STAR+PLUS to the region for the first time. In aggregate, we estimate annual regional expenditures will increase by roughly $270 million upon implementation.

Nueces

Nueces Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	70,235	78,279	Amerigroup, Driscoll Children's, Centene
STAR PLUS	18,632	20,926	Evercare, Centene
CHIP	12,890	13,321	Amerigroup, Driscoll Children's, Centene
STAR HEALTH	1,145	1,318	
RSA	0	0	
Total	**102,902**	**113,844**	
Estimated expenditures	*$312,298*	*$348,082*	
Rx carve-in	*$0*	*$84,217*	
S+P inpatient carve-in	*$0*	*$19,154*	
Estimated total expenditures	***$312,298***	***$451,454***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Nueces region is projected to increase by roughly 11,000 enrollees, entirely attributable to caseload expansion. Including the pharmacy and inpatient carve-ins, we estimate annual regional expenditures will increase by approximately $140 million upon implementation.

Lubbock

Lubbock Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	38,249	66,204	FirstCare, Centene
STAR PLUS	0	12,839	
CHIP	11,966	12,397	FirstCare, Centene
STAR HEALTH	906	1,470	
RSA	0	0	
Total	**51,121**	**92,910**	
Estimated expenditures	*$106,639*	*$263,041*	
Rx carve-in	*$0*	*$62,343*	
S+P inpatient carve-in	*$0*	*$12,163*	
Estimated total expenditures	***$106,639***	***$337,547***	

Source: Texas Health and Human Services Commission, HMA Estimates

Post-RFP enrollment in the Lubbock region is projected to increase by roughly 41,000 enrollees, as the state expands STAR+PLUS to the region for the first time and increases the STAR service area. In aggregate, we estimate annual regional expenditures will increase by roughly $230 million upon implementation.

Jefferson

Jefferson Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	0	66,593	
STAR PLUS	0	17,635	
CHIP	N/A	N/A	
STAR HEALTH	565	1,100	
RSA	0	0	
Total	**565**	**85,328**	
Estimated expenditures	*$1,017*	*$282,427*	
Rx carve-in	*$0*	*$71,843*	
S+P inpatient carve-in	*$0*	*$22,217*	
Estimated total expenditures	***$1,017***	***$376,487***	

Source: Texas Health and Human Services Commission, HMA Estimates

The Jefferson county contract will not be bid separately but will be rolled into the Harris county contract. Nevertheless, we break out the impact of the expansion into this region separately to illustrate the size of the opportunity, as Jefferson county represents a significant opportunity for growth. Specifically, we estimate that the RFP will result in over 85,000 enrollees shifting to managed care. Of that total, approximately 66,000 enrollees will be enrolled in STAR, and nearly 18,000 will be covered under STAR+PLUS contracts. We estimate annual regional expenditures will exceed $375 million upon implementation.

Rural Service Areas (RSA)

RSA Region ($ in thousands)	Current Enrollment	Post RFP Enrollment	Incumbent plans
STAR	0	0	
STAR PLUS	0	0	
CHIP	118,099	122,045	
STAR HEALTH	8,953	6,474	
RSA	0	529,602	
Total	**127,052**	**658,121**	
Estimated expenditures	*$146,497*	*$1,417,436*	
Rx carve-in	*$0*	*$458,113*	
S+P inpatient carve-in	*$0*	*$0*	
Estimated total expenditures	***$146,497***	***$1,875,549***	

Source: Texas Health and Human Services Commission, HMA Estimates

The Medicaid Rural Service Area (RSA) contracting expansion is projected to capture approximately 530,000 new lives in capitated managed care. We estimate the increased annual managed care expenditures post-RFP implementation will exceed $1.8 billion.

Prospective Vendors

As discussed above, we expect the incumbent plans to successfully defend their current contracts and win new business in the expansion areas. We also would not be surprised to see one or two new plans enter the market. Specifically, since a Special Needs Plan license is required to participate in the STAR+PLUS program, we would not be surprised

if companies with Medicare Advantage experience pursue business in the state, particularly given the success Bravo had in winning the Tarrant county contract.

Louisiana

Link: http://new.dhh.louisiana.gov/index.cfm/page/270

Status: RFP released 4/11/2011

As expected, on Monday of this week Louisiana issued an RFP for its Coordinated Care Network (CCN) program. The program contemplates shifting approximately 875,000 Medicaid beneficiaries into either a risk-based managed care plan or a "Shared Savings" primary care case management (PCCM) organization. The state has long operated a PCCM program, though in its redesigned state, PCCM vendors will be required to accept medical cost risk for covered beneficiaries and compete directly with the risk-based managed care organizations. The program will be implemented statewide and we estimate will result in a $4.6 billion annual market opportunity for participating organizations.

Most provisions within the RFP are similar to those outlined in a letter of intent that was published on February 14, 12011. In the description below, we outline the key provisions of the RFP and identify important changes relative to the letter of intent.

Program Structure

The CCN program will replace the state's existing CommunityCARE PCCM program and will offer beneficiaries the choice of delivery system models between:

- FFS/PCCM with shared savings (CCN-S); or
- prepaid risk-bearing managed care organizations (CCN-P).

Enrollment in the state will be divided into nine regions covering approximately 875,000 lives. These nine regions will be grouped into three Geographical Service Areas (GSAs). The creation of GSAs was not part of the letter of intent, which had the plans bidding on each region separately. Enrollment in each GSA will range from 255,000 beneficiaries to 317,000, and the RFP stipulates that the Department of Health and Hospitals (DHH) will select three plans in each GSA. The RFP does not specify a limit on the number of CCC– S (PCCM) participants per region. By combining the nine regions into three GSA's, the RFP allows for fewer total award winners but higher enrollment per awardee. Combining the regions also works to the disadvantage of the CCN-S options since they would have to cover beneficiaries across a much larger geographic area. We note that health plans can bid on one, two or all three regions.

Louisiana Proposed Regional Managed Care Structure

Region	Projected Enrollment
GSA 1	
1. New Orleans Area	161,527
9. Northshore Area	93,163
Total	**254,690**
GSA 2	
2. Capital Area	119,471
3. South Central Louisiana	78,940
4. Acadiana Area	118,388
Total	**316,799**
GSA 3	
5. Southwest Louisiana	54,016
6. Central Louisiana	62,827
7. Northwest Louisiana	105,492
8. Northeast Louisiana	80,090
Total	**302,425**
Total Enrollment	**873,914**

Source: Louisiana Coordinated Care Networks Proposal Notice of Intent Draft

For the purposes of auto-assignment, the CCN-Ps and CCN-Ss will be treated equally. Members that do not choose a plan or are not auto-assigned based on provider preference will be evenly distributed across all of the CCN-P and CCN-S options in that GSA.

Market Size

Using data provided by the state, we estimate that the annualized market opportunity in Louisiana is approximately $3.4 billion when the program is fully operational in 2012 (assuming the current timeline is achieved). This compares to our previous estimate of $4.0 billion. Interestingly, pharmacy services are carved out of the managed care benefit package. While this design feature was part of the letter of intent, we expected the state to carve the pharmacy benefit into the plan capitation with the final RFP, since there is no longer any financial benefit to the state to carving it out. Pharmacy costs represent over $1 billion of annual expenditures according to the rate book provided by the state. As expected, most mental health services are included, and the RFP mandates a minimum 85% MLR, both of which are consistent with the letter of intent.

Populations Covered:

Mandatory eligibility categories include:

- Children < 19 years old and their parents ;
- Qualified pregnant women and children;

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

Beneficiaries receiving long term care services and supports are excluded.

Procurement Timeline

The current CCN procurement timeline is as follows:

Procurement Schedule	
4/11/2011	Public Notice of RFP
4/18/2011	Vendor conference
6/24/2011	Proposals due
7/25/2011	Tentative award announcement
8/8/2011	Contracts signed
1/1/2012	Operational start date - GSA A
3/1/2012	Operational start date - GSA B
5/1/2012	Operational start date - GSA C

Source: Louisiana Coordinated Care Networks Proposal Notice of Intent Draft

Scoring Criteria

Below we list the state's criteria for evaluating and scoring each plan's proposal. We note that there is no price element to the proposal evaluation process.

Evaluation Category	Maximum Points Possible
Qualifications and experience	345
Provider network	200
Information Systems	200
Added value to Louisiana	200
Service coordination	170
Quality management	125
Planned approach to project	100
Chronic care/disease management	100
Customer Service	100
Other	360
Total	**1,900**

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 submitted a Letter of Intent (LOI) to participate in some or all regions of the program.

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 as the Medicaid Management Information Systems (MMIS) vendor in the state, Molina is prohibited from bidding on the CCN contract. Only two PCCM options have signed Letters of Intent to Participate, UniHealth and Louisiana Independent Physician's Association. The vendor's conference is on Monday, April 18th.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Gary Crayton

The budget conference committee is expected to convene on Thursday of this week to reconcile the House and Senate budget bills. One of the issues being sorted out is Medicaid provider rate cuts. We still believe these will fall somewhere between 7% and 10%, which are the parameters outlined by the House and Senate proposals.

As discussed in earlier Roundups, the Florida Senate has proposed to limit Medically Needy benefits for non-pregnant adults to physician services only, effective April 1, 2012. The impact of this cut on hospitals has been estimated in the $650 million to $700 million range. The House has not proposed this item, and the Senate has stated that if there are any incremental funds to spend, their first priority would be to offset this reduction. While the details are still to be finalized by the conference committee, there is increasing optimism that the Medically Needy cuts will be mitigated.

In the news

- **Scott: I'll cancel cuts to disabilities services**
  Gov. Rick Scott said Tuesday he will cancel massive cuts in the Agency for Persons with Disabilities if legislators come up with a $174-million budget patch. Scott ordered a 15-percent reduction in state payments to providers who care for those with developmental disabilities and other handicapped Floridians. Advocates for providers and clients say the impact of the 90-day order will be up to 30 percent or more. (Florida Capital News)

- **Jackson next leader to be chosen Wednesday**
  Jackson Health System's governing board is expected Wednesday to pick a new chief executive, who will almost immediately face hard decisions to keep Miami-Dade's public hospitals alive in the next few months in the face of severe cash shortages and major cuts in state funding. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The conference committee report on the budget bill was adopted by the House and Senate on Tuesday evening and is headed to Governor Deal's desk for his signature. The Governor has line item veto authority, but we don't expect him to exercise it. The key budget provisions impacting the state's healthcare programs are:

- Reducing Medicaid reimbursement by 0.5% for all providers except hospitals, skilled nursing facilities, and home and community based services ($5 million savings).
- Removing the payment floor for outpatient services from Medicaid managed care organizations ($5 million savings).
- Realizing the benefit from the drug rebate equalization provision of the federal healthcare reform bill that increases Medicaid managed care rebates ($14.5 million savings).
- Authorizing $10 million in bond funds to design and implement a new Medicaid eligibility system.
- Increasing funds for the Express Lane Eligibility Project, which will simplify the enrollment process ($1.3 million cost).

Three noteworthy items were proposed but not passed:

- Including the 2.25% premium tax within the existing administrative percentage for CMO cap rate range development.
- Implementing a minimum Medical Loss Ratio (MLR) of 87%.
- Transitioning Medicaid eligibility from 6 month reviews to 12 month reviews while still requiring clients to report changes in their status outside of the review time.

In the news

- **Tech upgrade critical to handling Medicaid expansion**
  A $100 million effort to upgrade the state's antiquated Medicaid enrollment system is vital to Georgia's ability to handle potentially hundreds of thousands of new enrollees when the program expands in 2014, officials say. Georgia is pumping $10 million, part of the state's 2012 budget, into improving its more-than-decade-old system with a federal match of $90 million. Anderson said he hopes to have the new system in place by Jan. 1, 2014. (Atlanta Journal-Constitution)

Illinois

HMA Roundup – Jane Longo

The Illinois Department of Healthcare and Family Services (HFS) is renewing its contract with Automated Health Systems, Inc., to administer the Primary Care Case Management program as well as for the Client Enrollment Broker program. Both contracts have been renewed for the July 1, 2011 through June 30, 2012 period. The Primary Care Case Management program contract is worth $29 million, while the Client Enrollment Broker Pro-gram is worth $5.2 million.

On the other hand, HFS has decided not to renew its disease management contract with McKesson (Your Healthcare Plus), which is scheduled to expire on June 30, 2011. The contract covers approximately 300,000 Illinois residents and represents approximately $30 million in annual spending.

In the news

- **Illinois agency OKs program to pay Medicaid bills**
  The Illinois Finance Authority gave initial approval to a program to accelerate Medicaid payments. Under the program, the state will assign Medicaid claims from hospitals, doctors, pharmacies, nursing homes and others to the Illinois Finance Authority, which in turn will assign the claims to a state-qualified group of investors. As of March 31, Illinois' bill backlog stood at $4.51 billion, with some claims dating back to mid-October, according to the state comptroller's office. (Reuters)

Massachusetts

HMA Roundup – Tom Dehner

The House and Senate have been at verbal odds over the issue of payment reform, a milestone in the Massachusetts Health Reform plan. The Senate president has been pushing lately to accelerate the process of looking at and implementing payment reform. The House has pushed back, saying the process is very complicated and should be given the time it deserves. The Senate seems to be pushing to take up payment reform this year, while the House is pushing for 2012. Both the House and Senate are likely to release budget proposals in late April or May. We are hearing that it is unlikely, however, that the Senate will attempt to push payment reform through in the budget process, opting to legislate separately.

Discussions continue in the Tufts Health Plan merger with Network Health. Network Health, a subsidiary of the Cambridge Health Alliance, serves roughly 170,000 Medicaid lives through the Massachusetts Commonwealth Care program.

The state issued an RFI on the subject of extending mandatory managed care for dual eligibles. The state is expected to receive federal innovation grant money for care coordination of the dual eligible population. The process may require Senior Care Options (SCOs) programs to convert to Special Needs Plans (SNPs).

Other State Headlines

Arizona

- **Federal government to aid Maricopa mental-health care**
  The federal government will begin offering financial incentives to mental-health-care providers who agree to serve low-income areas or areas with poor access to mental-health care in Maricopa County. The Arizona Department of Health Services will submit applications to the HHS on behalf of behavioral-health facilities or low-income areas, with the federal agency making final decisions on who may receive the tax-free loan repayments through the National Health Service Corps. (AZ Central)

California

- **Federal health care reform may cost California**
  California will spend $2 billion more per year on Medi-Cal when federal health care reform goes into full effect in 2016 and $4 billion more annually by 2020, according to a Rand Corp. study released this week. The law will add coverage for about 6 million Californians, raising the percentage of those covered to 96 percent from today's 80 percent. About 17 percent of residents are expected to buy insurance through a state insurance exchange created by the health law, the report said. The Rand study predicts that the percentage of California workers offered health insurance by employers will drop slightly by 2016. More large companies will offer coverage, Rand said, but fewer small businesses will provide insurance.
  (Mercury News)

Connecticut

- **State gets federal grant for care coordination**
  The state has received a $1 million federal grant to develop a system for coordinating care for seniors and adults with disabilities who are covered by both Medicaid and Medicare. (CT Mirror)
  Note: Federal Dual Eligible Care Coordination grant applications from California and Michigan were covered in a previous weekly roundup.
  Contact gnersessian@healthmanagement.com for availability if interested.

Kansas

- **Kansas Medicaid makeover moves forward**
  Details of various suggestions for improving the Kansas Medicaid program were made public last week. They ranged from the complicated, such as shifting the blind, disabled and elderly into managed-care programs or capping Medicaid payments, to the relatively straightforward - such as ending Medicaid payments for routine circumcisions. The article contains a link to the full list of proposed suggestions.
  (Kansas Health Institute)

Kentucky

- **Kentucky Radiology Benefits RFP**
  Kentucky released an RFP for radiology benefits management services. It is a fee-based contract with incentives for cost savings achieved relative to bid levels. Proposals are due May 25, with contract awards scheduled to be announced on June 24. The contract effective date is slated for July 1 and is effective for one year. Bidders are asked to compete on cost and technical factors, with cost representing 45% of the total scoring. The RFP can be found at this link:

  https://emars.ky.gov/online/vss/Advantage

Maryland

Gov. Martin O'Malley signed legislation (S.B. 182) Tuesday to create a health exchange. Maryland is now the third state to have passed exchange legislation, along with California and West Virginia. (Link to Bill)

Mississippi

- **Medicaid cost-control effort faces some criticism**
  Mississippi's three-month-old program to control Medicaid costs is running into early speed bumps, but proponents say MississippiCAN just needs time to root into health care institutions and the patients they serve. Medicaid officials say the new program — Mississippi Coordinated Access Network — will improve health care while cutting costs. Some health care providers, however, complain the program has failed to reimburse them or has disrupted patient treatments. (Picayune Item)

New Mexico

- **Health care exchange bill vetoed**
  On Friday, Gov. Susana Martinez vetoed legislation that would have created a one-stop shopping clearinghouse for tens of thousands of New Mexicans in need of health insurance. Martinez said Friday that she vetoed Senate Bill 38, which would have created a health care exchange, because of a lack of federal rules and regulations that lay out how states can set up such entities. (Santa Fe New Mexican)

Rhode Island

- **State looking to maintain Medicaid coverage level**
  Governor Chafee's budget plan proposes to manage increases in costs and a reduction in federal reimbursements in three main ways: reorganizing and coordinating care toward less-intensive care; reducing payments to nursing homes, hospitals and ambulance companies; seeking more than $14 million in new federal money. Some providers, especially nursing homes, are upset about proposed cuts in reimbursements. (Providence Journal)

Virginia

- **Medicaid managed care spending soars**
  Managed care enrollment rose 10 percent during the fiscal year ended June 30, while state spending on Medicaid managed care rose 25 percent. So far this year, spending is up 16 percent, state records show. Administrative expenses during calendar year

2010 rose 19 percent; spending on medical care, hospital stays and medication rose 5 percent; payments from the state rose 14 percent; the total number of people covered as of the end of the year declined 1 percent. (News Leader)

United States

- **HHS Unveils $1B Program to Reduce Medical Errors**
  Partnership for Patients is public-private that will focus on hospital safety with the goal of reducing patient care injuries by 40%, saving 60,000 lives, and reducing hospital readmissions by 20% over the next three years. Effective immediately, $500 million was made available through the Community-based Care Transitions Program. Up to $500 million more will be dedicated from the CMS Innovation Center to support demonstrations related to reducing hospital-acquired conditions. (Health Leaders)

- **Health Overhaul Could Double Community Health Centers' Caseload**
  Community health centers serve 20 million people every year, and that number is expected to double by 2015, thanks to an $11 billion infusion from the health-care overhaul and $2 billion in federal stimulus funds. Kaiser Health News looks in-depth at the status of community health centers now and with the impact of ACA. (Kaiser Health News)

- **Exchanges giving states migraines**
  The Department of Health and Human Services is expected to release the regulation spelling out requirements for state insurance exchanges in late spring. States are expressing concerns with the level of coordination and responsibility the exchanges put into place. One of the few companies with experience managing enrollment systems approaching that scale is Maximus, which currently handles enrollment in Medicaid managed-care plans that account for 16.5 million beneficiaries in 13 states. (Politico)

Private Company News

- **Tenet Claims CHS Overbilled Medicare $377M**
  Tenet Healthcare Corp., embroiled in a hostile takeover attempt by Community Health Systems Inc., has filed a federal complaint alleging that its bitter rival overbilled Medicare by as much as $377 million using medically unnecessary admissions that improved its bottom line and appeal to investors. (Health Leaders)

HMA Recently Published Research

CLASS Technical Assistance Briefs – Spring 2011

The SCAN Foundation

HMA Principals Susan Tucker and Marshall Kelly contributed a series of briefs to the SCAN Foundations CLASS Technical Assistance Briefs series, released earlier this month.

1. **Elements of a Functional Assessment for Medicaid Personal Care Services**

   By: Marshall E. Kelly and Susan M. Tucker

   This brief discusses the results of the identification and analysis of the assessment instruments and data elements states use for determining medical conditions, activities of daily living and cognitive functional ability within Medicaid-funded personal care services programs. It identifies the elements states use for an assessment of a person's physical and cognitive limitations and need and compares these elements to the requirements of the CLASS Plan. (Link to Report)

2. **Determining Need for Medicaid Personal Care Services**

   By: Susan M. Tucker and Marshall E. Kelly

   This brief focuses on the ranking and scoring criteria and mechanisms that state Medicaid programs use to determine functional need and the level of services provided for Medicaid-funded personal care services programs. Because CLASS requires a determination of need and must identify a benefit level for which regulations must be promulgated, this information can be very useful for the development of the CLASS Plan. (Link to Report)

3. **Functional Assessment Processes for Medicaid Personal Care Services**

   By: Susan M. Tucker and Marshall E. Kelly

   This brief focuses on components of states' Medicaid functional assessment processes with an eye toward how these processes could potentially inform the development of regulations for CLASS. We explore how states handle the assessment process and determine who performs the assessment and where it is performed. Each of these components is important to the design of CLASS so that those determined eligible can receive appropriate benefits. (Link to Report)

"Issues in Missouri Health Care in 2011"

Prepared for the Missouri Foundation for Health

HMA staff worked with the Missouri Foundation for Health (MFH) and Health Care Foundation of Greater Kansas City (HCF) to provide updated resources to help policymakers, health care professionals, and community-based organizations better understand important aspects of the state's health system. Among the topics covered in a series of issue briefs include the following:

- The State of Health in Missouri: Coverage, Access, and Health Status (PDF)

- Uninsured Prescription: Policy Options for Covering Missouri's Uninsured (PDF)
- Coverage Issues for Missourians with Chronic Health Care Conditions (PDF)
- Electronic Health Records and Health Information Exchange (PDF)
- Addressing Medicaid Fraud and Abuse: Facts and Policy Options (PDF)
- Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-Term Care (PDF)
- Treating the Whole Missourian: Mental Health and Substance Use Disorders (PDF)
- Basic Pharmacy Reimbursement Principles in MO HealthNet (PDF)
- Buying Value: Improving the Quality of Missourians' Health Care (PDF)
- Real Opportunities for Ending the Addiction: Tobacco Use Prevention and Cessation (PDF)
- Transforming Missouri Medicaid: Federal Waiver Options and Processes (PDF)
- Assuring an Adequate Health Care Workforce in Missouri's Medically Underserved Areas (PDF)

Concurrent Care for Children Requirement: Implementation Toolkit

National Hospice and Palliative Care Organization

With Contribution from Brenda Klutz and Nicky Moulton

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law enacting a new provision, Section 2302, termed the "Concurrent Care for Children" Requirement (CCCR). The District of Columbia Pediatric Palliative Care Collaborative (DCPPCC) and the National Hospice and Palliative Care Organization (NHPCO) are pleased to provide the Concurrent Care for Children Implementation Toolkit, which details information on the options available to states that are implementing Section 2302 or are considering expansion of pediatric palliative care services to children living with life-limiting or life-threatening conditions.

HMA is acknowledged in the publication.

Link to Report

Upcoming Appearances

CVS Caremark Client Forum: *Preparing for Imminent Change and Growth in Medicaid*

Vernon Smith, Principal
April 14-15, 2011
Orlando, Florida

Association of State and Territorial Health Officers Spring Conference: *Fiscal Impacts of Health Reform*

Vernon Smith, Principal
April 14-15, 2011
New Orleans, Louisiana

MACPAC Public Meeting: ***Monitoring Access to Care in Medicaid and CHIP***

Jennifer Edwards, Principal
April 15, 2011
Washington, DC

Communities of Practice (CoP): HMA Principals are leading CoP sessions with CMS for state Medicaid agency staff in the following areas:

Tom Dehner, Principal – Regional Collaboratives, April 18, 2011

Michigan's 27th Annual Developmental Disabilities Conference: ***Planning for Health Care Reform – A Michigan Update***

Eileen Ellis, Principal
April 20, 2011
East Lansing, Michigan

Health Care Leadership Forum: ***Health Care Reform Implementation in Michigan***

Eileen Ellis, Principal
April 26, 2011
Battle Creek, Michigan

The American Society on Aging's 2011 Aging in America Conference:
Understanding and Implementing the CLASS Act: A Breakthrough in Long-Term Services and Support
The Impact of the Economic Downturn on Long-Term Services and Supports

Susan Tucker, Principal
April 28-29, 2011
San Francisco, California

National Association of State Budget Officers: ***Budget Strategies & State Fiscal Conditions***

Mark Trail, Principal
April 30, 2011
Ft. Lauderdale, Florida

National Council of Behavioral Healthcare Annual Conference - Primary and Behavioral Health Care Integration Leadership Summit: ***Key Considerations in Designing the Health Home SPA***

Alicia Smith, Senior Consultant
May 1, 2011
San Diego, California

Thomson Reuters 2011 Healthcare Advantage Conference: ***What's Next for Medicaid: Unprecedented Challenges of Health Reform, Budget Stress and Political Uncertainty***

Vernon Smith, Principal
May 10, 2011
Salt Lake City, Utah

Medicaid Managed Care Congress

Vernon Smith, Principal
May 18-20, 2011
Baltimore, Maryland

National Commission on Correctional Health Care's "Updates in Correctional Health Care": *Medicaid Payment for Inpatient Hospitalizations: Now and 2014*

Donna Strugar-Fritsch, Principal
May 23, 2011
Phoenix, Arizona