HMA

HEALTH MANAGEMENT ASSOCIATES

# *HMA Investment Services Weekly Roundup*
# *Trends in State Health Policy*

**IN FOCUS: FOURTH QUARTER MEDICAID MCO ENROLLMENT TRENDS**

**HMA ROUNDUP:** CALIFORNIA RELEASES DUAL ELIGIBLE RFS; NEW YORK CONTEMPLATES EMBLEMHEALTH CONVERSION; FLORIDA CONSIDERS CHANGE TO IGT RATE CALCULATION; NEW MLTC PLANS APPROVED IN NEW YORK

**OTHER HEADLINES:** STATE TAX REVENUES CONTINUE TO GROW; LOUISIANA MEDICAID MANAGED CARE ROLL-OUT GETS UNDERWAY; ALABAMA CONSIDERS MEDICAID MANAGED CARE; CMS ISSUES MEDICAID PRESCRIPTION DRUG RULE

**HMA WELCOMES:**
JOAN HENNEBERRY – DENVER
SARAH JAGGER – INDIANAPOLIS
GARY YOUNG - AUSTIN

**FEBRUARY 1, 2012**

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

---

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO
HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
SACRAMENTO, CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

# Contents




***Edited by:***
*Gregory Nersessian*
*212.575.5929*
*gnersessian@healthmanagement.com*

*Andrew Fairgrieve*
*312.641.5007*
*afairgrieve@healthmanagement.com*

## IN FOCUS: REVIEWING FOURTH QUARTER MEDICAID MCO ENROLLMENT TRENDS

This week, our *In Focus* section reviews recent Medicaid MCO enrollment trends in 13 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, 15 states[1] have released monthly Medicaid managed care enrollment data through December 2011, with Georgia and Tennessee reporting enrollment through August and October, respectively. 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 nearly 7%. Assuming Georgia and Tennessee enrollments held relatively constant through the end of the 2011, total enrollments for the end of 2011 exceed 20.2 million covered lives.

In the discussion below, we discuss recent enrollment trends in the states where we track data. We also provide company-specific data for 10 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 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 the data are comprehensive in that they cover 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. Month-over-month and year-over-year enrollment growth and growth rates for September through December in the table below are based only on those states for which we have data for the given months. As such, total enrollment numbers across the 17 states are omitted for these months.

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

## Table 1 - Medicaid Managed Care Monthly Enrollment Apr. 2011 – Dec. 2011

| 2011 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|---|---|---|
| **Arizona** | **1,191,307** | **1,199,744** | **1,209,906** | **1,218,035** | **1,227,598** | **1,221,271** | **1,210,860** | **1,196,801** | **1,180,837** |
| +/- m/m | (1,210) | 8,437 | 10,162 | 8,129 | 9,563 | (6,327) | (10,411) | (14,059) | (15,964) |
| % y/y | -0.2% | 0.1% | 0.5% | 1.6% | 2.3% | 1.7% | 1.1% | -1.0% | -1.7% |
| **California** | **3,333,398** | **3,356,047** | **3,406,397** | **3,454,904** | **3,472,030** | **3,516,116** | **3,553,075** | **3,596,016** | **3,620,487** |
| +/- m/m | 21,425 | 22,649 | 50,350 | 48,507 | 17,126 | 44,086 | 36,959 | 42,941 | 24,471 |
| % y/y | 8.8% | 8.7% | 10.1% | 10.9% | 10.0% | 10.9% | 11.6% | 12.2% | 12.3% |
| **Connecticut** | **408,269** | **409,731** | **412,231** | **408,511** | **409,563** | **408,980** | **409,921** | **411,551** | **401,284** |
| +/- m/m | 1,384 | 1,462 | 2,500 | (3,720) | 1,052 | (583) | 941 | 1,630 | (10,267) |
| % y/y | 5.8% | 5.0% | 4.6% | 3.7% | 3.4% | 2.7% | 2.4% | 2.3% | -0.6% |
| **Florida** | **1,129,565** | **1,130,395** | **1,135,892** | **1,137,598** | **1,128,966** | **1,115,696** | **1,103,916** | **1,105,811** | **1,144,977** |
| +/- m/m | 1,301 | 830 | 5,497 | 1,706 | (8,632) | (13,270) | (11,780) | 1,895 | 39,166 |
| % y/y | 6.3% | 6.0% | 8.5% | 7.2% | 6.0% | 3.8% | 2.5% | 1.0% | 2.9% |
| **Georgia** | **1,128,062** | **1,115,413** | **1,125,867** | **1,126,780** | **1,116,150** | | | | |
| +/- m/m | (1,111) | (12,649) | 10,454 | 913 | (10,630) | | | | |
| % y/y | 1.5% | -0.1% | 3.3% | 1.1% | 2.8% | | | | |
| **Hawaii** | **43,260** | **43,329** | **43,344** | **43,404** | **43,552** | **43,807** | **44,238** | **44,370** | **44,600** |
| +/- m/m | 155 | 69 | 15 | 60 | 148 | 255 | 431 | 132 | 230 |
| % y/y | 2.7% | 2.3% | 2.6% | 4.5% | 4.8% | 5.1% | 5.7% | 5.7% | 4.1% |
| **Illinois** | **196,131** | **196,894** | **199,502** | **200,551** | **202,987** | **204,333** | **205,733** | **206,859** | **209,069** |
| +/- m/m | 350 | 763 | 2,608 | 1,049 | 2,436 | 1,346 | 1,400 | 1,126 | 2,210 |
| % y/y | 0.1% | 0.8% | 1.7% | 3.2% | 3.8% | 4.8% | 5.5% | 6.2% | 6.7% |
| **Maryland** | **739,737** | **738,818** | **738,272** | **744,579** | **747,403** | **749,459** | **754,705** | **755,498** | **755,675** |
| +/- m/m | 11,501 | (919) | (546) | 6,307 | 2,824 | 2,056 | 5,246 | 793 | 177 |
| % y/y | 12.1% | 10.4% | 9.7% | 9.6% | 8.7% | 8.1% | 7.6% | 6.8% | 5.6% |
| **Michigan** | **1,237,623** | **1,223,433** | **1,214,160** | **1,211,393** | **1,218,917** | **1,210,375** | **1,221,282** | **1,217,684** | **1,224,888** |
| +/- m/m | 10,147 | (14,190) | (9,273) | (2,767) | 7,524 | (8,542) | 10,907 | (3,598) | 7,204 |
| % y/y | N/A | 2.6% | 1.4% | 1.2% | 0.6% | 0.5% | 0.8% | -0.4% | 0.2% |
| **New York** | **2,923,379** | **2,938,256** | **2,964,826** | **2,970,809** | **2,987,325** | **2,993,718** | **2,987,600** | **3,016,811** | **3,036,100** |
| +/- m/m | 2,680 | 14,877 | 26,570 | 5,983 | 16,516 | 6,393 | (6,118) | 29,211 | 19,289 |
| % y/y | 6.8% | 6.7% | 6.5% | 6.3% | 6.8% | 6.3% | 5.8% | 5.6% | 5.7% |
| **Ohio** | **1,620,213** | **1,618,810** | **1,614,434** | **1,608,040** | **1,603,140** | **1,679,266** | **1,647,209** | **1,641,025** | **1,639,154** |
| +/- m/m | 6,938 | (1,403) | (4,376) | (6,394) | (4,900) | 76,126 | (32,057) | (6,184) | (1,871) |
| % y/y | 6.2% | 5.5% | 4.4% | 3.1% | 2.7% | 7.0% | 4.4% | 3.7% | 2.7% |
| **South Carolina** | **414,429** | **422,246** | **422,920** | **429,247** | **437,617** | **441,772** | **438,950** | **439,651** | **443,215** |
| +/- m/m | 5,583 | 7,817 | 674 | 6,327 | 8,370 | 4,155 | (2,822) | 701 | 3,564 |
| % y/y | 0.0% | 0.0% | 15.9% | 17.2% | 18.0% | 18.8% | 12.1% | 10.9% | 10.7% |
| **Tennessee** | **1,214,743** | **1,214,520** | **1,212,321** | **1,209,372** | **1,211,695** | **1,214,885** | **1,216,222** | | |
| +/- m/m | 4,553 | (223) | (2,199) | (2,949) | 2,323 | 3,190 | 1,337 | | |
| % y/y | 1.9% | 1.5% | 1.3% | 0.7% | 0.8% | 0.5% | 0.2% | | |
| **Texas** | **2,326,252** | **2,341,377** | **2,390,415** | **2,392,138** | **2,396,891** | **2,536,363** | **2,545,173** | **2,611,879** | **2,623,120** |
| +/- m/m | 4,750 | 15,125 | 49,038 | 1,723 | 4,753 | 139,472 | 8,810 | 66,706 | 11,241 |
| % y/y | 12.6% | 11.9% | 12.0% | 10.3% | 10.2% | 15.1% | 15.7% | 18.2% | 17.6% |
| **Wisconsin** | **700,518** | **705,184** | **708,806** | **705,853** | **709,696** | **706,611** | **702,889** | **707,678** | **709,972** |
| +/- m/m | 2,293 | 4,666 | 3,622 | (2,953) | 3,843 | (3,085) | (3,722) | 4,789 | 2,294 |
| % y/y | 5.0% | 5.6% | 5.6% | 5.5% | 7.4% | 8.5% | 9.6% | 8.7% | 5.4% |
| **Washington** | **698,891** | **698,616** | **702,214** | **698,814** | **700,149** | **704,163** | **709,319** | **710,260** | **703,845** |
| +/- m/m | (1,564) | (275) | 3,598 | (3,400) | 1,335 | 4,014 | 5,156 | 941 | (6,415) |
| % y/y | 5.1% | 6.4% | 3.2% | 1.7% | 2.2% | 1.5% | 2.4% | 1.9% | 0.0% |
| **West Virginia** | **167,823** | **168,228** | **168,504** | **166,555** | **165,935** | **166,373** | **167,890** | **170,099** | **171,838** |
| +/- m/m | 1,215 | 405 | 276 | (1,949) | (620) | 438 | 1,517 | 2,209 | 1,739 |
| % y/y | 1.2% | 1.3% | 2.0% | 2.1% | 2.7% | 3.4% | 5.2% | 5.7% | 6.3% |
| **Total** | **19,473,600** | **19,521,041** | **19,670,011** | **19,726,583** | **19,779,614** | | | | |
| +/- m/m | 70,390 | 47,441 | 148,970 | 56,572 | 53,031 | 249,724 | 5,794 | 129,233 | 77,068 |
| % y/y | | | 6.4% | 6.0% | 6.0% | 7.1% | 6.8% | 7.2% | 6.9% |

*Source: State Medicaid Agency websites*

## *State Specific Analysis*

### Arizona

From July through December 2011, Arizona enrollment declined by a net of more than 76,000 lives in MCO plans. Enrollment began to drop off in September and accelerated in each of the following three months, shedding nearly 16,000 lives in December alone. Despite the drop off during Q4 of 2011, overall enrollment has held steady around 1.2 million for the past year.

| Total | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total Arizona** | | | | | | |
| Acute Care | 1,166,721 | 1,176,183 | 1,169,815 | 1,159,271 | 1,145,074 | 1,129,057 |
| LTC | 51,314 | 51,415 | 51,456 | 51,589 | 51,727 | 51,780 |
| **Total Arizona** | **1,218,035** | **1,227,598** | **1,221,271** | **1,210,860** | **1,196,801** | **1,180,837** |
| *+/- m/m* | *8,129* | *9,563* | *(6,327)* | *(10,411)* | *(14,059)* | *(15,964)* |
| *% y/y* | *1.6%* | *2.3%* | *1.7%* | *1.1%* | *-1.0%* | *-1.7%* |

### California

At the end of June 2011, California enrolled over 3.4 million lives in MCO plans. Enrollment grew consistently through Q3 and Q4 2011, adding more than 210,000 total lives. This brings December 2011 final enrollment above 3.6 million lives. California's MCO enrollments have grown consistently over the past year, with year-over-year growth rates increasing over the past year, exceeding 10% in Q3 and continuing with 11-12% year over year enrollment growth throughout Q4 2011.

| | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total California** | **3,454,904** | **3,472,030** | **3,516,116** | **3,553,075** | **3,596,016** | **3,620,487** |
| *+/- m/m* | *48,507* | *17,126* | *44,086* | *36,959* | *42,941* | *24,471* |
| *% y/y* | *10.9%* | *10.0%* | *10.9%* | *11.6%* | *12.2%* | *12.3%* |

### Connecticut

At the end of June 2011, Connecticut enrolled 412,231 lives in MCO plans through its Husky A and Husky B programs. After two quarters of ups and downs in monthly enrollment, the Husky program shed nearly 11,000 net lives by the end of 2011. It should be noted that year-over-year growth rates have been consistently declining from over 9% a year ago to only 2.3% as of November 2011 and reporting negative year-over-year growth in December 2011.

| Connecticut | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Husky A | 393,111 | 394,480 | 393,868 | 394,967 | 396,681 | 386,410 |
| Husky B | 15,400 | 15,083 | 15,112 | 14,954 | 14,870 | 14,874 |
| **Total Husky** | **408,511** | **409,563** | **408,980** | **409,921** | **411,551** | **401,284** |
| *+/- m/m* | *(3,720)* | *1,052* | *(583)* | *941* | *1,630* | *(10,267)* |
| *% y/y* | *3.7%* | *3.4%* | *2.7%* | *2.4%* | *2.3%* | *-0.6%* |

## Florida

At the end of the Q2 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 more than 33,000 total enrollees in August through October. In November and December, however, enrollment grew by a net 41,000 lives, driven by more than 39,000 new lives in December alone.

| Florida | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| MMCP | 983,237 | 976,204 | 962,625 | 953,396 | 954,259 | 989,633 |
| Reform Pilot | 154,361 | 152,762 | 153,071 | 150,520 | 151,552 | 155,344 |
| **Total Florida** | **1,137,598** | **1,128,966** | **1,115,696** | **1,103,916** | **1,105,811** | **1,144,977** |
| *+/- m/m* | *1,706* | *(8,632)* | *(13,270)* | *(11,780)* | *1,895* | *39,166* |
| *% y/y* | *7.2%* | *6.0%* | *3.8%* | *2.5%* | *1.0%* | *2.9%* |

## Illinois

The steady growth seen in Illinois MCOs has continued, with close to 10,000 net lives added in Q3 and Q4 2011. This growth brings total enrollment up to 209,069. December enrollment represents a 6.7 percent increase in year-over-year enrollment. The Integrated Care Program has enrolled 33,200 of an expected 40,000 as of December 2011.

| Illinois | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total MCO** | **200,551** | **202,987** | **204,333** | **205,733** | **206,859** | **209,069** |
| *+/- m/m* | *1,049* | *2,436* | *1,346* | *1,400* | *1,126* | *2,210* |
| *% y/y* | *3.2%* | *3.8%* | *4.8%* | *5.5%* | *6.2%* | *6.7%* |
| **Integrated Care Program** | **12,343** | **16,875** | **27,088** | **31,722** | **32,650** | **33,264** |
| *+/- m/m* | *12,343* | *4,532* | *10,213* | *4,634* | *928* | *614* |
| **Total Managed Care** | **212,894** | **219,862** | **231,421** | **237,455** | **239,509** | **242,333** |
| *+/- m/m* | *13,392* | *6,968* | *11,559* | *6,034* | *2,054* | *2,824* |
| *% y/y* | *9.6%* | *12.5%* | *18.7%* | *21.8%* | *23.0%* | *23.7%* |

## Louisiana

While Louisiana is not included in the Q4 2011 summary, we wanted to note its inclusion in our future managed care enrollment updates. Louisiana's managed care expansion will go live today, February 1, 2011. The four-parish New Orleans-area region and five-parish Northshore region (Geographic Service Area A) are the first parts of the state to go live with BAYOU HEALTH. Of the 245,757 eligible recipients in GSA A, the breakdown among Health Plans for BAYOU HEALTH launch is:

- Amerigroup Real Solutions - 43,732
- LaCare (AmeriHealth) - 42,196
- Louisiana Healthcare Connections (Centene) - 49,538
- Community Health Solutions - 52,741
- UnitedHealthcare Community Plan - 57,139

There were 411 recipients whose enrollment in BAYOU HEALTH is voluntary who elected to remain in the current fee-for-service program

## Michigan

Michigan Medicaid managed care enrollments show a net loss in covered lives in Q3 and a net gain of covered lives in Q4, with a gain of more than 10,000 total lives over the six month period. December enrollment is basically flat on a year-over-year basis.

| Michigan | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total** | **1,211,393** | **1,218,917** | **1,210,375** | **1,221,282** | **1,217,684** | **1,224,888** |
| *+/- m/m* | *(2,767)* | *7,524* | *(8,542)* | *10,907* | *(3,598)* | *7,204* |
| *% y/y* | *1.2%* | *0.6%* | *0.5%* | *0.8%* | *-0.4%* | *0.2%* |

## Ohio

Despite five out of six months in Q3 and Q4 showing significant monthly declines in enrollment, a strong September bolstered the entire six month period, with net enrollments up close to 25,000 lives. Year-over-year growth is up 2.7 percent in December 2011.

| Ohio | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| CFC | 1,482,994 | 1,478,011 | 1,549,999 | 1,519,992 | 1,516,008 | 1,513,237 |
| ABD | 125,046 | 125,129 | 129,267 | 127,217 | 125,017 | 125,917 |
| **Total** | **1,608,040** | **1,603,140** | **1,679,266** | **1,647,209** | **1,641,025** | **1,639,154** |
| *+/- m/m* | *(6,394)* | *(4,900)* | *76,126* | *(32,057)* | *(6,184)* | *(1,871)* |
| *% y/y* | *3.1%* | *2.7%* | *7.0%* | *4.4%* | *3.7%* | *2.7%* |

## South Carolina

South Carolina enrolled more than 20,000 new lives in HMO plans in the last six months, with only one month showing a negative enrollment. For Q3 and Q4 2011, South Carolina has seen consistent double-digit year-over-year growth in MCO enrollment.

| South Carolina | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **HMO total** | **429,247** | **437,617** | **441,772** | **438,950** | **439,651** | **443,215** |
| *+/- m/m* | *6,327* | *8,370* | *4,155* | *(2,822)* | *701* | *3,564* |
| *% y/y* | *17.2%* | *18.0%* | *18.8%* | *12.1%* | *10.9%* | *10.7%* |

## Texas

As of December 2011, Texas enrolled more than 2.6 million lives in MCO plans. Enrollment increased by more than 232,000 in Q3 and Q4 with average monthly enrollment growth of more than 35,000 lives. Year-over-year growth rates have generally held consistently in double-digits, from 15% to 18% in Q4.

| Texas | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| STAR | 1,561,299 | 1,561,171 | 1,675,356 | 1,678,517 | 1,729,422 | 1,746,861 |
| STAR+PLUS | 258,224 | 259,191 | 279,446 | 281,025 | 283,025 | 281,464 |
| STAR HEALTH | 32,199 | 32,092 | 31,980 | 31,952 | 32,102 | 32,245 |
| CHIP | 540,416 | 544,437 | 549,581 | 553,679 | 567,330 | 562,550 |
| **Total all programs** | **2,392,138** | **2,396,891** | **2,536,363** | **2,545,173** | **2,611,879** | **2,623,120** |
| *+/- m/m* | *1,723* | *4,753* | *139,472* | *8,810* | *66,706* | *11,241* |
| *% y/y* | *10.3%* | *10.2%* | *15.1%* | *15.7%* | *18.2%* | *17.6%* |

## Washington

Washington managed care enrollment peaked in November, with more than 710,00 enrolled lives. Enrollment declined by roughly 6,500 lives in December, the first month of negative enrollment since July. Washington's year-over-year growth rates in enrollment have continued to decline, from nearly 16% in mid-2010, to end flat in December.

| Washington | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total** | **698,814** | **700,149** | **704,163** | **709,319** | **710,260** | **703,845** |
| *+/- m/m* | *(3,400)* | *1,335* | *4,014* | *5,156* | *941* | *(6,415)* |
| *% y/y* | *1.7%* | *2.2%* | *1.5%* | *2.4%* | *1.9%* | *0.0%* |

## West Virginia

West Virginia enrolled roughly 166,500 million lives in MCO plans at the end of June. Q3 enrollments declined by more than 2,000 lives but rebounded in Q4, finishing the year at nearly 172,000 enrolled lives. Despite a sluggish year, the strong Q4 brings year-over-year enrollment is up to 6.3% as of December.

| West Virginia | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| **Total** | **166,555** | **165,935** | **166,373** | **167,890** | **170,099** | **171,838** |
| *+/- m/m* | *(1,949)* | *(620)* | *438* | *1,517* | *2,209* | *1,739* |
| *% y/y* | *2.1%* | *2.7%* | *3.4%* | *5.2%* | *5.7%* | *6.3%* |

## Wisconsin

As of June 2011, Wisconsin enrolled 708,800 lives in MCO plans. After three out of four months showing enrollment declines in Q3 and the beginning of Q4, November and December showed strong enrollment growth, bringing year-end enrollment up to nearly 710,000 lives. It should be noted that year-over-year growth rates have generally declined from over 16% a year ago to only 5.4% in December 2011.

| Wisconsin | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| BadgerCare+ | 673,595 | 676,916 | 673,633 | 669,876 | 674,585 | 676,739 |
| SSI | 32,258 | 32,780 | 32,978 | 33,013 | 33,093 | 33,233 |
| **Total** | **705,853** | **709,696** | **706,611** | **702,889** | **707,678** | **709,972** |
| *+/- m/m* | *(2,953)* | *3,843* | *(3,085)* | *(3,722)* | *4,789* | *2,294* |
| *% y/y* | *5.5%* | *7.4%* | *8.5%* | *9.6%* | *8.7%* | *5.4%* |

## *Select Company Analysis*

### Aetna

We track monthly enrollment data in four states where Aetna operates. We present three of those states below (excluding Missouri, who has not made released Q3 or Q4 enrollment data). December 2011 year-over-year enrollment is up 1.5% despite Q4 net declines in Arizona and Connecticut. December 2011 enrollment in Texas is up 17% over the previous year. As of December 2011, Aetna covered close to 480,000 lives in the three states below, though we note that the company lost all of its Connecticut enrollment on January 1, 2012 when the managed care program in that states was discontinued.

| Aetna | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Arizona | 315,306 | 317,576 | 315,730 | 315,727 | 312,314 | 308,827 |
| +/- m/m | 1,924 | 2,270 | (1,846) | (3) | (3,413) | (3,487) |
| % y/y | 0.0% | 0.7% | 0.3% | 0.9% | -1.0% | -1.4% |
| Connectictut | 98,748 | 99,189 | 99,236 | 99,394 | 100,005 | 97,396 |
| +/- m/m | (673) | 441 | 47 | 158 | 611 | (2,609) |
| % y/y | 5.7% | 5.5% | 4.9% | 4.2% | 4.3% | 1.0% |
| Texas | 65,854 | 66,567 | 68,069 | 68,293 | 71,555 | 72,496 |
| +/- m/m | 217 | 713 | 1,502 | 224 | 3,262 | 941 |
| % y/y | 14.4% | 14.2% | 13.9% | 13.8% | 17.6% | 17.0% |
| **Total Aetna** | **479,908** | **483,332** | **483,035** | **483,414** | **483,874** | **478,719** |
| +/- m/m | 1,468 | 3,424 | (297) | 379 | 460 | (5,155) |
| % y/y | 2.9% | 3.3% | 2.9% | 3.2% | 2.5% | 1.5% |

*Source: State Medicaid Enrollment data*

### Amerigroup

We track monthly enrollment data in six of the eleven states where Amerigroup operates. Unfortunately, Georgia has not updated Q3 or Q4 data, while Tennessee has not released data since October 2011. Within the three states that have reported monthly enrollment through December, Amerigroup covers over 845,000 lives, which compares to the roughly 2 million reported in the third quarter of 2011. Additionally, we note that Amerigroup has enrolled more than 43,000 new managed care lives in Lousiana's BAYOU HEALTH program as of today, February 1.

| Amerigroup | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Florida | 180,636 | 177,948 | 175,647 | 173,350 | 173,357 | 178,806 |
| +/- m/m | 516 | (2,688) | (2,301) | (2,297) | 7 | 5,449 |
| % y/y | 5.7% | 4.0% | 1.9% | 0.6% | 0.2% | 2.5% |
| Ohio | 54,671 | 54,607 | 58,020 | 57,352 | 57,066 | 55,107 |
| +/- m/m | (26) | (64) | 3,413 | (668) | (286) | (1,959) |
| % y/y | -5.4% | -5.7% | -0.7% | -1.5% | 1.1% | -3.0% |
| Tennessee | 197,269 | 198,516 | 199,478 | 199,883 | | |
| +/- m/m | (2,527) | 1,247 | 962 | 405 | | |
| % y/y | 1.2% | 1.3% | 0.8% | 0.3% | | |
| Texas | 572,767 | 570,948 | 591,212 | 589,537 | 607,373 | 612,059 |
| +/- m/m | (1,554) | (1,819) | 20,264 | (1,675) | 17,836 | 4,686 |
| % y/y | 8.3% | 7.7% | 10.1% | 10.1% | 13.2% | 13.2% |
| **Total Amerigroup** | **1,005,343** | **1,002,019** | **1,024,357** | **1,020,122** | **837,796** | **845,972** |
| +/- m/m | (3,591) | (3,324) | 22,338 | (4,235) | 17,557 | 8,176 |
| % y/y | 5.6% | 4.9% | 6.1% | 5.7% | 9.3% | 9.6% |

*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 nearly 990,000, which compares to the 1.61 million reported in Q3 2011. Across these states, Centene has experienced sequential monthly enrollment growth in five of the last six months, with total membership up 40,000 lives and up 8% on a year over year basis through December 2011. We note that Centene has enrolled more than 49,500 new managed care lives in Louisiana's BAYOU HEALTH program, which goes live today, February 1.

| Centene | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Arizona | 20,878 | 21,122 | 20,967 | 22,375 | 22,298 | 22,070 |
| +/- m/m | (10) | 244 | (155) | 1,408 | (77) | (228) |
| % y/y | 2.3% | 3.8% | 1.9% | 8.7% | 8.5% | 7.3% |
| Florida | 188,299 | 185,982 | 185,068 | 184,151 | 186,090 | 195,410 |
| +/- m/m | 226 | (2,317) | (914) | (917) | 1,939 | 9,320 |
| % y/y | 64.2% | 60.6% | 59.3% | 58.5% | 43.9% | 1.3% |
| Ohio | 157,883 | 157,470 | 164,851 | 161,138 | 160,159 | 158,491 |
| +/- m/m | (728) | (413) | 7,381 | (3,713) | (979) | (1,668) |
| % y/y | -0.2% | -0.6% | 3.8% | 1.2% | 0.3% | -0.9% |
| South Carolina | 82,797 | 84,624 | 85,486 | 78,397 | 79,512 | 81,904 |
| +/- m/m | 1,080 | 1,827 | 862 | (7,089) | 1,115 | 2,392 |
| % y/y | -0.9% | 1.3% | 3.0% | -11.9% | -10.5% | -7.9% |
| Texas | 457,997 | 459,447 | 480,672 | 482,020 | 490,674 | 491,070 |
| +/- m/m | 1,119 | 1,450 | 21,225 | 1,348 | 8,654 | 396 |
| % y/y | 1.0% | 1.3% | 18.2% | 18.0% | 19.0% | 17.9% |
| Wisconsin | 40,702 | 41,100 | 40,676 | 40,334 | 40,791 | 40,579 |
| +/- m/m | (221) | 398 | (424) | (342) | 457 | (212) |
| % y/y | -49.5% | -48.1% | -32.6% | -20.2% | 8.6% | 7.3% |
| **Total Centene** | **948,556** | **949,745** | **977,720** | **968,415** | **979,524** | **989,524** |
| +/- m/m | 1,466 | 1,189 | 27,975 | (9,305) | 11,109 | 10,000 |
| % y/y | 4.1% | 4.3% | 15.6% | 14.7% | 15.5% | 8.0% |

*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 467,000 reported in Q3 2011. Coventry operates a Medicaid managed care plan in Pennsylvania where monthly enrollment figures are not available. Across these three states, Coventry experienced three straight months of net enrollment decline in Q3 and three straight months of modest enrollment growth in Q4, bringing year end enrollment up just 0.2% on a year over year basis through December 2011.

| Coventry | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Florida | 42,101 | 42,000 | 42,005 | 41,885 | 41,887 | 42,969 |
| +/- m/m | 352 | (101) | 5 | (120) | 2 | 1,082 |
| % y/y | -5.1% | -4.8% | -4.8% | -3.9% | -4.1% | -0.8% |
| Michigan | 47,140 | 46,987 | 46,512 | 46,359 | 46,002 | 45,638 |
| +/- m/m | (418) | (153) | (475) | (153) | (357) | (364) |
| % y/y | -8.9% | -9.4% | -9.4% | -9.7% | -9.9% | -9.5% |
| West Virginia | 57,404 | 57,532 | 57,856 | 58,305 | 59,539 | 59,674 |
| +/- m/m | (694) | 128 | 324 | 449 | 1,234 | 135 |
| % y/y | 7.0% | 7.9% | 8.7% | 9.7% | 10.6% | 10.0% |
| **Total Coventry** | **146,645** | **146,519** | **146,373** | **146,549** | **147,428** | **148,281** |
| +/- m/m | (760) | (126) | (146) | 176 | 879 | 853 |
| % y/y | -2.1% | -1.9% | -1.5% | -1.0% | -0.7% | 0.2% |

*Source: State Medicaid Enrollment data*

## Health Net

We track Health Net's monthly enrollment data in California where the company covers nearly 670,000 Medicaid members through December 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 988,000 Medi-Cal/Medicaid lives in the third quarter of 2011. We note that Health Net's Fresno contract (123,000 lives) was awarded to a local plan called CalViva in March for whom Health Net is serving as a subcontractor.

| Health Net | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| California | 638,170 | 640,116 | 647,845 | 656,005 | 664,300 | 669,507 |
| +/- m/m | 8,470 | 1,946 | 7,729 | 8,160 | 8,295 | 5,207 |
| % y/y | -9.4% | -10.5% | -9.8% | -8.7% | -8.1% | -8.1% |

*Source: State Medicaid Enrollment data*

## Humana

We track Humana's monthly enrollment data in Florida where the company covers 44,000 Medicaid members through December 2011. Humana reported 621,500 Medicaid lives in the third quarter of 2011, most of which is in Puerto Rico. In Florida, Humana has continued to shed Medicaid membership nearly every month 2011. Enrollment is down 15.4 percent year over year.

| Humana | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Florida | 49,028 | 48,104 | 47,107 | 45,042 | 43,658 | 44,094 |
| +/- m/m | (163) | (924) | (997) | (2,065) | (1,384) | 436 |
| % y/y | -3.9% | -6.3% | -8.7% | -12.5% | -16.1% | -15.4% |

*Source: State Medicaid Enrollment data*

## Molina

We track monthly enrollment data in seven of the ten states where Molina operates risk-based health plans. Within these seven remaining states that have reported monthly enrollment through December, Molina covers 1.21 million lives, which compares to the 1.68 million reported in Q3 2011. The differential resulting from the absence of the New Mexico, Missouri, 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 the last six 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 two states where Molina has experienced net disenrollment in the last year are Michigan and Washington.

| Molina | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| California | 194,107 | 194,863 | 195,812 | 196,893 | 199,233 | 199,971 |
| +/- m/m | 2,351 | 756 | 949 | 1,081 | 2,340 | 738 |
| % y/y | 7.5% | 6.1% | 6.6% | 6.7% | 6.6% | 6.0% |
| Florida | 65,775 | 65,128 | 64,941 | 64,666 | 65,329 | 67,765 |
| +/- m/m | 227 | (647) | (187) | (275) | 663 | 2,436 |
| % y/y | 19.5% | 15.9% | 13.3% | 10.6% | 9.2% | 11.0% |
| Michigan | 209,944 | 209,836 | 207,818 | 208,530 | 207,398 | 211,972 |
| +/- m/m | (1,141) | (108) | (2,018) | 712 | (1,132) | 4,574 |
| % y/y | -3.6% | -4.4% | -4.6% | -4.4% | -5.4% | -3.0% |
| Ohio | 243,417 | 242,536 | 255,358 | 250,082 | 249,324 | 246,503 |
| +/- m/m | (1,102) | (881) | 12,822 | (5,276) | (758) | (2,821) |
| % y/y | 4.3% | 3.8% | 8.6% | 5.3% | 3.4% | 0.8% |
| Texas | 125,022 | 126,162 | 141,318 | 144,265 | 148,527 | 148,660 |
| +/- m/m | 581 | 1,140 | 15,156 | 2,947 | 4,262 | 133 |
| % y/y | 216.4% | 220.6% | 57.7% | 64.4% | 69.3% | 69.0% |
| Washington | 332,443 | 334,392 | 336,683 | 342,022 | 342,968 | 340,972 |
| +/- m/m | 424 | 1,949 | 2,291 | 5,339 | 946 | (1,996) |
| % y/y | -1.2% | -0.4% | -0.9% | 0.6% | 0.7% | -0.5% |
| Wisconsin | 40,783 | 40,940 | 41,037 | 40,900 | 41,009 | 41,408 |
| +/- m/m | 111 | 157 | 97 | (137) | 109 | 399 |
| % y/y | 125.2% | 130.0% | 46.1% | 38.1% | 10.5% | 14.9% |
| **Total Molina** | **1,170,708** | **1,172,917** | **1,201,930** | **1,206,458** | **1,212,779** | **1,215,843** |
| +/- m/m | 1,340 | 2,209 | 29,013 | 4,528 | 6,321 | 3,064 |
| % y/y | 10.2% | 9.8% | 7.0% | 7.1% | 6.8% | 6.3% |

*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 1.25 million lives, which compares to the 3.52 million reported in Q4 2011. In this subset of markets, UnitedHealth saw three months of enrollment growth in Q3 and three months of modest enrollment decline in Q4, driven by declines mainly in Arizona, Ohio, and South Carolina. UnitedHealth has enrolled just over 57,000 new managed care lives as part of Louisiana's BAYOU HEALTH program, which goes live today, February 1.

| UnitedHealth | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Arizona | 257,351 | 259,546 | 258,960 | 261,406 | 258,674 | 255,055 |
| +/- m/m | 2,040 | 2,195 | (586) | 2,446 | (2,732) | (3,619) |
| % y/y | 2.7% | 3.1% | 2.5% | 3.6% | 1.2% | 0.4% |
| Connectictut | 51,843 | 52,077 | 52,315 | 52,803 | 53,210 | 51,638 |
| +/- m/m | (393) | 234 | 238 | 488 | 407 | (1,572) |
| % y/y | 10.6% | 9.7% | 8.7% | 8.5% | 7.7% | 3.6% |
| Florida | 119,069 | 118,026 | 115,787 | 114,035 | 113,299 | 114,303 |
| +/- m/m | 360 | (1,043) | (2,239) | (1,752) | (736) | 1,004 |
| % y/y | 11.3% | 9.4% | 5.9% | 3.8% | 1.9% | 1.2% |
| Michigan | 238,599 | 240,424 | 238,825 | 240,905 | 240,084 | 241,999 |
| +/- m/m | 1,222 | 1,825 | (1,599) | 2,080 | (821) | 1,915 |
| % y/y | 5.3% | 4.6% | 4.5% | 4.9% | 3.2% | 3.4% |
| Ohio | 117,699 | 117,423 | 123,689 | 120,687 | 119,719 | 119,259 |
| +/- m/m | (553) | (276) | 6,266 | (3,002) | (968) | (460) |
| % y/y | -3.4% | -3.7% | 1.3% | -1.6% | -2.2% | -0.7% |
| South Carolina | 75,015 | 75,741 | 75,880 | 75,187 | 73,643 | 70,834 |
| +/- m/m | 440 | 726 | 139 | (693) | (1,544) | (2,809) |
| % y/y | 15.4% | 13.8% | 13.3% | 6.4% | 2.9% | -1.6% |
| Texas | 93,062 | 93,755 | 104,614 | 104,992 | 106,176 | 105,528 |
| +/- m/m | 799 | 693 | 10,859 | 378 | 1,184 | (648) |
| % y/y | 8.0% | 8.7% | 19.9% | 20.0% | 20.8% | 20.2% |
| Wisconsin | 290,490 | 291,938 | 292,329 | 291,975 | 293,426 | 295,188 |
| +/- m/m | (351) | 1,448 | 391 | (354) | 1,451 | 1,762 |
| % y/y | 20.8% | 23.0% | 20.7% | 19.2% | 13.3% | 11.2% |
| **Total UnitedHealth** | **1,243,128** | **1,248,930** | **1,262,399** | **1,261,990** | **1,258,231** | **1,253,804** |
| +/- m/m | 3,564 | 5,802 | 13,469 | (409) | (3,759) | (4,427) |
| % y/y | 8.6% | 8.7% | 9.1% | 8.2% | 5.8% | 4.8% |

*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 the three states below, excluding Missouri, who has not reported data since June, WellCare covers more than 577,000 Medicaid lives, which compares to the 1.31 million reported in Q3 2011. The differential results from the absence of the New York and Missouri enrollments 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 five of the last six months with total membership down 2.3% on a year-over-year basis through December 2011. However, we note that Florida showed a significant enrollment increase in December, adding more than 11,500 lives.

| WellCare | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| Florida | 340,819 | 339,969 | 334,732 | 331,570 | 332,226 | 343,879 |
| +/- m/m | (946) | (850) | (5,237) | (3,162) | 656 | 11,653 |
| % y/y | -3.4% | -2.8% | -4.3% | -4.5% | -4.3% | -1.2% |
| Illinois | 134,233 | 134,309 | 133,704 | 132,804 | 132,528 | 133,068 |
| +/- m/m | (1,063) | 76 | (605) | (900) | (276) | 540 |
| % y/y | -6.2% | -6.2% | -6.0% | -5.9% | -5.4% | -5.4% |
| Ohio | 100,427 | 100,295 | 104,408 | 102,603 | 101,967 | 100,529 |
| +/- m/m | (451) | (132) | 4,113 | (1,805) | (636) | (1,438) |
| % y/y | -0.5% | -0.7% | 2.7% | 0.7% | 0.0% | -2.0% |
| **Total WellCare** | **575,479** | **574,573** | **572,844** | **566,977** | **566,721** | **577,476** |
| +/- m/m | (2,460) | (906) | (1,729) | (5,867) | (256) | 10,755 |
| % y/y | -3.6% | -3.3% | -3.5% | -4.0% | -3.8% | -2.3% |

*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 554,000 lives, which compares to the 1.87 million reported in the company's state-sponsored programs for Q4 2011. In this subset of markets, WellPoint has experienced sequential monthly enrollment growth in four of the last six months, with an net gain of more than 93,000 lives since Q2 2011. Year-over-year enrollment is up 4.6% as of December 2011.

| WellPoint | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 |
|---|---|---|---|---|---|---|
| California | 430,778 | 430,214 | 432,917 | 433,240 | 435,856 | 435,121 |
| +/- m/m | 2,789 | (564) | 2,703 | 323 | 2,616 | (735) |
| % y/y | 4.3% | 4.0% | 4.9% | 5.5% | 6.3% | 6.4% |
| Texas | 19,834 | 20,100 | 20,592 | 20,958 | 22,400 | 22,883 |
| +/- m/m | 229 | 266 | 492 | 366 | 1,442 | 483 |
| % y/y | -25.2% | -20.8% | -15.3% | -8.8% | 2.4% | 8.5% |
| Wisconsin | 23,894 | 23,980 | 23,535 | 23,121 | 23,179 | 22,993 |
| +/- m/m | (344) | 86 | (445) | (414) | 58 | (186) |
| % y/y | -23.2% | -21.7% | -21.5% | -20.4% | -21.1% | -22.1% |
| West Virginia | 81,912 | 81,537 | 81,537 | 82,625 | 83,482 | 83,125 |
| +/- m/m | (1,017) | (375) | 0 | 1,088 | 857 | (357) |
| % y/y | 0.8% | 1.4% | 1.9% | 4.6% | 4.6% | 4.0% |
| **Total WellPoint** | **556,418** | **555,831** | **558,581** | **559,944** | **564,917** | **564,122** |
| +/- m/m | 1,657 | (587) | 2,750 | 1,363 | 4,973 | (795) |
| % y/y | 0.8% | 1.1% | 2.1% | 3.4% | 4.4% | 4.6% |

*Source: State Medicaid Enrollment data*

# HMA Medicaid Roundup

## *California*

### HMA Roundup – Jennifer Kent

Last Friday, the California Department of Health Care Services released a "Request for Solutions" on the Dual Integration Demonstration Pilots as authorized under the state's 1115 waiver and in cooperation with the federal Centers for Medicare and Medicaid Services. With responses due on February 24, 2012, this RFS is seeking to identify plans and specific locations in California to provide a comprehensive benefit of physical, behavioral, social, and long-term care services for California's dually-eligible beneficiaries. With over 1.2 million dual eligibles in California, the RFS initially seeks to identify four counties and existing Medi-Cal managed care plans to provide these integrated benefits. In addition to the initial four counties as authorized under the current state law, the Governor recently released his 2012-13 budget and requested an expansion of this pilot to include up to six additional counties. The Department estimates that if the expansion is approved for up to 10 counties, over 800,000 duals could be enrolled in managed care plans by the end of 2013.

California's RFS not only seeks qualified managed care plans to provide comprehensive benefits, but it is also asking for plans to demonstrate collaborative partnerships with county mental health and welfare departments to administer key sections of the benefit package. The RFS will give "additional consideration" to plans that provide letters of support or draft agreements/contracts with county agencies that oversee behavioral health, aging programs, transportation, housing, public health, and the agencies that administer the state's in-home supportive services (IHSS) program. California has three delivery models of managed care (County Organized Health Systems, Two-Plan models, and Geographic Managed Care [GMC] models) that will also make this RFS a unique process. In both the Two-Plan and Geographic Care models, the state is seeking evidence from applicants that local plans will collaborate with each other in this Demonstration. This is especially evident by the requirement that for both Two Plan and GMC models, at least two plans are required to apply in order for the county to be considered for a demonstration site. The RFS is not "competitive" because the state is requiring plans to have existing Medi-Cal contracts in the same county as the proposed dual eligible site. Sites will be announced in mid-to-late March and the Demonstration Proposal will be submitted to CMS in late April/early May.

While many components of the RFS are closely aligned with the recent CMS guidance to states on the capitated model, some of the key features of the California RFS include:

1. No diagnostic carve-outs. (The state had initially proposed excluding beneficiaries with HIV/AIDS, ESRD, and ALS.)
2. Individuals with developmental disabilities are carved in for medical and long-term care services, but HCBS waiver services will be carved out and administered through the Department of Developmental Services. (The state had initially proposed carving the entire population out of the pilot.)

3. The Department will be seeking a six-month enrollment lock-in from CMS; all beneficiaries will be passively enrolled and allowed to opt out to another Demonstration site, Medicare Advantage, Medicare fee-for-service, or PACE (but not the services offered through Medi-Cal).
4. All benefits will be included in the demonstration pilots, including long-term custodial care in nursing facilities, adult day health care, and in-home supportive services.
5. Plans will be required to meet a minimum Medical Loss Ratio of 85%.

### In other news

- **Judge blocks cut to healthcare for poor Californians**

  U.S. District Court Judge Christina Snyder said Monday she will temporarily block a 10% cut in Medi-Cal payments to doctors, dentists and other healthcare providers. In a 25-page order, the Los Angeles-based judge said she recognized the state's budget problems but that the cuts raised the risk of "irreparable harm in the absence of an injunction." If the judge makes the block permanent, the state is going to have to cut spending elsewhere to compensate, said H.D. Palmer, a spokesman for Gov. Jerry Brown's Department of Finance. Thanks to court orders and delays in federal approval, the state expects to shell out an extra $2 billion during the current and upcoming budget years combined. (Los Angeles Times)

- **Universal health care measure stalls in California Senate**

  Legislation to create a universal health care system in California stalled in the state Senate Thursday ahead of a key legislative deadline, signaling it will likely fail to advance this year. The so-called "Medicare for all" proposal, Senate Bill 810, fell short of the 21 votes needed to pass the upper house, by a vote of 19-15. Four moderate Democrats abstained and one joined Republicans in voting against the bill. The Assembly, meanwhile, approved several health-related bills, including measures requiring private health insurance plans to cover costs of oral chemotherapy and the treatment of mental illness and substance abuse. The apparent defeat of SB 810, which faces a Tuesday deadline for passing the Senate, was the latest setback for supporters of the single-payer movement, who have pushed the proposal multiple times in recent years. (Sacramento Bee)

## *Florida*

### HMA Roundup – Gary Crayton

At a Senate Medicaid Impact Conference last week, there was discussion related to the impact of excluding intergovernmental transfers (IGTs), which fund hospital rate reduction buybacks from the calculation of HMO rates. If this were to happen, local governments would have increase the level of IGTs or HMOs would pay hospitals the lower county billing rate. This lower county rate would result in a loss of roughly $596 billion in reimbursements to approximately 75 hospitals. We note that this conference addresses "what if" scenarios and this is not currently an issue proposed to the legislature.

### In other news

- **Florida's shift to private managed care means longer Medicaid waiting lists, study finds**

  Florida has three main Medicaid programs that divert people from nursing homes by providing home health care, aides for chores, assisted living and other services. One uses a for-profit, managed care model. Waiting lists for those programs rose 30 percent last year, the Office of Program Policy Analysis and Government Accountability reported. Meanwhile, the cost of the managed care program was significantly higher than the two traditional nonprofit programs. Florida is now asking the federal government to eliminate the less expensive programs and turn all at-home services over to managed care beginning in 2013. The enabling legislation, which passed last session, would cap spending below current levels, adding clients on the waiting lists when the money runs out. (Tampa Bay Times)

## *Michigan*

### HMA Roundup – Esther Reagan

Governor Rick Snyder gave his second State of the State message before the Legislature on January 18, 2012. The speech was generally focused on accomplishments during his first year in office, and he mentioned the "dashboard" he established to show how the State is progressing on various initiatives. He announced a pilot program called Pure Michigan Fit that will focus on childhood obesity. He renewed his request for approval of the MiHealth Marketplace health insurance exchange as well as legislation mandating that insurance companies cover treatment for autism.

Governor Snyder will be presenting his Executive Budget recommendation to the Legislature for Fiscal Year 2012-2013 on February 9, 2012. He is expected to simultaneously request a supplemental appropriation for the current year that will expend some of the more than $400 million in surplus funds from the fiscal year ending last September.

## *New York*

### HMA Roundup – Denise Soffel

The Medicaid Redesign team provided an updated list of managed care organizations that have been approved to participate in the MLTC program. In January, the following plans were approved:

- Guildnet
- HHH Choices
- Senior Whole Health

There are 26 additional organizations whose applications are still pending approval, of which five are PACE centers.

Beginning in April 2012, enrollment in MLTC plans will be required for Medicaid enrollees living in New York City currently being served in personal care, Long-Term Home Health Care, and Certified Home Health Agencies as well as people who are new to

long-term care if they need care for more than 120 days. MLTC plans would be required to ensure continuity of health care workers for their members when they transition from a fee-for-service plan.

Mandatory enrollment will expand throughout the rest of the state as MLTC plans become available. Individuals exempted for now would include those in the Assisted Living Program and those served through the Office for People with Developmental Disabilities as well as others

Medicaid Director Jason Helgerson conducted a budget briefing on the Medicaid budget today (February 1) at 3:30 pm EST. Contact HMA for details.

**EmblemHealth Update**

In 2007 EmblemHealth, Inc., the parent company of Health Insurance Plan of Greater New York (HIP) and Group Health Incorporated (GHI), submitted a plan to convert and combine the two not-for-profit health insurance providers into a single for-profit public company to the New York State Insurance Department. The EmblemHealth, HIP and GHI boards of directors have approved the move, and legislation was enacted in 2007 that provides a legal framework for the conversion. Efforts to convert were put on hold in 2008 amid concerns raised by New York City. Many of EmblemHealth's members are municipal employees, and increased premiums as a result of a conversion would have an immediate financial impact on the City. Discussions appear to have restarted, driven in part by the state's fiscal condition. The City unsuccessfully sued in federal court in an effort to block the merger of the two insurers that now make up Emblem, Group Health Inc. and the Health Insurance Plan of Greater New York, and the City has since that time urged state regulators to prevent the combined company from becoming for-profit.

As a combined for-profit company, EmblemHealth argues that it will be better able to compete against large national commercial insurers, as access to the capital markets allows improvements to technology infrastructure, product offerings and customer service. The combination is also expected to result in economies of scale that will enhance EmblemHealth's competitiveness. EmblemHealth has approximately 2.9 million members, including 260,000 members enrolled in New York's public coverage programs (Medicaid, Family health Plus and Child Health Plus).

The conversion requires approval from the Department of Financial Services. Superintendent Benjamin Lawsky has made no comment. EmblemHealth's conversion plan can be found on the DFS website: (Link to plan)

Governor Cuomo's executive budget provides a small piece of information about the status of discussions about the EmblemHealth conversion to a for-profit company. While no revenue tied to the conversion appears in the Governor's 2012-13 budget, the out-year budget indicates revenue to the state of $250 million in 2013-14 and $300 million in each of the two subsequent fiscal years.

## *Pennsylvania*

### HMA Roundup – Izanne Leonard-Haak

Beginning April 1, 2012, Coventry will enter the Southwest Zone where it will join existing plans Gateway, United, and UPMC. Coventry already operates in the Southeast Zone.

Beginning July 1, 2012, seven rural counties where ACCESS Plus currently operates will no longer offer ACCESS Plus (the PCCM program administered by APS Healthcare) but will instead be incorporated into existing HealthChoices zones. Bedford, Blair, Cambria, and Somerset counties will join the HealthChoices Southwest Zone. Franklin, Fulton, and Huntingdon counties will join the HealthChoices Lehigh-Capital Zone. Current ACCESS Plus enrollees will be required to join a managed care plan for their Medicaid coverage, and those currently enrolled in a Voluntary Managed Care Plan will also have to choose a Health-Choices Managed Care plan in their zone. If a consumer does not make a choice, the state will auto-assign them to one of the available plans. Open Enrollment in these counties begins in May 2012.

As a reminder, the Department of Public Welfare (DPW) is expanding HealthChoices statewide. The remaining 35 counties in the state where ACCESS Plus will continue to do business will be split into two new zones-New West Zone and New East Zone. Beneficiaries in these zones will be able to choose between ACCESS Plus and one of the HealthChoices plans available. The target start dates are September 1, 2012 for the New West Zone and March 1, 2013 for the New East Zone.

According to comments from DPW, nine managed care organizations submitted RFP responses, with seven responses each in the New East and New West zones. DPW did not reveal the identities of the plans. The Medicaid MCOs currently operating in HealthChoices are:

- Aetna
- Keystone/AmeriHealth Mercy
- Coventry
- Gateway
- Health Partners of Philadelphia
- UnitedHealth
- UPMC

This suggests there were two new bidders on the New East and New West procurements. As a reminder, the state has indicated it expects to select up to three plans in each of the new zones.

## OTHER HEADLINES

### Alabama

- **Medicaid proposal draws criticism**

  The chairman of the House Ways and Means General Fund committee thinks the state could reduce Medicaid costs by putting the Alabama Medicaid Agency in the hands of a private firm. The proposal has drawn criticism from physicians' groups and an advocacy group for low-income Alabamians, both of which say there's nothing left to cut in Medicaid except essential care. Rep. Jim Barton, R-Mobile, said Thursday he has reached out to three companies -- including Missouri-based Centene and Virginia-based Amerigroup -- about the possibility of managing Medicaid. The $1.7 billion General Fund, which provides state funding for the agency, could see an estimated $400 million shortfall in next year's budget. Medicaid makes up about 36 percent of the General Fund, and its share of the Fund is expected to grow significantly in the next few years. (Montgomery Advertiser)

### Colorado

- **Medicaid dispute pits "shared responsibility," care of poor**

  Colorado policymakers are wrestling to bring the burgeoning Medicaid budget under control, as critics fear health insurance for the poor will consume the state budget. But even the smallest cuts or cost-shares raise protests from patient advocates and objections that such measures will prove more expensive in the long run. Medicaid's move to address some critics with higher shared fees is considered a start by some, but health-care analysts say studies prove those fee increases deflect the poor from the best kind of care and backfire against the budget. Colorado expects to spend $5.4 billion in federal and state health care money next fiscal year, with the state's contribution rising 11 percent over this year. State health officials' most specific cost-cutting idea is a modest start: shaving $3.4 million in spending next year — less than one-tenth of 1 percent — by raising fees clients pay for Medicaid and the related Child Health Plan Plus. The new Medicaid co-pays, for example, would include raising the client's share of an inpatient hospital day from $10 to $12, with some exemptions for pregnant women and other protected groups. A generic drug refill would cost $1.30 instead of $1. (Denver Post)

### Connecticut

- **Demand for home care workers soaring, but will there be enough takers?**

  One frequently cited 2010 estimate developed by the state Department of Social Services suggested that by 2016, the state would need 9,000 more home care workers. But the need is now expected to be even larger. State officials expect that the increased demand for home care will be accompanied by a drop in demand for nursing home beds, potentially leaving nursing home workers available to serve clients at home. But that could also mean trading jobs with health insurance, retirement benefits and paid time off for jobs with lower wages and no benefits. Nationally, more than half of home care workers live in households that rely on public benefits like Medicaid or food stamps. (CT Mirror)

## Delaware

- **Del. governor would boost Medicaid, schools but calls for no tax hikes in $3.5 billion budget**

  Delaware Gov. Jack Markell's $3.54 billion operating budget proposal for the next fiscal year includes additional spending for Medicaid and schools but calls for no tax or fee increases. The budget, proposed by the Democratic governor on Thursday, represents an increase of 1 percent over this year's operating budget. Markell also is recommending about $22 million in additional spending for Medicaid to meet enrollment growth in the government health care program for the poor. Officials expect an additional 20,000 people to be added to the state's Medicaid rolls, bringing the total to about 234,000. Delaware must address skyrocketing costs for Medicaid and state employee health care, noting that Medicaid beneficiaries, state employees and retirees represent almost 40 percent of Delaware's health insurance market, with an annual taxpayer price tag of $1.7 billion in state and federal funds. His budget assumes only about $4 million in Medicaid savings, partly from copays for prescription drugs and therapy visits. (The Republic)

## Georgia

- **State Discusses Ideas on New Medicaid Design**

  The head of Georgia's Medicaid agency said Thursday that despite criticism of the program's current model of care, doctors and other medical providers agree with the idea of ''well-managed care'' for patients. The state currently operates a managed care system for most Medicaid and all PeachCare members. A report from consulting firm Navigant, released last Friday, called for Georgia to consider adopting an enhanced managed care system that would cover new segments of Medicaid patients. David Cook, commissioner of the Department of Community Health, told reporters in a media briefing that while people often have a negative impression of managed care, they generally agree with its principles of coordinating a patient's treatment. The Georgia Hospital Association recently criticized the state's current HMO-like set-up. It called instead for a Medicaid system similar to North Carolina's ''patient home'' model, which is run by physicians, not insurers. The North Carolina Medicaid system "is not off the table,'' Cook said to reporters. "It's a great model to look at.'' (Georgia Health News)

## Illinois

- **State pushes Cook County Medicaid plan**

  Illinois is asking the federal government to allow an early expansion of Medicaid coverage to low-income childless adults in order to bring millions of federal dollars into the struggling Cook County health system. Illinois Department of Healthcare and Family Services Director Julie Hamos sent a letter Monday to the U.S. Department of Health and Human Services supporting the proposal and asking for an expedited review. Any change would require state lawmakers to lift a freeze they put on Medicaid eligibility expansion last year. The Cook County Health and Hospitals System collected only $190 million in patient fees last year when it was expecting nearly twice that amount. County health system officials estimate expanding Medicaid would cover

100,000 currently uninsured patients a year who already receive care, bringing in federal matching dollars now unavailable. Only legal residents would be eligible. Medicaid costs generally are shared by the federal and state governments. But the proposed expansion wouldn't use state money because Cook County pays its share of Medicaid. (State Journal Register)

- **Cook County health system to bolster front line in effort to improve patient services**

  The Cook County Health & Hospitals System plans to hire up to 85 nurses and front-line health care workers in coming months as the cash-strapped public hospital system tries to boost patient satisfaction in preparation for national health care changes. Ramanathan Raju, the health system's new chief executive, laid out on Monday a series of initiatives its plans this year to ramp up services amid intensifying competition among the region's hospitals. Raju, speaking at a City Club of Chicago-sponsored event, said the county fears that once roughly 100,000 of its nonpaying patients become eligible in 2014 for an expanded Medicaid program, they may flee the county hospital system for for-profit and nonprofit health systems, like Northwestern Memorial and Rush University hospitals. A mass exodus of these patients could cripple the system's fragile finances by shifting its patient mix further toward the uninsured, county officials said. (Chicago Tribune)

- **Civic report: IL faces struggle to control exploding Medicaid costs**

  A new report released Monday from the Civic Federation, a Chicago-based nonpartisan policy group that focuses on state spending, predicts Illinois' Medicaid costs will skyrocket over the next five years. According to the Federation, lawmakers and governors have spent Illinois into a deep hole by expanding Medicaid, which provides health-care coverage to low-income families. But even with additional revenue, a 67 percent personal income tax increase and a 48 percent corporate income tax increase in January 2011, Illinois lawmakers still had to pay more than $1 billion in 2011 Medicaid bills. The Civic Federation report highlights three key points:

  1. Illinois is on pace to spend a total of nearly $14 billion on Medicaid this year
  2. Illinois' Medicaid costs are expected to increase 41 percent over the next five years.
  3. Gov. Pat Quinn is budgeting only a 13 percent spending increase.

  Illinois will see as many as 296,000 new people enroll in Medicaid once the federal Patient Protection and Affordable Care Act takes effect in 2014. (Statehouse News Online)

## Kansas

- **Attorney says bilking Medicaid is easy**

  The head of the Medicaid fraud unit at the Kansas Attorney General's Office told legislators it was easy to cheat programs that provide in-home services for the disabled and the frail elderly. The Office has about 60 active cases, most of which involved case managers or attendant care workers who had figured out how to bill the state's Medicaid program for services that weren't provided. The House Social Services Budget Committee's chairman, Rep. David Crum, R-Augusta, said he thought that a 2011 audit

that tied the Center for Independent Living in Southwest Kansas to more than $790,000 in undocumented Medicaid billings was just the "tip of the iceberg." (Kansas Health Institute)

- **Kan. Gov. has no plans to slow Medicaid overhaul**

  Kansas asked the federal government Thursday to waive some of its rules so that the state can overhaul its $2.9 billion Medicaid program, despite concerns among legislators that Gov. Sam Brownback is moving too quickly to turn all of it over to private health insurance companies. Brownback expects the state to issue contracts this year to three companies to manage the program, which provides health coverage to poor families and disabled and elderly Kansans. The contracts would take effect Jan. 1, 2013, and Kansas wants federal officials to issue a waiver so the state can include services for the disabled and elderly and build in financial incentives for improving services while controlling costs. If approved, it would mark the first time the state has attempted to cover the disabled and the elderly, including those in nursing homes, in a managed-care program. (CBS News)

## Kentucky

- **Human services in peril for elderly and disabled Kentuckians**

  Services for elderly and disabled Kentuckians are facing another round of budget cuts over the next two years — which could force more people into nursing homes and ultimately cost the state even more to care for them, according to lawmakers and advocates. Advocates said the state must find a way to fund services such as meals on wheels and personal in-home care, contending that the demand will only increase as Kentucky's population ages. (Courier-Journal)

- **Home health agencies say Medicaid payments are three months overdue**

  Home health agency officials told the House Health and Welfare Committee on Thursday that Kentucky's new managed care system for Medicaid is three months behind in its payments to them. The home health agencies are the latest group of providers to complain about the state's switch to Medicaid managed care. The state moved more than 500,000 people from traditional Medicaid to managed care on Nov. 1. On Monday, the Program Review and Investigations Committee voted to pursue subpoenas against managed care companies if it did not get more answers concerning low reimbursement rates for pharmacies. Independent pharmacists have said reimbursement rates are much lower than they were under traditional Medicaid, which means they are having to lay off employees. Others have said they might have to close long-time, family-run businesses because they can't pay their bills. (Kentucky.com)

## Maine

- **Feds tell Maine proposed Medicaid cuts unlikely to be approved**

  The federal agency that will decide whether some of Gov. Paul LePage's proposed Medicaid cuts qualify for waivers to make the reductions legal reaffirmed Thursday that the exemptions face long odds. In a written response to the Democratic leaders on the Legislature's budgetary committee, the federal Centers for Medicare & Medicaid Services confirmed that legislative action was not a consideration in whether the agen-

cy will grant a waiver from the federal health care law. Cindy Mann, the director of CMS, noted that no state has been granted a so-called Maintenance of Effort waiver from the Affordable Care Act. Mann added that Maine could only achieve the Medicaid waiver, known as Section 1115 in the Social Security Act, if it were adopting an experimental project designed to expand coverage — not to achieve budgetary savings. (Bangor Daily News)

## Minnesota

- **Battle over how health insurance is sold in Minnesota begins**

Governor Dayton's Exchange task force announced the following recommendations and suggested guidelines for an exchange:

1. The exchange should be led by a board of 15 to 20 people, some appointed and some elected by the board itself, in a public-private partnership. Most should represent consumers and small businesses, and a "small minority" could have conflicts of interests, including working for health insurance companies.
2. A wide range of "navigators" -- including insurance agents, advocates and people from health clinics, ethnic organizations and faith-based groups -- would help those who need assistance shopping for insurance.
3. To avoid some insurers getting hit with the most-expensive patients, the rules should be the same for policies sold inside and outside the exchange, and should promote competition, innovation, health improvement and affordability.
4. It should be financed by those who benefit, including Medicaid, but not unfairly burden businesses or other groups, starting by July 2013 to help fund the navigators

The Republican Party has had its own task force at work since fall, with 20 to 30 legislators and people from business involved. (Star Tribune)

## Nebraska

- **Nebraska lawmakers hear arguments on restoring proposed cuts to state Medicaid program**

Bolstered by more than 175 Medicaid recipients and their families crowded into two meeting rooms, members of several groups spoke at the Capitol in favor of a bill that would prohibit the implementation of $21 million in planned cuts to the Medicaid program. The proposed cuts include limiting home health services to 240 hours per year, eliminating oral nutritional supplements such as formula and nutritional drinks like Ensure and limiting behavioral health therapy visits to 60 per year. (The Republic)

## Tennessee

- **Health-care programs avoid some painful cuts in budget**

Doctors and other health-care providers would avoid a proposed 1.25 percent payment decrease for seeing TennCare patients in Gov. Bill Haslam's proposed budget. While the figure may appear small, it carried big consequences. The move would have saved the state $18.9 million but cost it $37 million in federal matching funds. Beyond dollars,

the cutback could have limited access to care — particularly in rural areas where many primary-care physicians already operate clinics on thin margins. The governor also would restore $12 million to support community health centers that treat people regardless of their ability to pay. (The Tennessean)

## Utah

- **Bill seeks surcharge for Utah smokers on Medicaid**

  Utah Republican Rep. Paul Ray has proposed a bill that could become a first-in-the-nation state law imposing a higher co-payment for tobacco-using residents enrolled in Medicaid. Although Medicaid recipients in Utah do not pay premiums, some are required to pay up to $5 co-payments for prescriptions or doctor visits. According to the American Lung Association, smokers enrolled in Medicaid smoke at a rate 60% greater than the general population. Ray said smokers on Medicaid cost Utah $104 million annually. (USA Today)

- **Accused Utah hospitals fire back at state's Medicaid sheriff**

  Hospitals have fired their first salvo against efforts by Utah's Medicaid program to crack down on fraud, waste and abuse. Three IASIS Healthcare Inc. facilities — Davis Hospital & Medical Center, Salt Lake Regional Medical Center and Jordan Valley Medical Center — are suing Medicaid's new Office of the Inspector General (OIG), saying the agency has no authority to demand repayment of $2.7 million in allegedly overpaid emergency department charges. The state informed IASIS of the overbillings in a letter on Oct. 7. The bills were for services provided between 2008 and 2009, according to documents filed Wednesday in 3rd District Court in Salt Lake City. (Salt Lake Tribune)

## Virginia

- **Virginia to transform system of caring for developmentally disabled**

  Virginia will close all but one of its large institutions for the developmentally disabled and move thousands of people into their own homes, their family's homes or group homes as part of a 10-year, $2.1 billion settlement announced Thursday with the U.S. Justice Department. After decades of legislative reports urging a shift toward community care, Virginia is one of the few states that still place people with developmental disabilities in large institutions. Virginia expects to spend $340.6 million to meet the terms of the settlement. It will receive $935 million from the federal government, virtually all of it through Medicaid reimbursements. It intends to cover the rest of the cost through savings, primarily by closing the training centers. The state had agreed to spend $30 million last year to move developmentally disabled residents from large institutions to community-based care. Gov. Robert F. McDonnell (R) has requested an additional $30 million in his $85 billion spending plan for the two fiscal years that begin in July 2013. The General Assembly has not yet acted on his request. (Washington Post)

## United States

- **Medicaid Prescription Drug Rule Saves $17.7 Billion, U.S. Says**

  Medicaid spending on prescription drugs will fall about $17.7 billion over five years under a rule that shifts more of the cost to drugmakers and pharmacies, the Centers for Medicare and Medicaid Services said. The rule issued today carries out provisions in the U.S. 2010 health-care law that raised the rebates that drugmakers led by Pfizer Inc. (PFE) pay each time their products are dispensed to Medicaid patients. Medicaid is the joint federal-state health insurance program for the poor. The rebates also apply to drugs sold by managed-care insurance plans that administer Medicaid benefits. Medicaid payments to pharmacies would additionally be pared by about $4 billion over five years under the rule. (Bloomberg)

- **States' Tax Revenues Rise Again, but Remain Below Peak with Growth Slowing**

  States' tax collections grew for a seventh straight quarter and are now topping pre-recession levels, though slowing growth will complicate states' recovery from the Great Recession, according to the latest State Revenue Report from the Rockefeller Institute of Government. State tax revenues were up 6.1 percent for the third quarter of 2011 compared to the same period of 2010, according to the report by Lucy Dadayan. Local property tax revenues grew modestly in the third quarter, after three consecutive quarters of decline. Preliminary October-November figures from 44 early reporting states suggest revenue gains continued for an eighth consecutive quarter, but growth softened considerably in the second half of 2011. Overall collections showed growth of 5.2 percent in the October-November months of 2011 compared to the same months of 2010. (Rockefeller Institute)

## 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 added the California dual eligible RFS dates to the calendar.

| Date | State | Event | Beneficiaries |
|---|---|---|---|
| January 27, 2012 | Virginia Behavioral | Proposals due | 265,000 |
| February 1, 2012 | Louisiana | Implementation (GSA A) | 255,000 |
| February 22, 2012 | Kansas | Proposals due | 313,000 |
| February 24, 2012 | California Dual Eligibles | Applications due | N/A |
| February 27, 2012 | Ohio | LOIs due | 1,650,000 |
| February 28, 2012 | Nebraska | Contract awards | 75,000 |
| March | New Hampshire | Contract awards | 130,000 |
| March 1, 2012 | Texas | Implementation | 3,200,000 |
| March 1, 2012 | Massachusetts Behavioral | Implementation | 386,000 |
| Mid to late March | California Dual Eligibles | Site Selection | N/A |
| March 19, 2012 | Ohio | Proposals due | 1,650,000 |
| April 1, 2012 | New York LTC | Implementation | 200,000 |
| April 1, 2012 | Louisiana | Implementation (GSA B) | 315,000 |
| April 9, 2012 | Ohio | Contract awards | 1,650,000 |
| June 1, 2012 | Louisiana | Implementation (GSA C) | 300,000 |
| July 1, 2012 | Washington | Implementation | 800,000 |
| July 1, 2012 | Hawaii | Implementation | 225,000 |
| July 1, 2012 | Florida | LTC RFP released | 100,000 |
| July 1, 2012 | New Hampshire | Implementation | 130,000 |
| July 1, 2012 | Nebraska | Implementation | 75,000 |
| July 1, 2012 | Missouri | Implementation | 425,000 |
| July 1, 2012 | Virginia Behavioral | Implementation | 265,000 |
| July 15, 2012 | California (Central Valley) | Implementation | N/A |
| July/August, 2012 | Georgia | RFP Released | 1,500,000 |
| September 1, 2012 | Pennsylvania | Implementation - New West Zone | 175,000 |
| January 1, 2013 | Georgia | Contract awards | 1,500,000 |
| January 1, 2013 | Kansas | Implementation | 313,000 |
| January 1, 2013 | Florida | TANF/CHIP RFP released | 2,800,000 |
| January 1, 2013 | Ohio | Implementation | 1,650,000 |
| March 1, 2013 | Pennsylvania | Implementation - New East Zone | 290,000 |
| October 1, 2013 | Florida | LTC enrollment complete | 100,000 |
| October 1, 2014 | Florida | TANF/CHIP enrollment complete | 2,800,000 |
| February 1, 2014 | Georgia | Implementation | 1,500,000 |

## HMA WELCOMES…

### Joan Henneberry, Principal – Denver, CO

Joan Henneberry joins HMA as a Principal and will be the first colleague in our new office in Denver, Colorado. Joan comes to HMA after serving as the Planning Director for the Health Insurance Exchange during 2011, where she developed the strategic plan for the establishment of the Exchange in Colorado. Prior to that assignment, Joan served as the Executive Director of the Colorado Department of Health Care Policy and Financing and led the state agency responsible for all public health insurance programs, with a staff of 300 and budget of $4.5 billion. Before returning to state government, Joan was Senior Vice President of Government Health Services for Policy Studies, Inc. where she was responsible for contracts in eight states with operations ranging from eligibility and enrollment in public health insurance programs to provider relations and customer contact centers. Earlier in her career Joan served as the Director of Health Policy Studies in the Center for Best Practices at the National Governors Association, where she also served as the Deputy Director and the Program Director for Maternal and Child Health. Joan earned her Bachelor of Arts degree at Blackburn College and her Master of Science degree at Regis University.

### Sarah Jagger, Senior Consultant – Indianapolis, IN

Sarah Jagger joins HMA as a Senior Consultant in the Indianapolis office. Sarah comes to HMA from the Indiana Office of Medicaid Policy and Planning (OMPP) where she has served most recently as the Director of Policy. In this role, Sarah was accountable for all program policy development, relationship and contract management, internal and external communications, and for overseeing federal and state compliance activities for the Indiana Family and Social Services Agency (FSSA). Previously, Sarah served as the Mental Health Liaison and Legislative Manager and developed the liaison relationship between two divisions within FSSA, while also overseeing the Agency's legislative agenda and special projects. Earlier in her career, Sarah worked at the Congressional Research Service in the Sommers Aging & Long Term Care Research Internship where, among other things, she authored a report entitled *Long-Term Care: Facts on Adult Day Care* describing the various models of care, the legislative history, and summarizing the federal funding sources associated with adult day care. Sarah earned her Bachelor of Arts degree at the University of Notre Dame, and her Juris Doctorate and Master of Public Health at Saint Louis University.

### Gary Young, Senior Consultant – Austin, TX

Gary Young joins HMA as a Senior Consultant in the Austin office. Gary comes to HMA from the Texas Health and Human Services Commission where he has served as a Senior Policy Advisor in the Medicaid and CHIP division. Gary was responsible for the design, planning, and management of the $6 billion competitive procurement for the Medicaid managed care expansion, and participated on the team responsible for designing and negotiating the State's new 1115 waiver, which was approved in December 2011. Also, during his tenure at the Health and Human Services Commission (HHSC), Gary was responsible for developing 1915(b) and 1915(c) waivers for federal approval, integrating value-based purchasing into Medicaid and CHIP managed care contracts, reviewing health

plan financial performance, and assisting actuaries in rate development. Prior to his time at HHSC, Gary served as a Research Associate at the Texas Office of Public Insurance Counsel, where he initiated and directed implementation of the state's first HMO consumer report card, and analyzed underwriting practices and financial data of the managed care industry. Gary earned his Bachelor of International Studies at the School for International Training, and his Juris Doctor at the University of Denver College of Law.

## HMA Recently Published Research

### Commonwealth Fund - Why Not the Best? Series: Eliminating Central Line Infections and Spreading Success at High-Performing Hospitals

**Sharon Silow-Carroll, Managing Principal**
**Jennifer Edwards, Managing Principal**

One of the most common types of health care–associated infections is the central line–associated bloodstream infection (CLABSI), which can result when a central venous catheter is not inserted or maintained properly. About 43,000 CLABSIs occurred in hospitals in 2009, and nearly one of five infected patients died as a result. This report synthesizes lessons from four hospitals reporting that they did not experience any CLABSIs in their intensive care units in 2009. Lessons include: the importance of following evidence-based protocols to prevent infection; the need for dedicated teams to oversee all central line insertions; the value of participating in statewide, national, or regional CLABSI collaboratives or initiatives; and the necessity for close monitoring of infection rates, giving feedback to staff, and applying internal and external goals. The report also presents ways these hospitals are spreading prevention techniques to non-ICU units and strategies for preventing other health care–associated infections.

Read the case studies from the four hospitals:

- Bronson Methodist Hospital of Kalamazoo, Michigan;
- Englewood Hospital and Medical Center of Englewood, New Jersey;
- Presbyterian Intercommunity Hospital of Whittier, California; and
- Southern Ohio Medical Center of Portsmouth, Ohio.

Comparative performance data for these and other hospitals can be found on WhyNotTheBest.org.