HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: THIRD QUARTER MEDICAID MCO ENROLLMENT TRENDS

HMA ROUNDUP: CALIFORNIA ADULT DAY CARE TRANSITION STALLS; PENNSYLVANIA CASELOADS DECLINE FOLLOWING ELIGIBILITY REVIEW; NEW YORK MEDICAID REDESIGN SAVINGS PROJECTIONS IMPERILED; ILLINOIS MEDICAID CARE COORDINATION PROJECT MOVES FORWARD

OTHER HEADLINES: PENNSYLVANIA LEGISLATURE INTERVENES IN HIGHMARK/UPMC DISPUTE; ARKANSAS MEDICAID OVERHAUL UNDERWAY; NOT FOR PROFIT HOSPITAL TAX BREAKS SCRUTINIZED IN ILLINOIS, IOWA; MASSACHUSETTS' PURSUIT OF PAYMENT REFORM CONTINUES

RFP CALENDAR: NEW HAMPSHIRE MEDICAID MCO RFP TIMELINE ADDED

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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: REVIEWING THIRD QUARTER MEDICAID MCO ENROLLMENT TRENDS

This week, our *In Focus* section reviews recent Medicaid MCO enrollment trends in thirteen states. Many state Medicaid agencies elect to post to their website monthly enrollment figures by health plan for their Medicaid managed care population. We believe this data allows for the most timely analysis of enrollment trends across states and managed care organizations. As the discussion below describes, eighteen states[1] have released monthly Medicaid managed care enrollment data through June 2011. Of these, Medicaid managed care enrollment has increased in all of the states on a year over year basis with total membership up by more than 1.1 million lives, or 6.0%, to 20.1 million. We note that thirteen[2] of these states have released August 2011 MCO enrollment reports and eleven[3] states have released September 2011 reports. Thus far, we see continued strong enrollment trends with year over year growth above 7%, and the thirteen states adding an additional 192,000 covered lives in August. However, for the eleven states reporting September data, we begin to see some decline in the overall growth, particularly in states like Florida, Arizona, Michigan, and New York, all reporting declines in September enrollment.

In the discussion below, we discuss recent enrollment trends in the states where we track data. We also provide company-specific data for ten Medicaid managed care organizations. Before continuing, however, it is important to note the limitations of the data that is presented. First, we note that not all of the states report the data at the same time during the month so some of these figures reflect beginning of the month tallies while others reflect an end of the month snapshot. Second, in some cases this data is comprehensive in that it covers all of the state-sponsored health programs for which the state offers managed care, while in others, the data only reflects a subset of the broader population. For example, the state of Florida posts Medicaid managed care enrollment on a monthly basis for its Medicaid and Medicaid Reform populations, but not for its Healthy Kids (CHIP) programs. This is a significant limitation of the data and the key factor in drawing direct ties between the data described below and figures publicly reported by Medicaid MCOs. As such, the data we review in Table 1 should be viewed as a sampling of the enrollment trends across these states, as opposed to a comprehensive summary which, unfortunately, is not available on a monthly basis.

[1] AZ, CA, CT, FL, GA, HI, IL, MD, MI, MO, NY, OH, SC, TN, TX, WI, WA, WV

[2] AZ, CA, CT, FL, IL, MD, MI, NY, SC, TX, WI, WA, WV

[3] AZ, CA, CT, FL, IL, MD, MI, NY, SC, TX, WA

Table 1 - Medicaid Managed Care Monthly Enrollment Jan 2011 – Sept 2011

2011	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Arizona	1,195,485	1,196,548	1,192,517	1,191,307	1,199,744	1,209,906	1,218,035	1,227,598	1,221,271
+/- m/m	(5,693)	1,063	(4,031)	(1,210)	8,437	10,162	8,129	9,563	(6,327)
% y/y	0.7%	0.4%	0.1%	-0.2%	0.1%	0.5%	1.6%	2.3%	1.7%
California	3,255,675	3,255,750	3,311,973	3,333,398	3,356,047	3,406,397	3,454,904	3,472,030	3,516,116
+/- m/m	31,187	75	56,223	21,425	22,649	50,350	48,507	17,126	44,086
% y/y	8.1%	7.4%	8.8%	8.8%	8.7%	10.1%	10.9%	10.0%	10.9%
Connectictut	405,928	406,734	406,885	408,269	409,731	412,231	408,511	409,563	408,980
+/- m/m	2,087	806	151	1,384	1,462	2,500	(3,720)	1,052	(583)
% y/y	8.8%	6.9%	6.2%	5.8%	5.0%	4.6%	3.7%	3.4%	2.7%
Florida	1,107,471	1,120,566	1,128,264	1,129,565	1,130,395	1,135,892	1,137,598	1,128,966	1,115,696
+/- m/m	(5,122)	13,095	7,698	1,301	830	5,497	1,706	(8,632)	(13,270)
% y/y	5.9%	6.4%	6.4%	6.3%	6.0%	8.5%	7.2%	6.0%	3.8%
Georgia	1,126,183	1,120,860	1,129,173	1,128,062	1,115,413	1,125,867			
+/- m/m	(2,222)	(5,323)	8,313	(1,111)	(12,649)	10,454			
% y/y	0.5%	1.2%	1.3%	1.5%	-0.1%	3.3%			
Hawaii	42,863	43,004	43,105	43,260	43,329	43,344			
+/- m/m	1	141	101	155	69	15			
% y/y	2.9%	2.9%	2.7%	2.7%	2.3%	2.6%			
Illinois	196,739	196,365	196,060	196,403	197,160	199,765	200,810	203,246	204,581
+/- m/m	579	(374)	(305)	343	757	2,605	1,045	2,436	1,335
% y/y	-1.0%	N/A	-0.3%	0.2%	0.9%	1.9%	3.2%	3.8%	4.7%
Maryland	719,267	723,522	728,236	739,737	738,818	738,272	739,005	747,384	745,885
+/- m/m	3,990	4,255	4,714	11,501	(919)	(546)	733	8,379	(1,499)
% y/y	12.1%	12.5%	11.7%	12.1%	10.4%	9.7%	8.7%	8.7%	7.6%
Michigan	1,223,264	1,229,783	1,227,476	1,237,623	1,223,433	1,214,160	1,211,393	1,218,917	1,210,375
+/- m/m	789	6,519	(2,307)	10,147	(14,190)	(9,273)	(2,767)	7,524	(8,542)
% y/y	N/A	N/A	N/A	N/A	2.6%	1.4%	1.2%	0.6%	0.5%
Missouri	429,240	432,684	432,409	433,049	430,165	425,017			
+/- m/m	144	3,444	(275)	640	(2,884)	(5,148)			
% y/y	2.0%	2.5%	2.3%	2.3%	1.9%	0.8%			
New York	2,888,798	2,907,820	2,920,699	2,923,379	2,938,256	2,964,826	2,987,325	2,993,718	2,987,600
+/- m/m	16,067	19,022	12,879	2,680	14,877	26,570	22,499	6,393	(6,118)
% y/y	N/A	N/A	7.1%	6.8%	6.7%	6.5%	6.9%	7.0%	6.0%
Ohio	1,606,333	1,613,275	1,620,213	1,618,810	1,614,434	1,608,040	1,603,140		
+/- m/m	5,577	6,942	6,938	(1,403)	(4,376)	(6,394)	(4,900)		
% y/y	7.2%	6.6%	6.2%	5.5%	4.4%	3.1%	2.7%		
South Carolina	408,542	408,846	414,429	422,246	422,920	429,247	437,617	441,772	438,950
+/- m/m	2,867	304	5,583	7,817	674	6,327	8,370	4,155	(2,822)
% y/y	N/A	N/A	N/A	N/A	N/A	17.2%	18.0%	18.8%	12.1%
Tennessee	1,207,762	1,209,649	1,210,190	1,214,743	1,214,520	1,212,321			
+/- m/m	(4,953)	1,887	541	4,553	(223)	(2,199)			
% y/y	1.7%	1.7%	2.3%	1.9%	1.5%	1.3%			
Texas	2,321,899	2,321,502	2,326,252	2,341,377	2,390,415	2,392,138	2,396,891	2,536,363	2,545,173
+/- m/m	64,336	(397)	4,750	15,125	49,038	1,723	4,753	139,472	8,810
% y/y	16.1%	14.8%	12.6%	11.9%	12.0%	10.3%	10.2%	15.1%	15.7%
Wisconsin	683,093	698,429	698,225	700,518	705,184	708,806	705,853	709,696	
+/- m/m	9,471	15,336	(204)	2,293	4,666	3,622	(2,953)	3,843	
% y/y	10.4%	6.6%	6.2%	5.0%	5.6%	5.6%	5.5%	7.4%	
Washington	699,199	705,339	699,414	697,780	697,336	700,555	696,568	696,700	699,337
+/- m/m	(3,552)	6,140	(5,925)	(1,634)	(444)	3,219	(3,987)	132	2,637
% y/y	6.9%	7.2%	5.5%	4.9%	6.2%	3.0%	1.4%	1.7%	0.8%
West Virginia	168,663	166,608	167,823	168,228	168,504	166,555	165,935	166,373	
+/- m/m	1,350	(2,055)	1,215	405	276	(1,949)	(620)	438	
% y/y	1.7%	1.0%	1.2%	1.3%	2.0%	2.1%	2.7%	3.4%	
Total	**19,686,404**	**19,757,284**	**19,853,343**	**19,927,754**	**19,995,804**	**20,093,339**			
+/- m/m	116,903	70,880	96,059	74,411	68,050	97,535	76,795	191,881	17,707
% y/y					6.0%	6.0%	6.8%	7.8%	7.5%

Source: State Medicaid Agency websites

State Specific Analysis

Arizona

From May through August 2011, Arizona enrollment surpassed 1.2 million lives in MCO plans with steady month over month growth of roughly 8,100 to 10,100 lives. In September however, enrollments declined by roughly 6,300 lives. Arizona's MCO plans have seen a lot of fluctuation in month to month enrollments over the past year, however overall enrollment has held steady around 1.2 million.

Total	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total Arizona									
Acute Care	1,144,752	1,145,736	1,141,576	1,140,289	1,148,632	1,158,714	1,166,721	1,176,183	1,169,815
LTC	50,733	50,812	50,941	51,018	51,112	51,192	51,314	51,415	51,456
Total Arizona	**1,195,485**	**1,196,548**	**1,192,517**	**1,191,307**	**1,199,744**	**1,209,906**	**1,218,035**	**1,227,598**	**1,221,271**
+/- m/m	*(5,693)*	*1,063*	*(4,031)*	*(1,210)*	*8,437*	*10,162*	*8,129*	*9,563*	*(6,327)*
% y/y	*0.7%*	*0.4%*	*0.1%*	*-0.2%*	*0.1%*	*0.5%*	*1.6%*	*2.3%*	*1.7%*

California

At the end of June 2011, California enrolled over 3.4 million lives in MCO plans. Enrollment grew consistently through Q3 2011, adding roughly 48,000 lives in July, 17,000 in August, and another 44,000 in September. This brings September 2011 final enrollment above 3.5 million lives. California's MCO enrollments have grown consistently over the past year, with year-over-year growth rates increasing over the past several months, exceeding 10% in June and continuing with 10% year over year enrollment growth throughout Q3 2011.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total	**3,255,675**	**3,255,750**	**3,311,973**	**3,333,398**	**3,356,047**	**3,406,397**	**3,454,904**	**3,472,030**	**3,516,116**
+/- m/m	*31,187*	*75*	*56,223*	*21,425*	*22,649*	*50,350*	*48,507*	*17,126*	*44,086*
% y/y	*8.1%*	*7.4%*	*8.8%*	*8.8%*	*8.7%*	*10.1%*	*10.9%*	*10.0%*	*10.9%*

Connecticut

At the end of June 2011, Connecticut enrolled 412,231 lives in MCO plans through its Husky A and Husky B programs. Enrollment declined by roughly 3,700 in July, rebounded with 1,000 new lives in August, but declined again in September by nearly 600 lives. September 2011 enrollment finished at 408,980 lives, a loss of roughly 4,000 lives in Q3 2011. It should be noted that year-over-year growth rates have been consistently declining from over 9% a year ago, to only 2.7% as of September 2011.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Husky total									
Husky A	391,054	391,894	392,000	393,214	394,623	396,960	393,111	394,480	393,868
Husky B	14,874	14,840	14,885	15,055	15,108	15,271	15,400	15,083	15,112
Total Husky	**405,928**	**406,734**	**406,885**	**408,269**	**409,731**	**412,231**	**408,511**	**409,563**	**408,980**
+/- m/m	*2,087*	*806*	*151*	*1,384*	*1,462*	*2,500*	*(3,720)*	*1,052*	*(583)*
% y/y	*8.8%*	*6.9%*	*6.2%*	*5.8%*	*5.0%*	*4.6%*	*3.7%*	*3.4%*	*2.7%*

Florida

At the end of the second quarter of 2011, Florida enrolled more than 1.1 million lives in MCO plans through its Medicaid and Medicaid Reform programs. Enrollment grew by roughly 1,700 lives in July, but dropped by nearly 22,000 total enrollees in August and September combined, although total membership remains just above 1.1 million lives. Since last fall, Florida had experienced consistent mid to high single digit year over year growth in MCO enrollment until September 2011.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
MMCP	958,570	969,647	974,091	975,054	975,115	981,159	983,237	976,204	962,625
Reform Pilot	148,901	150,919	154,173	154,511	155,280	154,733	154,361	152,762	153,071
Total FL	**1,107,471**	**1,120,566**	**1,128,264**	**1,129,565**	**1,130,395**	**1,135,892**	**1,137,598**	**1,128,966**	**1,115,696**
+/- m/m	*(5,122)*	*13,095*	*7,698*	*1,301*	*830*	*5,497*	*1,706*	*(8,632)*	*(13,270)*
% y/y	*5.9%*	*6.4%*	*6.4%*	*6.3%*	*6.0%*	*8.5%*	*7.2%*	*6.0%*	*3.8%*

Illinois

The significant growth seen in Illinois MCOs beginning in June has continued, with more than 4,800 lives added in the third quarter of 2011. This growth brings total enrollment up to 204,581. September enrollment represents a nearly 5% increase in year-over-year enrollment.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total MCO	**196,739**	**196,365**	**196,060**	**196,403**	**197,160**	**199,765**	**200,810**	**203,246**	**204,581**
+/- m/m	*579*	*(374)*	*(305)*	*343*	*757*	*2,605*	*1,045*	*2,436*	*1,335*
% y/y	*-1.0%*	*-0.5%*	*-0.3%*	*0.2%*	*0.9%*	*1.9%*	*3.2%*	*3.8%*	*4.7%*
IL Health Connect (PCCM)	1,840,682	1,853,162	1,798,274	1,800,543	1,816,153	1,816,193	1,822,661	1,831,373	1,833,585
+/- m/m	*12,628*	*12,480*	*(54,888)*	*2,269*	*15,610*	*40*	*6,468*	*8,712*	*2,212*
% y/y	*6.3%*	*6.1%*	*2.8%*	*2.8%*	*1.6%*	*2.2%*	*2.1%*	*2.0%*	*2.1%*
% of total	*90.3%*	*90.4%*	*90.2%*	*90.2%*	*90.2%*	*90.1%*	*90.1%*	*90.0%*	*90.0%*
Total managed care	**2,037,421**	**2,049,527**	**1,994,334**	**1,996,946**	**2,013,313**	**2,015,958**	**2,023,471**	**2,034,619**	**2,038,166**
+/- m/m	*13,207*	*12,106*	*(55,193)*	*2,612*	*16,367*	*2,645*	*7,513*	*11,148*	*3,547*

We note that the above enrollments do not include the Medicaid managed care expansion to the Chicago suburbs which went live in May 2011 and for which enrollment has been reported for July through September in the enrollment data below. The enrollments associated with this expansion are projected to be just less than 40,000 lives.

	Jul-11	Aug-11	Sep-11
Aetna Better Health	6,630	8,740	13,561
+/- m/m	*6,630*	*2,110*	*4,821*
% y/y	*N/A*	*N/A*	*N/A*
% of total	*53.7%*	*51.8%*	*50.0%*
IlliniCare Health Plan (Centene)	5,713	8,135	13,563
+/- m/m	*5,713*	*2,422*	*5,428*
% y/y	*N/A*	*N/A*	*N/A*
% of total	*46.3%*	*48.2%*	*50.0%*
Total MCO	**12,343**	**16,875**	**27,124**
+/- m/m	*12,343*	*4,532*	*10,249*
% y/y	*N/A*	*N/A*	*N/A*

Michigan

Michigan Medicaid managed care enrollment continued the enrollment decline of over 23,000 lives in May and June, losing another 2,700 enrollees in July. Although enrollment picked up more than 7,500 lives in August, the downward trend resumed in September, losing more than 8,500 lives. Michigan has only seen four months of positive enrollment growth through the third quarter of the year, with a net decline of more than 12,000 covered lives.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total	**1,223,264**	**1,229,783**	**1,227,476**	**1,237,623**	**1,223,433**	**1,214,160**	**1,211,393**	**1,218,917**	**1,210,375**
+/- m/m	*789*	*6,519*	*(2,307)*	*10,147*	*(14,190)*	*(9,273)*	*(2,767)*	*7,524*	*(8,542)*
% y/y	*N/A*	*N/A*	*N/A*	*N/A*	*2.6%*	*1.4%*	*1.2%*	*0.6%*	*0.5%*

New York

June's high enrollment growth increased through July, adding another 22,500 lives before slowing to just under 6,400 additional lives in August. September showed the first decline in enrollment of 2011 for the state, keeping September 2011 final enrollment below 3.0 million lives. For the past several months, year-over-year growth has hovered between 6% and 7%, even with September's enrollment decline.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total	**2,888,798**	**2,907,820**	**2,920,699**	**2,923,379**	**2,938,256**	**2,964,826**	**2,987,325**	**2,993,718**	**2,987,600**
+/- m/m	*16,067*	*19,022*	*12,879*	*2,680*	*14,877*	*26,570*	*22,499*	*6,393*	*(6,118)*
% y/y	*N/A*	*N/A*	*7.1%*	*6.8%*	*6.7%*	*6.5%*	*6.9%*	*7.0%*	*6.0%*

South Carolina

South Carolina enrolled more than 12,000 new lives in MCO plans in July and August. However, September saw the first monthly enrollment decline of 2011, losing more than 2,800 enrollees and bringing final September enrollment down to just under 439,000. For the latter part of Q2 and Q3 of 2011, South Carolina has seen consistent double digit year-over-year growth in MCO enrollment.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
HMO Total	**408,542**	**408,846**	**414,429**	**422,246**	**422,920**	**429,247**	**437,617**	**441,772**	**438,950**
+/- m/m	*2,867*	*304*	*5,583*	*7,817*	*674*	*6,327*	*8,370*	*4,155*	*(2,822)*
% y/y	*N/A*	*N/A*	*N/A*	*N/A*	*15.9%*	*17.2%*	*18.0%*	*18.8%*	*12.1%*

Texas

As of June 2011, Texas enrolled about 2,392,000 lives in MCO plans. Enrollment increased by close to 5,000 lives in July, and grew significantly by nearly 140,000 covered lives in August. An additional 8,800 enrolled lives in September bring Q3 2011 final enrollment up above 2,545,000 lives. Year-over-year growth rates have generally held consistently in double-digits, above 15% for the August and September.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
STAR	1,506,748	1,501,457	1,504,787	1,519,561	1,561,723	1,561,299	1,561,171	1,675,356	1,678,517
STAR+PLUS	251,003	254,626	255,859	256,164	257,509	258,224	259,191	279,446	281,025
STAR HEALTH	30,906	31,218	31,374	31,545	32,046	32,199	32,092	31,980	31,952
CHIP	533,242	534,201	534,232	534,107	539,137	540,416	544,437	549,581	553,679
Total all programs	**2,321,899**	**2,321,502**	**2,326,252**	**2,341,377**	**2,390,415**	**2,392,138**	**2,396,891**	**2,536,363**	**2,545,173**
+/- m/m	*64,336*	*(397)*	*4,750*	*15,125*	*49,038*	*1,723*	*4,753*	*139,472*	*8,810*
% y/y	*16.1%*	*14.8%*	*12.6%*	*11.9%*	*12.0%*	*10.3%*	*10.2%*	*15.1%*	*15.7%*

Washington

As of June 2011, Washington enrolled just over 700,000 lives in MCO plans. Enrollment declined by roughly 4,000 lives in July, but regained more than 2,600 enrollees over August and September, with final Q3 2011 enrollment of a little over 699,000. Washington's year-over-year growth rates in enrollment have continued to decline, from nearly 16% in mid-2010, to just 0.8% in September.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total	**699,199**	**705,339**	**699,414**	**697,780**	**697,336**	**700,555**	**696,568**	**696,700**	**699,337**
+/- m/m	*(3,552)*	*6,140*	*(5,925)*	*(1,634)*	*(444)*	*3,219*	*(3,987)*	*132*	*2,637*
% y/y	*6.9%*	*7.2%*	*5.5%*	*4.9%*	*6.2%*	*3.0%*	*1.4%*	*1.7%*	*0.8%*

West Virginia

West Virginia enrolled roughly 166,500 million lives in MCO plans at the end of June. Enrollment declined by 620 enrollees in July, but saw the first enrollment growth in 3 months in August, adding roughly 440 enrollees. All told, in the nearly three quarters of 2011 reported, West Virginia has had a net decline of more than 2,000 MCO lives. However, year-over-year enrollment is up 3.4% as of August.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Total	**168,663**	**166,608**	**167,823**	**168,228**	**168,504**	**166,555**	**165,935**	**166,373**	
+/- m/m	*1,350*	*(2,055)*	*1,215*	*405*	*276*	*(1,949)*	*(620)*	*438*	
% y/y	*1.7%*	*1.0%*	*1.2%*	*1.3%*	*2.0%*	*2.1%*	*2.7%*	*3.4%*	

Wisconsin

As of June 2011, Wisconsin enrolled 708,800 lives in MCO plans. Enrollment increased by declined by roughly 2,900 in July, but rebounded in August, adding more than 3,800 lives and bringing final August enrollment up to nearly 709,700 lives. It should be noted that year-over-year growth rates have generally declined from over 16% a year ago, to only 5.5% in July 2011, although growth was up 7.4% in August, its highest level since January 2011.

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
BadgerCare+	651,940	666,021	666,838	669,019	672,768	677,013	673,595	676,916	
SSI	31,153	32,408	31,387	31,499	32,416	31,793	32,258	32,780	
Total WI	**683,093**	**698,429**	**698,225**	**700,518**	**705,184**	**708,806**	**705,853**	**709,696**	
+/- m/m	*9,471*	*15,336*	*(204)*	*2,293*	*4,666*	*3,622*	*(2,953)*	*3,843*	
% y/y	*10.4%*	*6.6%*	*6.2%*	*5.0%*	*5.6%*	*5.6%*	*5.5%*	*7.4%*	

Select Company Analysis

Aetna

We track monthly enrollment data in four states where Aetna operates risk-based managed care plans. We present three of those states below (excluding Missouri, who has not made public Q3 enrollment data).

Aetna	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Arizona	311,542	311,201	309,938	308,964	310,534	313,382	315,306	317,576	315,730
+/- m/m	(1,798)	(341)	(1,263)	(974)	1,570	2,848	1,924	2,270	(1,846)
% y/y	-0.5%	-0.8%	-1.4%	-1.9%	-1.8%	-1.2%	0.0%	0.7%	0.3%
Connectictut	97,070	97,574	98,006	98,304	98,756	99,421	98,748	99,189	99,236
+/- m/m	605	504	432	298	452	665	(673)	441	47
% y/y	9.8%	7.7%	7.9%	7.6%	6.8%	6.6%	5.7%	5.5%	4.9%
Texas	61,352	61,133	61,704	62,942	65,637	65,854	66,567	68,069	68,293
+/- m/m	(2,023)	(219)	571	1,238	2,695	217	713	1,502	224
% y/y	17.5%	16.8%	15.2%	14.5%	17.3%	14.4%	14.2%	13.9%	13.8%
Total Aetna	**469,964**	**469,908**	**469,648**	**470,210**	**474,927**	**478,657**	**480,621**	**484,834**	**483,259**
+/- m/m	(3,216)	(56)	(260)	562	4,717	3,730	1,964	4,213	(1,575)
% y/y					2.2%	2.3%	2.9%	3.3%	2.9%

Source: State Medicaid Enrollment data

Amerigroup

We track monthly enrollment data in six of the eleven states where Amerigroup operates. Unfortunately, two of them (Georgia and Tennessee) have not updated their monthly enrollment figures recently, while Ohio has not updated since the end of July. Within the three states that have reported monthly enrollment through September, Amerigroup covers over 965,000 lives, which compares to the 1.98 million reported in the second quarter of 2011.

Amerigroup	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Florida	174,912	177,240	177,959	178,525	179,034	180,120	180,636	177,948	175,647
+/- m/m	536	2,328	719	566	509	1,086	516	(2,688)	(2,301)
% y/y	6.8%	7.2%	7.0%	7.1%	6.5%	6.3%	5.7%	4.0%	1.9%
Maryland	199,748	200,273	201,156	204,008	202,897	202,307	201,781	202,918	202,004
+/- m/m	306	525	883	2,852	(1,111)	(590)	(526)	1,137	(914)
% y/y	3.1%	3.7%	3.5%	4.3%	2.9%	2.5%	2.4%	2.6%	2.2%
Ohio	54,767	55,031	55,285	55,091	54,697	54,671	54,607		
+/- m/m	(333)	264	254	(194)	(394)	(26)	(64)		
% y/y	-5.5%	0.6%	-0.8%	-1.5%	-3.6%	-5.4%	-5.7%		
Texas	564,527	563,649	563,547	565,433	574,321	572,767	570,948	591,212	589,537
+/- m/m	17,366	(878)	(102)	1,886	8,888	(1,554)	(1,819)	20,264	(1,675)
% y/y	15.7%	14.7%	12.4%	11.2%	10.4%	8.3%	7.7%	10.1%	10.1%
Total Amerigroup	**993,954**	**996,193**	**997,947**	**1,003,057**	**1,010,949**	**1,009,865**	**1,007,972**		
+/- m/m	17,875	2,239	1,754	5,110	7,892	(1,084)	(1,893)		
% y/y					7.3%	5.9%	5.4%		

Source: State Medicaid Enrollment data

Centene

We track monthly enrollment data in seven of the nine states where Centene operates risk-based health plans. Unfortunately, Georgia has not updated its monthly enrollment figures recently. Within the six states that have reported monthly enrollment through July, Centene covers over 951,000 lives, which compares to the 1.59 million reported in the second quarter of 2011. Across these state, Centene has experienced sequential monthly enrollment growth in eight of the last twelve months with total membership up 40,000 lives or 4.4% on a year over year basis through July 2011.

Centene	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Arizona	20,612	20,720	20,731	20,807	20,905	20,888	20,878	21,122	20,967
+/- m/m	53	108	11	76	98	(17)	(10)	244	(155)
% y/y	3.4%	3.4%	3.2%	3.1%	3.0%	2.3%	2.3%	3.8%	1.9%
Florida	185,721	187,081	186,866	186,713	186,962	188,073	188,299	185,982	185,068
+/- m/m	(7,133)	1,360	(215)	(153)	249	1,111	226	(2,317)	(914)
% y/y	78.1%	78.5%	76.4%	69.6%	67.8%	66.3%	64.2%	60.6%	59.3%
Ohio	158,741	159,233	159,724	159,399	158,611	157,883	157,470		
+/- m/m	(84)	492	491	(325)	(788)	(728)	(413)		
% y/y	5.2%	3.5%	3.1%	2.2%	0.7%	-0.2%	-0.6%		
South Carolina	87,920	83,545	82,516	82,904	81,717	82,797	84,624	85,486	78,397
+/- m/m	(1,134)	(4,375)	(1,029)	388	(1,187)	1,080	1,827	862	(7,089)
% y/y	0.0%	0.0%	0.0%	0.0%	-4.7%	-0.9%	1.3%	3.0%	-11.9%
Texas	442,756	443,165	444,084	447,473	456,878	457,997	459,447	480,672	482,020
+/- m/m	22,138	409	919	3,389	9,405	1,119	1,450	21,225	1,348
% y/y	3.7%	2.4%	1.1%	0.8%	1.8%	1.0%	1.3%	18.2%	18.0%
Wisconsin	40,528	41,096	41,052	40,787	40,816	40,923	40,702	41,100	
+/- m/m	2,695	568	(44)	(265)	29	107	(221)	398	
% y/y	-50.1%	-50.2%	-50.1%	-50.0%	-50.0%	-49.8%	-49.5%	-48.1%	
Total Centene	**936,278**	**934,840**	**934,973**	**938,083**	**945,889**	**948,561**	**951,420**		
+/- m/m	16,535	(1,438)	133	3,110	7,806	2,672	2,859		
% y/y					4.4%	4.2%	4.4%		

Source: State Medicaid Enrollment data

Coventry

We track monthly enrollment data in four states where Coventry operates risk based health plans. However, Missouri has not updated enrollment figures since June. Coventry covered 343,404 lives in these states in May, about 200,000 of which is in Missouri, which compares to the 468,000 reported in the first quarter of 2011. Coventry operates a Medicaid managed care plan in Pennsylvania where monthly enrollment figures are not available. Across these three states, Coventry has experienced monthly enrollment declines in five of the last 9 months (not including West Virginia) with total membership down 1.6% on a year over year basis through August 2011.

Coventry	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Florida	42,714	42,643	42,218	41,780	41,726	41,749	42,101	42,000	42,005
+/- m/m	(598)	(71)	(425)	(438)	(54)	23	352	(101)	5
% y/y	-3.8%	-4.2%	-5.3%	-5.9%	-5.7%	-5.5%	-5.1%	-4.8%	-4.8%
Michigan	50,215	50,145	49,600	49,756	48,619	47,558	47,140	46,987	46,512
+/- m/m	(241)	(70)	(545)	156	(1,137)	(1,061)	(418)	(153)	(475)
% y/y	N/A	N/A	N/A	N/A	-7.7%	-8.8%	-8.9%	-9.4%	-9.4%
West Virginia	57,751	56,902	57,478	57,944	58,098	57,404	57,532	57,856	
+/- m/m	778	(849)	576	466	154	(694)	128	324	
% y/y	7.4%	5.9%	5.9%	6.3%	6.6%	7.0%	7.9%	8.7%	
Total Coventry	**150,680**	**149,690**	**149,296**	**149,480**	**148,443**	**146,711**	**146,773**	**146,843**	
+/- m/m	(61)	(990)	(394)	184	(1,037)	(1,732)	62	70	
% y/y					-2.0%	-2.2%	-1.8%	-1.6%	

Source: State Medicaid Enrollment data

Health Net

We track Health Net's monthly enrollment data in California where the company covers nearly 648,000 Medicaid members through September 2011. The figures listed below do not include enrollment in the state's Healthy Families program which is operated separately and for which monthly enrollment is not available. Health Net reported 963,000 Medi-Cal/Medicaid lives in the second quarter of 2011. We note that Health Net's Fresno contract (123,000 lives) was awarded to a local plan called CalViva in March Health for whom Health Net is serving as a subcontractor. Outside of this change, Health Net has experienced sequential monthly enrollment growth in every month for the last year. Excluding the contract loss, Health Net's Medi-Cal membership is up 52,000 lives organically over the 12 months through September 2011.

Health Net	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
California	737,407	737,855	615,047	618,629	621,268	629,700	638,170	640,116	647,845
+/- m/m	9,180	448	(122,808)	3,582	2,639	8,432	8,470	1,946	7,729
% y/y					-11.0%	-10.0%	-9.4%	-10.5%	-9.8%

Source: State Medicaid Enrollment data

Humana

We track Humana's monthly enrollment data in Florida where the company covers 47,000 Medicaid members through September 2011. Humana reported 619,200 Medicaid lives in the second quarter of 2011, most of which is in Puerto Rico. In Florida, Humana has continued to shed Medicaid membership in every month so far in 2011. Enrollment is down 8.7% year over year.

Humana	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Florida	51,830	51,471	50,949	49,965	49,657	49,191	49,028	48,104	47,107
+/- m/m	(295)	(359)	(522)	(984)	(308)	(466)	(163)	(924)	(997)
% y/y					-1.7%	-3.1%	-3.9%	-6.3%	-8.7%

Source: State Medicaid Enrollment data

Molina

We track monthly enrollment data in eight of the ten states where Molina operates risk based health plans, with only New Mexico and Utah unavailable. Within these seven states that have reported monthly enrollment through July, Molina covers 1.21 million lives, which compares to the 1.65 million reported in the second quarter of 2011. The differential resulting from the absence of the New Mexico and Utah enrollment as well as membership covered in programs for which monthly data is available such as the California Healthy Families program. Across these states, Molina has experienced sequential monthly enrollment growth in nine of the last twelve months. This growth was driven by contract wins in Texas (rural CHIP, Dallas STAR+PLUS) and the acquisition of Abri Health Plan in Wisconsin. The only state where Molina has experienced net disenrollment in the last year is Michigan.

Molina	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
California	189,561	189,057	189,071	189,392	189,989	191,756	194,107	194,863	195,812
+/- m/m	838	(504)	14	321	597	1,767	2,351	756	949
% y/y	8.5%	7.0%	6.9%	6.3%	5.8%	6.7%	7.5%	6.1%	6.6%
Florida	61,336	63,289	64,897	64,870	65,054	65,548	65,775	65,128	64,941
+/- m/m	272	1,953	1,608	(27)	184	494	227	(647)	(187)
% y/y	20.8%	23.6%	25.6%	25.3%	24.2%	22.2%	19.5%	15.9%	13.3%
Michigan	218,083	218,027	216,867	217,453	213,734	211,085	209,944	209,836	207,818
+/- m/m	(397)	(56)	(1,160)	586	(3,719)	(2,649)	(1,141)	(108)	(2,018)
% y/y	N/A	N/A	N/A	N/A	-2.6%	-3.5%	-3.6%	-4.4%	-4.6%
Ohio	242,704	244,084	245,228	245,231	244,519	243,417	242,536		
+/- m/m	115	1,380	1,144	3	(712)	(1,102)	(881)		
% y/y	10.9%	8.8%	7.9%	7.3%	5.8%	4.3%	3.8%		
Texas	120,955	122,406	122,840	123,055	124,441	125,022	126,162	141,318	144,265
+/- m/m	32,181	1,451	434	215	1,386	581	1,140	15,156	2,947
% y/y	221.5%	222.4%	220.9%	211.4%	214.4%	216.4%	220.6%	57.7%	64.4%
Washington	333,181	331,543	327,560	326,597	328,450	331,122	331,255	332,590	334,240
+/- m/m	(9,061)	(1,638)	(3,983)	(963)	1,853	2,672	133	1,335	1,650
% y/y	4.4%	3.2%	1.0%	-0.1%	2.3%	-0.4%	-1.5%	-1.0%	-1.6%
Wisconsin	39,307	39,780	39,763	39,990	40,649	40,672	40,783	40,940	
+/- m/m	3,273	473	(17)	227	659	23	111	157	
% y/y	124.4%	115.5%	112.7%	118.8%	122.2%	120.2%	125.2%	130.0%	
Total Molina	**1,205,127**	**1,208,186**	**1,206,226**	**1,206,588**	**1,206,836**	**1,208,622**	**1,210,562**		
+/- m/m	27,221	3,059	(1,960)	362	248	1,786	1,940		
% y/y					13.7%	12.3%	12.0%		

Source: State Medicaid Enrollment data

UnitedHealth

We track monthly enrollment data in eight states where UnitedHealth operates risk-based health plans. Within these eight states, UnitedHealth covers 1.24 million lives, which compares to the 3.49 million reported in the third quarter of 2011. In this subset of markets, UnitedHealth has experienced sequential monthly enrollment growth in each of the last twelve months with total membership up 98,069 lives or 8.6% on a year over year basis through July 2011. Enrollment growth benefited by a contract expansion in Wisconsin but was primarily caused by solid organic expansion in every market other than Ohio.

UnitedHealth	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Arizona	252,376	251,983	250,899	250,383	252,358	255,311	257,351	259,546	258,960
+/- m/m	(1,579)	(393)	(1,084)	(516)	1,975	2,953	2,040	2,195	(586)
% y/y	2.3%	1.7%	1.4%	0.9%	1.1%	1.6%	2.7%	3.1%	2.5%
Connectictut	50,422	50,572	50,737	51,262	51,677	52,236	51,843	52,077	52,315
+/- m/m	577	150	165	525	415	559	(393)	234	238
% y/y	16.8%	15.8%	14.7%	13.9%	12.2%	11.5%	10.6%	9.7%	8.7%
Florida	114,293	116,589	117,537	117,569	117,998	118,709	119,069	118,026	115,787
+/- m/m	1,378	2,296	948	32	429	711	360	(1,043)	(2,239)
% y/y	13.8%	15.1%	14.1%	14.0%	13.7%	12.7%	11.3%	9.4%	5.9%
Michigan	235,158	237,160	237,053	239,144	236,664	237,377	238,599	240,424	238,825
+/- m/m	1,157	2,002	(107)	2,091	(2,480)	713	1,222	1,825	(1,599)
% y/y	N/A	N/A	N/A	N/A	7.2%	5.6%	5.3%	4.6%	4.5%
Ohio	118,784	119,054	119,264	118,908	118,252	117,699	117,423		
+/- m/m	185	270	210	(356)	(656)	(553)	(276)		
% y/y	-0.2%	0.0%	-0.4%	-1.3%	-2.4%	-3.4%	-3.7%		
South Carolina	73,513	73,918	74,976	75,436	74,575	75,015	75,741	75,880	75,187
+/- m/m	630	405	1,058	460	(861)	440	726	139	(693)
% y/y	N/A	N/A	N/A	N/A	17.1%	15.4%	13.8%	13.3%	6.4%
Texas	89,597	89,930	90,421	91,005	92,263	93,062	93,755	104,614	104,992
+/- m/m	668	333	491	584	1,258	799	693	10,859	378
% y/y	8.9%	9.1%	8.8%	8.6%	8.9%	8.0%	8.7%	19.9%	20.0%
Wisconsin	275,043	283,469	283,515	285,581	289,779	290,841	290,490	291,938	
+/- m/m	9,564	8,426	46	2,066	4,198	1,062	(351)	1,448	
% y/y	26.5%	23.5%	21.2%	20.1%	21.6%	20.9%	20.8%	23.0%	
Total UnitedHealth	**1,209,186**	**1,222,675**	**1,224,402**	**1,229,288**	**1,233,566**	**1,240,250**	**1,244,271**		
+/- m/m	12,580	13,489	1,727	4,886	4,278	6,684	4,021		
% y/y					9.3%	8.6%	8.6%		

Source: State Medicaid Enrollment data

WellCare

We track monthly enrollment data in four of the five states where WellCare operates risk based Medicaid health plans (New York excluded). Within these four states, WellCare covers just under 600,000 Medicaid lives, which compares to the 1.32 million reported in the second quarter of 2011. The differential results from the absence of the New York enrollment as well as membership in programs for which monthly data is available such as the Florida Healthy Kids program. Across these states, WellCare has experienced sequential monthly enrollment attrition in nine of the last twelve months with total membership down 19,446 lives or 3.2% on a year over year basis through June 2011. Enrollment losses have been most pronounced in Florida and Illinois.

WellCare	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
Florida	345,800	346,560	345,347	344,176	342,385	341,765	340,819	339,969	334,732
+/- m/m	(2,101)	760	(1,213)	(1,171)	(1,791)	(620)	(946)	(850)	(5,237)
% y/y	-4.0%	-3.7%	-3.7%	-3.0%	-3.1%	-2.9%	-3.4%	-2.8%	-4.3%
Illinois	138,921	138,262	137,496	136,713	135,296	134,233	134,309	133,704	
+/- m/m	(1,349)	(659)	(766)	(783)	(1,417)	(1,063)	76	(605)	
% y/y	-5.3%	-5.3%	-5.4%	-5.7%	-6.8%	-6.2%	-6.2%	-6.0%	
Ohio	100,420	100,832	101,139	100,975	100,878	100,427	100,295		
+/- m/m	(390)	412	307	(164)	(97)	(451)	(132)		
% y/y	1.0%	1.4%	1.2%	0.8%	0.6%	-0.5%	-0.7%		
Total WellCare	**585,141**	**585,654**	**583,982**	**581,864**	**578,559**	**576,425**	**575,423**		
+/- m/m	(3,840)	513	(1,672)	(2,118)	(3,305)	(2,134)	(1,002)		
% y/y					-5.9%	-3.3%	-3.6%		

Source: State Medicaid Enrollment data

WellPoint

We track monthly enrollment data in four states where WellPoint operates risk based health plans. Within these four states, WellPoint covers 556,000 lives which compares to the 1.84 million reported in the company's state-sponsored programs for second quarter of 2011. In this subset of markets, WellPoint has experienced sequential monthly enrollment growth in seven of the last twelve months with total membership up 7,792 lives or 1.4% on a year over year basis through August 2011.

WellPoint	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
California	409,094	406,011	422,332	422,089	423,927	427,989	430,778	430,214	432,917
+/- m/m	100	(3,083)	16,321	(243)	1,838	4,062	2,789	(564)	2,703
% y/y	-3.0%	-3.3%	1.1%	1.2%	1.9%	3.4%	4.3%	4.0%	4.9%
Texas	16,780	17,020	17,652	18,493	19,605	19,834	20,100	20,592	20,958
+/- m/m	(3,522)	240	632	841	1,112	229	266	492	366
% y/y	-39.6%	-38.1%	-35.8%	-33.0%	-29.6%	-25.2%	-20.8%	-15.3%	-8.8%
Wisconsin	24,412	24,775	24,665	24,553	23,973	24,238	23,894	23,980	
+/- m/m	(5,086)	363	(110)	(112)	(580)	265	(344)	86	
% y/y	-18.4%	-20.0%	-21.4%	-22.1%	-24.0%	-22.8%	-23.2%	-21.7%	
West Virginia	83,154	82,250	82,753	82,742	82,929	81,912	81,537	81,537	
+/- m/m	635	(904)	503	(11)	187	(1,017)	(375)	0	
% y/y	0.2%	0.1%	0.2%	0.1%	1.0%	0.8%	1.4%	1.9%	
Total WellPoint	**533,440**	**530,056**	**547,402**	**547,877**	**550,434**	**553,973**	**556,309**	**556,323**	
+/- m/m	(7,873)	(3,384)	17,346	475	2,557	3,539	2,336	14	
% y/y					-1.3%	0.2%	1.2%	1.4%	

Source: State Medicaid Enrollment data

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

The State's elimination of its adult day health care program continues to generate controversy and opposition in the courts. As a reminder, the state eliminated the adult day health care benefit during the most recent budget session and reduced funding to provide funds only for transitional services. The state currently plans to eliminate this benefit on December 1, 2011. A major component of the state's transition plan was to move people receiving adult day health center services into capitated managed care contracts so that health plans could assess their health care needs and arrange transitional/replacement services. 26,000 beneficiaries that access adult day care services were scheduled to be transitioned to managed care plans on October 1. Less than 1,000 chose a health plan, approximately 15,000 opted out of managed care, and approximately 10,000 were enrolled in managed care because they did not select either fee for service or a managed care plan. Those people not enrolling in managed care will receive assessments and case management services from a state contractor specializing in care management, APS Healthcare Inc. On November 8, 2011 the U.S. District Court will hold a hearing on whether the state can proceed with the elimination of this benefit on December 1, 2011.

CMS continues to review California's proposed rate cuts, copayments, and proposed benefit limits. Our expectation is that some or most of those reductions will be approved, though it is less likely the increase in co-pays at the level proposed by the state will be approved. Those portions of the most recent 10 percent provider rate reduction that are approved by CMS would be effective retroactively to June 1, 2011. It is likely that there will be additional court action on these reductions. These reductions, if approved and if they go into effect, will apply to both the Medi-Cal fee for service and managed care programs.

The Department of Health Care Services (DHCS) announced last week the intent to award five contracts to regional health care organizations for pilot projects aimed at improving care for children with special health care needs through the California Children's Services (CCS) program. Part of the state's ongoing Bridge to Reform waiver, the program will launch in Alameda, Imperial, parts of Los Angeles, Orange, San Diego and San Mateo counties. DHCS issued "intent to award" notices to Rady Children's Hospital of San Diego County, Children's Hospital of Orange County, L.A. Care Health Plan, Health Plan of San Mateo County and Alameda County Health Care.

In the news

- **State to clinics: Send back payments for dental care**

  State coverage for Medi-Cal patient dental and podiatry services was cut amid budget shortfalls in mid-2009, but reinstated by court order after clinics sued in October of last year. Clinics offered the services again until May, when the state met the procedural hurdle to eliminate state coverage of benefits such as dental care and podiatry, which are considered optional under the state and federal Medicaid program. Now, leaders of

clinics are bracing for bills in the hundreds of thousands of dollars as the Department of Health Care Services says it wants its money back. (California Watch)

- **Many Opt Out of State's ADHC Plan**

  In August, a letter and application packet went out to about 26,000 people in the adult day health care system, a program slated for elimination as a Medi-Cal benefit on Dec. 1. Beneficiaries were asked to choose between three options: They could sign up for one of the managed care options; they could send in a form to opt out of those plans; or they could do nothing, and would be automatically enrolled. Of those 26,068 patients, 654 chose a managed care plan, and another 10,297 people did nothing and were automatically enrolled in a managed care plan. The majority -- 15,117 people -- chose to remain in their fee-for-service plans. (California Healthline)

Florida

HMA Roundup – Gary Crayton

Florida Medicaid has contracted with two Prepaid Dental Health Plans (PDHPs), DentaQuest and Managed Care of North America (MCNA), to provide children's dental services in all Florida counties except Miami-Dade and the Medicaid Reform Pilot counties, which are Baker, Broward, Clay, Duval, and Nassau.

In the news

- **Medicaid 'reform' plans get rate hike**

  Medicaid managed-care plans in Florida's five Medicaid "reform" counties have been granted a 10.8 percent rate increase because of ever-increasing hospital costs, the president of Florida Association of Health Plans confirmed today. Meanwhile, said Michael Garner, the managed-care plans in most counties of the state were granted an average 1.3 percent rate increase. The need for a double-digit rate increase in the five-county pilot program -- where most Medicaid beneficiaries are required to be enrolled in an HMO or provider-sponsored network -- indicates that plans lack the market power to hold down costs unilaterally. (Health News Florida)

Illinois

HMA Roundup – Matt Powers / Jane Longo

The state held a Care Coordination Innovations Project Meeting last Thursday, October 13. The Innovations Project is in response to the state law requiring 50% Medicaid recipients be in "risk-based Care Coordination" by 2015. About 1,000 called in for the webinar and about 100 were in–person at the meeting. Some of the key points included:

- Phase I: January 2012 RFP for non-MCO providers coming together to present care coordination models. Contracts to be executed in summer 2012. MCOs can provide "back-office" functions. No auto-assignment has been discussed for the Phase I project.
- Phase II: April 2012 RFP for Medicare Advantage providers for dual eligibles
    - MCO RFPs in summer of 2012

    - Contracts executed in fall of 2012
- Comments to HFS by November 1, 2011

Additionally, the Governor's Healthcare Reform Implementation Council met on Friday, October 14. Items discussed featured the Exchange, governance structure, and financing the Exchange. Authorizing legislation is important and will be a key issue this fall.

In the news

- **Hospitals fight for tax breaks while state wrestles with rules**

  For more than a century, nonprofit hospitals in Illinois generally have not had to pay property, income and sales taxes. In exchange, the hospitals individually grant millions of dollars in free or reduced-cost care to patients who qualify because they are poor or uninsured. Many Chicago-area medical centers say they provide millions more in community benefits in the form of research, education and free walk-in care clinics. Last month, Gov. Pat Quinn declared a moratorium on hospital tax rulings while the stakeholders try to negotiate a resolution of the issue by March 1. Central to the issue is that — although charity care is among the factors that determine a hospital's tax status — there is no minimum charity care threshold that a hospital must meet to be tax-free. There's also disagreement on the extent to which community benefits should count. If nonprofit hospitals were required to pay property taxes like their for-profit counterparts, that could generate hundreds of millions of dollars annually in the Chicago area alone to help schools, parks and police and fire departments. Hospital executives counter that they would have to cut services or — in the case of one northwest Illinois medical center — shut down. (Chicago Tribune)

- **State owes millions to suburban hospitals, and tab threatens to grow rapidly**

  Hospitals are among the biggest businesses in the suburbs and, as such, hold some of the biggest IOUs from the state of Illinois — a tab that threatens to quickly grow much bigger. Illinois' deliberate policy of not paying its overdue bills for months at a time leaves it more than $12 million in debt to Advocate Health Care, which has hospitals in Barrington, Libertyville, Park Ridge, Downers Grove, Chicago and other locations. Hospitals have another possible problem looming. Gov. Pat Quinn cut $276 million in hospital reimbursements from the state budget. Hospital supporters will be fighting that cut as lawmakers return to Springfield later this month. (Daily Herald)

- **Illinois gives $7.3-million IT health contract to Massachusetts firm**

  The Quinn administration has awarded a $7.25-million contract to a New England-based software company to set up a statewide system for doctors and hospitals to share patient records. Privately held InterSystems Corp. outbid Medicity Inc., a subsidiary of Hartford, Conn.-based health insurance company Aetna Inc., which made a $10.7-million offer, Illinois procurement records show. The contract for InterSystems to set up the state's electronic health information exchange can be extended to nearly five years with three one-year renewals. The first phase of service is expected to be rolled out in April. (Crain's Chicago)

New York

HMA Roundup – Denise Soffel

Last year, as part of prior approval legislation, the then-State Insurance Department gained new power to review rate increases proposed for those covered by individual and small-group policies (about 3 million people in New York). Major health insurance companies seeking steep premium increases in New York are required to submit memos to state officials to justify rate increases. The Superintendent of the newly-created Department of Financial Services, Benjamin Lawsky, has ordered that the memos be made public. His decision ends a longstanding policy that exempted the insurance companies from public access under a "trade secret" exception. The insurance industry is fighting to keep the memos from the public. Ten insurance plans in New York have filed objections, contending that disclosure would provide competitors with an unfair advantage, possibly reducing competition and raising premium prices. If the insurance companies do not obtain a court injunction, the memos will be made public by the end of November.

An analysis of the Medicaid Redesign Team progress in meeting budget targets identifies causes for concern that savings may not be implemented on time. In a blog post from the Citizen's Budget Commission the post notes that much remains to be done before the state will reach its goals. The progress report on MRT savings presented last week shows that while the state is well on its way to meeting its goal, much of the savings to date has come from across-the-board rate cuts and the elimination of inflation-based trend factors – what CBC calls low-hanging fruit. Much less has been realized through utilization control proposals that require reductions in excessive utilization or changes in the way that services are provided, a more challenging task.

A report in Crain's Health Pulse indicates that New York's Medicaid managed care plans are reporting significant financial stress. The plans experienced rate cuts in 2010 and 2011 at the same time that enrollment has been climbing. As part of New York's impetus to move the entire Medicaid population into Medicaid managed care plans over the next 3 years, plans are being asked to take on more complex patients, and to oversee additional benefits. Their ability to do this effectively may be compromised by inadequate reimbursement rates

In the news

- **Cuomo Says He Will Reform Agencies Serving Disabled**

  Gov. Andrew M. Cuomo, saying he was startled by problems with the handling of abuse and neglect allegations at state facilities, on Wednesday vowed reforms at six agencies that provide residential care for the disabled, the elderly, children and the mentally ill. Speaking to reporters as he met with his cabinet, Mr. Cuomo and his staff said a review of the agencies had found myriad clashing procedures — differing definitions of abuse, varying directives about when to call law enforcement, inconsistent standards of proof and sometimes no standard of proof at all. (New York Times)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak / Stacy Mitchell

This week, the Department of Public Welfare sent a "Dear Stakeholder" letter seeking input on program design options to test financial alignment Models for Medicare-Medicaid enrollees. As a reminder, Pennsylvania submitted a letter of intent to participate in the program outlined by CMS' State Medicaid Director letter but did not specify which model it would pursue. In the stakeholder letter, DPW notes that the CMS opportunity requires that, over a three-year period, states test a capitated model and/or a fee-for-service model that integrates all physical health (PH), behavioral health (BH), and long-term care (LTC) (institutional and home and community based services[HCBS]) services for dual eligibles. We note that Pennsylvania has historically carved out behavioral health benefits for its Medicaid population state-wide.

At least partially in response to pressure from the State Auditor General and the Legislature, the Pennsylvania Department of Public Welfare has recently taken measures to tighten its enforcement of its Medicaid eligibility rules. In July 2011, State eligibility staff started a special review of close to 70,000 of its Medical Assistance cases (primarily Medicaid eligibles) that were overdue for renewal. As a result, over 30,000 cases have been closed due to failure by the consumer to provide required documentation within specified time frames. Not surprisingly , consumer advocates in Pennsylvania have expressed concern over the fairness of the state's actions and have stepped up efforts to assist consumers in appealing and complying with the documentation requirements.

Eligibility data recently posted by the state shows a drop from 2,333, 807 Medical Assistance eligibles in August to 2,302, 066 eligibles in September – a 1.4% drop. This is a notable change since, like most states, Pennsylvania has seen the number of its Medical Assistance eligibles continuously trend upward for years. See Pennsylvania trend data here: (Link to report)

It is too soon to tell how many of those who lost eligibility will eventually re-qualify once the appropriate documentation is provided. It is also too early to predict if this change in policy will cause any longer term change in the eligibility trend.

In late September 2011, The Pennsylvania Department of health (PADOH) released the 2010 Healthcare-Associated Infections (HAI) Report. This is the third report PADOH has issued on the occurrence and patterns of health care associated infections (HAIs) since the implementation of state Act 52 of 2007. This report demonstrates a continued decline in the overall incidence of HAIs in Pennsylvania, along with substantial declines in two of the three categories of HAIs used for benchmarking purposes (catheter-associated urinary tract infections, or CAUTIs, and central line-associated bloodstream infections, or CLABSIs). The report also contains the first reported information on surgical site infections (SSIs), the third category of HAIs used for benchmarking. All hospitals in the commonwealth are required to report any HAI that occurs in an in-patient location.

The full report can be seen here: (Link to report)

In the news

- **State Legislature to get involved in Highmark-UPMC dispute**

  Department of Health officials were the focus of a hearing on legislation aimed at forcing UPMC to negotiate a new contract with Highmark. The contract expires in June, and UPMC is refusing to renew it at any price because its officials are concerned about unfair competition from West Penn Allegheny Health System, which Highmark is acquiring. Medical center officials have said they fear Highmark would tout UPMC facilities and reputation when it markets its insurance plans but later would direct patients to West Penn Allegheny. Lawmakers want the Department of Health to take action. Health officials said they can force Highmark to provide a study of the impact of ending the contract, but existing regulations don't provide for a similar study by UPMC. (Pittsburgh Post-Gazette)

OTHER HEADLINES

Alaska

- **Advocates push for a boost in Denali KidCare funding**

  Denali KidCare supporters are making what could be a last-ditch push against Gov. Sean Parnell's thwarting of efforts to restore the state health insurance program for lower-income children and pregnant women to the level it was before the Legislature made cuts to eligibility in 2003. The upcoming 90-day legislative session, which begins in January, could be the best chance supporters have to get the bill through the Legislature for a while. That's because the redrawing of legislative districts, done after the 2010 Census, will make it harder for Democrats to remain in power as part of the bipartisan majority that controls the state Senate. (Anchorage Daily News)

Arizona

- **State health care rolls plummet in strapped Arizona**

  Arizona officials estimated that 100,000 Medicaid recipients could lose their health insurance coverage in the first year after the state stopped enrolling childless adults in the program in July. After three months, their expectations are right on track. The Cronkite News Service reports that 25,000 Arizonans have lost their health insurance since the rule change went into effect. The plummeting enrollment includes 14,000 residents who were denied coverage in September, the largest monthly decline since the new policy began. All of the affected residents are low-income childless adults. Arizona had previously offered these individuals coverage in what was considered a generous state version of Medicaid, the state-federal health insurance program for the poor. Only five other states offer coverage to childless adults, Cronkite notes. But facing an extremely tight state budget, Arizona asked for — and received — a waiver from the federal government to make basic changes to its enrollment rules, leading to the July policy shift. Originally, Arizona Governor Jan Brewer had proposed cutting as many as 250,000 people from state coverage. (Stateline.org)

Arkansas

- **State Medicaid director to resign**

  Gene Gessow gave verbal notice Monday that he plans to resign in early November. The departure of the state's Medicaid chief will not slow efforts to change the way the government health program pays for services, Gov. Mike Beebe said today. Gessow is leaving as work groups begin to hammer out details of a plan to change the way the state Medicaid program and private insurers pay for health care services in Arkansas. Gessow has played a key role in the initiative, which seeks to develop a new payment system in which health care providers are paid for entire episodes of care rather than for each service provided. The initiative seeks to lessen the impact of a projected Medicaid shortfall and make health care more affordable and efficient for all Arkansans. (Arkansas News)

- **Work begins on setting details of state Medicaid overhaul**

  Gov. Mike Beebe's project to change the way the state Medicaid program pays for services moved a step forward today with the initial meeting of one of nine work groups tasked with hammering out the details of those changes. More than 50 people participated in the first meeting of the work group on pregnancy and neonatal intensive care at the University of Arkansas for Medical Sciences in Little Rock. Eight other work groups will meet in the coming weeks to begin discussing other areas of health care that state officials are targeting. (Arkansas News)

- **Ark. insurance officials look at health exchange**

  Arkansas insurance officials held a summit Tuesday to discuss how to set up an insurance exchange required under the federal health care overhaul, prompting complaints from Republican legislators who have objected to the state seeking funds for the program. The daylong summit came more than a week after Gov. Mike Beebe decided against asking the federal government for a $3.8 million planning and study grant after GOP lawmakers objected to the move. (Business Week)

Iowa

- **Hospitals avoid taxes despite little free care**

  Scores of Iowa hospitals are exempt from most taxes because they're classified as charities, but some spend less than 1 percent of their money on free care for the poor, a Des Moines Register analysis shows. At issue are tens of millions of dollars in taxes on property and income that hospitals are excused from paying because of their charity status. (Des Moines Register)

Maryland

- **Program could reduce by half those without health insurance, state official says**

  Maryland should be able to cut the number of uninsured by half and garner $850 million in savings during 10 years through changing how health care is paid for and delivered, a state health official told a House committee Monday. Officials and consultants are figuring out how to do that now, as they work out details of how to operate, finance, promote and enroll residents for coverage they can afford through the Maryland

Health Benefit Exchange, which was mandated in legislation passed in the 2011 regular session of the General Assembly, Carolyn Quattrocki, executive director of the Governor's Office of Health Care Reform, told the House Health and Government Operations Committee. The exchange will create a single point of entry that can be used by Marylanders to look for more affordable health care insurance, with computer-based navigation tools and advisers available to help them find and assess plans for which they qualify. (Gazette.net)

Massachusetts

- **Massachusetts posts dual eligible integration LOI**

  The state not only submitted an LOI for a non-elderly duals demonstration, but they also expressed an interest in returning their Senior Care Options (SCO) Program for elderly duals to a 3-way contract. The SCO program was first structured as a 3-way contract before they were required to develop 2 way contracts (SCO to Medicaid and SCO to Medicare) and the SCOs had to become SNPs. (Link to LOIs)

- **Massachusetts Tries to Rein In Its Health Costs**

  After three years of study, the state's legislative leaders appear close to producing bills that would make Massachusetts the first state — again — to radically revamp the way doctors, hospitals and other health providers are paid. Although important details remain to be negotiated, the legislative leaders and Gov. Deval Patrick, all Democrats, are working toward a plan that would encourage flat "global payments" to networks of providers for keeping patients well, replacing the fee-for-service system that creates incentives for excessive care by paying for each visit and procedure. (New York Times)

- **Blue Cross to remain nonprofit public charity**

  Blue Cross Blue Shield of Massachusetts has decided to remain a nonprofit public charity after examining whether it should seek a different legal status given its extensive business operations as the state's largest health insurer. (Boston Globe)

Nebraska

- **Nebraska Insurance Director Needs More Data on Exchange Cost**

  Nebraska insurance officials can't decide whether to recommend a state-based health insurance exchange or follow a proposed federal model until they know how much the national plan will cost, Nebraska Department of Insurance Director Bruce Ramge said. The department is also heeding Gov. Dave Heineman's preference to wait until the U.S. Supreme Court rules on the constitutionality of a new national health care law under which the federal plan would be offered, Ramge said. The state applied for a second federal grant of about $5.5 million in September to help study and design possible plans without committing to one, he said. The state received a $1 million grant last year to help plan for the change. (Insurance Journal)

New Hampshire

- **New Hampshire Managed Care RFP Released**

  (Link to RFP homepage)

- **Sparring to heat up over managed care**

  The control of billions of dollars and associated medical decisions for about 150,000 people go up for grabs starting Monday. The state will reveal specifics of what it expects from companies that want to bid on providing managed care for the state's Medicaid program. That will begin what will be the largest contract process in state history. The state's fragile budget counts on things going smoothly. Once it's in place, managed care is supposed to save the state about $16 million a year in Medicaid costs for people with low incomes, the disabled and the mentally ill. The state wants to bring in three companies to make sure clients have the kinds of choices that federal law requires. The plan calls for winners of the five-year contracts to be selected by January, approved by March and operating by July 1. Some say that is too soon for major changes to the most complex state-federal program in the state. The program spends more than $1 billion annually. (Union Leader)

New Jersey

- **N.J. targets Medicaid fraud**

  The review of oversight by Horizon NJ Health, performed by the state comptroller, comes as the state pushes to reduce its insurance costs, largely by asking public workers to pay more of the cost of their own health care but with little changed for the insurance firms themselves. Horizon is one of four that contract with the New Jersey to manage how state dollars are paid out for Medicaid reimbursement to providers and enrollees. False claims by doctors or patients drain state dollars. Another reason for better review of the $1.3 billion in Medicaid money is New Jersey's intent to move more toward a managed care system, state Comptroller Matt Boxer said. According to the audit, Horizon understaffed its mandatory unit that investigates fraudulent claims. The unit investigated nine providers in the state in the last two years. It recovered $188,207 in improper Medicaid payments, less than one-tenth of 1 percent of the $1.3 billion the state pays out. Horizon further failed to provide full information to the state about all of those fraudulent claims, which meant the state still reimbursed $161,666 in undeserved premiums to providers. (NorthJersey.com)

Oregon

- **Hospitals See Their Medicaid Rates Cut by 15 Percent**

  Oregon's largest hospitals aren't pleased with a decision by Governor Kitzhaber that reduced their Medicaid payments by 15 percent on October 1. Because of the lagging economy, the decision to lower hospital rates was unavoidable, said Dr. Bruce Goldberg, director of the Oregon Health Authority. Under the new rate structure, hospitals that have contracts with managed care plans are being paid 68 percent, rather than 80 percent of the Medicare DRG value, which represents a flat rate based on a patient's diagnosis and treatment. (The Lund Report)

Texas

- **Pharmacies Feeling Pressure of Reduced Medicaid Fees**

  Beginning in March, a new managed-care plan goes into effect that reduces the amount pharmacies receive for filling Medicaid prescriptions. The plan, approved by the Legislature earlier this year, is expected to save the state $100 million over the next two years. Switching to managed Medicaid means pharmacy benefit managers will offer contracts to pharmacies with a lower dispensing fee that will replace the current $6.50 fee per prescription. Dispensing fees make up about 10 percent of the total reimbursement pharmacies receive from Medicaid, depending on the cost of the medication.(Texas Tribune)

United States

- **MACPAC meetings in Washington tomorrow and Friday, October 20/21**

- **Medicaid expansion seen covering nearly all state prisoners**

  The federal health law's controversial Medicaid expansion is expected to add billions to states' already overburdened Medicaid budgets. But it also offers a rarely discussed cost-cutting opportunity for state corrections agencies. Starting in 2014, virtually all state prison inmates could be eligible for Medicaid coverage of hospital stays—at the expense of the federal government. In most states, Medicaid is not an option for prison inmates. But a little known federal rule allows coverage for Medicaid-eligible inmates who leave a prison and check into a private or community hospital. Technically, those who stay in the hospital for 24 hours or more are no longer considered prison inmates for the duration of their stay. (Stateline.org)

- **Some states seek flexibility to push health-care overhaul further**

  A handful of states are pursuing health measures that go far beyond the Obama administration's signature legislative accomplishment, the Affordable Care Act. They stand in contrast to Republican governors, who have aggressively opposed the law. Twenty-seven states are challenging the law in the courts as unconstitutional, while two, Florida and Louisiana, have just refused to implement much of the law. For Democratic governors who want to push changes further, navigating the federal law is a much more complex and nuanced task. They want to implement the law, as well as be waived from key parts of it. (Washington Post)

- **Should states lead Medicaid-Medicare cost-cutting effort?**

  A new report argues that Washington, not the states, should take the cost-reduction reins on dual-eligible Medicaid-Medicare beneficiaries. In *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead*, the Robert Wood Johnson Foundation and the Urban Institute say the federal government is "relying far too heavily on states to find a solution." According to the report, states pay only 20 percent of the health care bill for so-called "dual eligibles" — people who qualify for both Medicare and Medicaid. Very little of that 20 percent goes toward hospital stays, where the greatest savings can be achieved. Moreover, giving cash-strapped states more responsibility for overall spending increases the risk of cost-shifting to Medicare, which unlike Medicaid

is funded entirely by the federal government. The authors say this could undermine the quality of care for vulnerable beneficiaries. (Stateline)

- **Health Insurers Bid to Take Elderly Poor Out of U.S. Plans**

  The U.S. may save as much as $125 billion over a decade if health insurers manage care for about 9 million people now covered by Medicare because of their age and Medicaid because they're poor, the companies have told Congress. America's Health Insurance Plans, or AHIP, the Washington- based trade group for insurers, is lobbying the congressional supercommittee studying debt reduction to allow states to hire health plans such as UnitedHealth to direct care for the indigent elderly and disabled, whose medical needs now cost taxpayers as much as $230 billion a year. More than half of this group suffers from five or more chronic conditions, and their care costs twice as much on average as patients just covered by Medicare, a study published by the insurers' group found. The cost gap is occurring because the programs don't coordinate medical services, said Ken Thorpe, the study author and chairman of health policy at Emory University's Rollins School of Public Health in Atlanta (Bloomberg)

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order. This week, we highlight an updated timeline related to the Hawaii Quest procurement.

Date	State	Event	Beneficiaries
October 15, 2011	New Hampshire	RFP Released	N/A
October, 2011	Pennsylvania	RFP Released	565,000
November 1, 2011	Kentucky RBM	Contract awards	N/A
November 1, 2011	Kentucky	Implementation	460,000
November 18, 2011	Hawaii	Proposals due	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Kentucky RBM	Implementation	N/A
December 2, 2011	Washington	Proposals due	800,000
December 6, 2011	Nebraska	Proposals due	75,000
December 23, 2011	Hawaii	Contract awards	225,000
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 16, 2011	Hawaii	Implementation	225,000
January 17, 2012	Washington	Contract awards	800,000
January 31, 2012	Ohio	RFP Released	1,650,000
February 1, 2012	Louisiana	Implementation (GSA A)	892,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
February 28, 2012	Nebraska	Contract awards	75,000
April 1, 2012	New York LTC	Implementation	200,000
February 1, 2012	Louisiana	Implementation (GSA B)	892,000
February 1, 2012	Louisiana	Implementation (GSA C)	892,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
July 1, 2012	Nebraska	Implementation	75,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	270,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	295,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA Recently Published Research

Managing Medicaid Pharmacy Benefits: Current Issues and Options

Vernon K. Smith, Managing Principal
Sandy Kramer, Senior Consultant

This report examines reimbursement, benefit management and cost sharing issues in Medicaid pharmacy programs. The analysis, conducted by researchers from the Foundation's Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, focuses on the potential of several measures recently highlighted by HHS Secretary Kathleen Sebelius to reduce Medicaid pharmacy costs and is informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011 to discuss current Medicaid pharmacy issues. (Link to report)

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Vernon K. Smith, Managing Principal
Kathleen Gifford, Principal
Dyke Snipes, Principal

This 50-state survey, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, provides a comprehensive look at state Medicaid managed care programs, documenting their diversity, examining how states monitor access and quality, and exploring emerging efforts to improve care, including managed long-term care and initiatives targeted toward dual eligibles. The survey was released September 13, 2011, at a public briefing at the Kaiser Family Foundation's Washington, D.C. office.

Links to the report and presentations below:

Link to report: (PDF)
Link to presentations: (.WMV Video); (.MP3 Audio)

Upcoming HMA Appearances

American Evaluation Association: A Mixed-Methods Approach to Understanding the Impact of Requiring Citizenship Documentation for Medicaid Enrollment

Caroline Davis, speaker

November 3, 2011

Anaheim, California