HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID MANAGED CARE ENROLLMENT UPDATE – Q2 2012

HMA ROUNDUP: FLORIDA RELEASES LTC RATE BOOK; ILLINOIS RELEASES HEALTH INSURANCE EXCHANGE (HIE) RFP; CALIFORNIA HIE BOARD ISSUES RECOMMENDATIONS FOR PLAN SELECTION CRITERIA, GUIDANCE ON HEALTH INSURANCE EXCHANGE POLICIES; NEW YORK DEVELOPING MANAGED CARE WAIVER FOR DD POPULATION

OTHER HEADLINES: FIDELIS CARE CEO LANE DIES UNEXPECTEDLY; MICHIGAN RELEASES PRISON HEALTH CARE RFP; WEST VIRGINIA DELAYS ABD MANAGED CARE EXPANSION; HIE UPDATES IN ALABAMA, NEBRASKA

JULY 25, 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
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
BAY AREA, CALIFORNIA • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Edited by:
Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: MANAGED CARE ENROLLMENT UPDATE Q2 2012

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, 13 states[1] have released monthly Medicaid managed care enrollment data through most of the second quarter of 2012.

In the discussion below, we describe 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. As a result, 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; in other cases, the data reflects only a subset of the broader population. For example, 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 limiting 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] Arizona, California, Florida, Illinois, Louisiana, Maryland, Michigan, Missouri, New York, Texas, Washington, West Virginia, Wisconsin

Table 1 - Medicaid Managed Care Monthly Enrollment January 2012 – June 2012

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Arizona	**1,169,340**	**1,160,342**	**1,148,086**	**1,137,709**	**1,130,317**	**1,123,925**
+/- m/m	(11,497)	(8,998)	(12,256)	(10,377)	(7,392)	(6,392)
% y/y	-2.2%	-3.0%	-3.7%	-4.5%	-5.8%	-7.1%
California	**3,659,651**	**3,687,119**	**3,752,840**	**3,803,418**	**3,822,201**	**3,841,213**
+/- m/m	39,164	27,468	65,721	50,578	18,783	19,012
% y/y	12.4%	13.2%	13.3%	14.1%	13.9%	12.8%
Florida	**1,150,999**	**1,161,940**	**1,151,228**	**1,163,410**	**1,182,542**	**1,190,601**
+/- m/m	6,022	10,941	(10,712)	12,182	19,132	8,059
% y/y	3.9%	3.7%	2.0%	3.0%	4.6%	4.8%
Georgia						
+/- m/m	N/A	N/A	N/A	N/A	N/A	N/A
% y/y						
Hawaii	**44,536**	**44,631**	**44,661**			
+/- m/m	(64)	95	30	N/A	N/A	N/A
% y/y	3.9%	3.8%	3.6%			
Illinois	**211,038**	**211,627**	**211,675**	**211,542**	**213,253**	**214,428**
+/- m/m	1,969	589	48	(133)	1,711	1,175
% y/y	7.4%	7.9%	8.1%	7.9%	8.3%	7.5%
Louisiana		**253,051**	**258,502**	**569,379**	**875,629**	**875,958**
+/- m/m			5,451	310,877	306,250	329
% y/y		N/A	N/A	N/A	N/A	N/A
Maryland	**762,345**	**763,714**	**774,610**	**779,433**	**773,720**	**773,869**
+/- m/m	2,304	1,369	10,896	4,823	(5,713)	149
% y/y	6.0%	5.6%	6.4%	5.4%	4.7%	4.8%
Michigan	**1,226,733**	**1,228,180**	**1,229,799**	**1,234,814**	**1,233,133**	**1,229,778**
+/- m/m	1,845	1,447	1,619	5,015	(1,681)	(3,355)
% y/y	0.3%	-0.1%	0.2%	-0.2%	0.8%	1.3%
Missouri	**427,995**	**428,573**	**429,005**	**428,383**	**424,999**	**413,738**
+/- m/m	(189)	578	432	(622)	(3,384)	(11,261)
% y/y	-0.3%	-1.0%	-0.8%	-1.1%	-1.2%	-2.7%
New York	**3,055,389**	**3,074,678**	**3,093,967**	**3,113,256**	**3,132,545**	**3,151,834**
+/- m/m	19,289	19,289	19,289	19,289	19,289	19,289
% y/y	5.8%	5.7%	5.9%	6.5%	6.6%	6.3%
Ohio						
+/- m/m	N/A	N/A	N/A	N/A	N/A	N/A
% y/y						
Pennsylvania	**1,261,489**	**1,271,999**				
+/- m/m		10,510	N/A	N/A	N/A	N/A
% y/y	-5.7%	-4.9%				
South Carolina	**448,328**	**450,048**	**449,064**	**452,120**		
+/- m/m	5,113	1,720	(984)	3,056	N/A	N/A
% y/y	10.5%	10.2%	9.8%	9.1%		
Tennessee	**1,209,579**	**1,208,209**	**1,206,538**			
+/- m/m	(2,234)	(1,370)	(1,671)	N/A	N/A	N/A
% y/y	0.2%	-0.1%	-0.3%			
Texas	**2,597,230**	**2,607,320**	**3,226,109**	**3,445,402**	**3,435,918**	**3,442,989**
+/- m/m	(25,890)	10,090	618,789	219,293	(9,484)	7,071
% y/y	15.0%	12.3%	39.0%	48.1%	46.7%	44.0%
Washington	**699,936**	**699,222**	**699,147**	**697,885**	**696,257**	**685,349**
+/- m/m	(3,909)	(714)	(75)	(1,262)	(1,628)	(10,908)
% y/y	0.0%	-1.0%	-0.2%	-0.1%	-0.3%	-2.4%
West Virginia	**168,104**	**171,215**	**170,370**	**170,174**	**167,520**	**169,735**
+/- m/m	(3,734)	3,111	(845)	(196)	(2,654)	2,215
% y/y	0.5%	1.5%	2.3%	1.4%	-0.4%	0.7%
Wisconsin	**707,220**	**708,261**	**705,863**	**703,735**	**707,298**	**706,195**
+/- m/m	(3,303)	1,041	(2,398)	(2,128)	3,563	(1,103)
% y/y	3.5%	1.4%	1.1%	0.5%	0.3%	-0.4%

Source: State Medicaid Agency websites

State Specific Analysis

Arizona

Continuing a trend from Q1 2012, Q2 enrollment continued to decline through June, with Arizona managed care enrollment down by more than 100,000 lives in the past ten months. Enrollment began to drop off in September 2011 and has since declined an average of more than 9,000 lives per month in 2012. Overall, year-over-year enrollment as of June 2012 is down 7.1 percent.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Acute Care	1,117,429	1,108,529	1,096,019	1,085,450	1,078,056	1,071,555
LTC	51,911	51,813	52,067	52,259	52,261	52,370
Total Arizona	**1,169,340**	**1,160,342**	**1,148,086**	**1,137,709**	**1,130,317**	**1,123,925**
+/- m/m	*(11,497)*	*(8,998)*	*(12,256)*	*(10,377)*	*(7,392)*	*(6,392)*
% y/y	*-2.2%*	*-3.0%*	*-3.7%*	*-4.5%*	*-5.8%*	*-7.1%*

California

At the end of September 2011, California enrolled over 3.5 million lives in MCO plans. Enrollment grew consistently through Q4 2011 and Q1 2012 and continued through Q2. This brings June 2012 final enrollment well above 3.8 million lives. California's MCO enrollments have grown consistently from month to month, with year-over-year growth rates holding steady above 12 percent.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total California	**3,659,651**	**3,687,119**	**3,752,840**	**3,803,418**	**3,822,201**	**3,841,213**
+/- m/m	*39,164*	*27,468*	*65,721*	*50,578*	*18,783*	*19,012*
% y/y	*12.4%*	*13.2%*	*13.3%*	*14.1%*	*13.9%*	*12.8%*

Florida

Florida managed care enrollments have continued a general trend upward over the past six months, with only one month, March 2012, of negative enrollment. As of June 2012, Florida managed care plans enroll nearly 1.2 million total lives, up almost 5 percent on a year-over-year basis.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
MMCP	994,384	1,004,446	995,256	1,006,240	1,024,111	1,031,486
Reform Pilot	156,615	157,494	155,972	157,170	158,431	159,115
Total Florida	**1,150,999**	**1,161,940**	**1,151,228**	**1,163,410**	**1,182,542**	**1,190,601**
+/- m/m	*6,022*	*10,941*	*(10,712)*	*12,182*	*19,132*	*8,059*
% y/y	*3.9%*	*3.7%*	*2.0%*	*3.0%*	*4.6%*	*4.8%*

Illinois

As of June 2012, Illinois managed care plans enrolled just over 250,000 Medicaid lives. June 2012 enrollment represents a 7.5 percent increase in year-over-year enrollment in the voluntary MCO program, while the addition of the Integrated Care Program for non-dual Medicaid ABD lives brings year-over-year enrollment up by more than 25 percent. The Integrated Care Program has enrolled 35,700 of an expected 40,000 as of June 2012.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Voluntary MCO	**211,038**	**211,627**	**211,675**	**211,542**	**213,253**	**214,428**
+/- m/m	*1,969*	*589*	*48*	*(133)*	*1,711*	*1,175*
% y/y	*7.4%*	*7.9%*	*8.1%*	*7.9%*	*8.3%*	*7.5%*
Integrated Care Program	**34,892**	**35,214**	**35,436**	**35,518**	**35,924**	**35,768**
+/- m/m	*1,628*	*322*	*222*	*82*	*406*	*(156)*
Total Illinois	**245,930**	**246,841**	**247,111**	**247,060**	**249,177**	**250,196**
+/- m/m	*3,597*	*911*	*270*	*(51)*	*2,117*	*1,019*
% y/y	*25.2%*	*25.9%*	*26.2%*	*26.0%*	*26.6%*	*25.4%*

Louisiana

This is our second quarterly managed care enrollment update to include Louisiana's statewide Medicaid managed care expansion, currently in the second of three geographic rollout phases. June's enrollment shows the rollout of the third and final phase, GSA C, which went live on June 1, 2012.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total Louisiana	N/A	253,051	258,502	569,379	875,629	875,958
+/- m/m	*N/A*	*253,051*	*5,451*	*310,877*	*306,250*	*329*

Maryland

As of June 2012, Maryland enrolled nearly 774,000 Medicaid managed care lives. Month-to-month enrollment increases have varied significantly over the past six months. However, despite the variations in month-to-month enrollment, year-over-year enrollment is up 4.8 percent, only slightly less than January's 6.0 percent.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total Maryland	**762,345**	**763,714**	**774,610**	**779,433**	**773,720**	**773,869**
+/- m/m	*2,304*	*1,369*	*10,896*	*4,823*	*(5,713)*	*149*
% y/y	*6.0%*	*5.6%*	*6.4%*	*5.4%*	*4.7%*	*4.8%*

Michigan

Michigan's managed care enrollment had its highest month-to-month enrollment increase in April, adding more than 5,000 lives. However, for the first time this calendar year, enrollments declined in both May and June, bringing total enrollment down to 1.23 million. Enrollment is up slightly (1.3 percent) on a year-over-year basis.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total Michigan	**1,226,733**	**1,228,180**	**1,229,799**	**1,234,814**	**1,233,133**	**1,229,778**
+/- m/m	*1,845*	*1,447*	*1,619*	*5,015*	*(1,681)*	*(3,355)*
% y/y	*0.3%*	*-0.1%*	*0.2%*	*-0.2%*	*0.8%*	*1.3%*

Missouri

Missouri Medicaid managed care enrollments have declined slightly over the past six months, with steeper enrollment drops in Q2 2012. Total June enrollment of 413,700 was down more than 11,000 on a month-to-month basis and down 2.7 percent year-over-year.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total Medicaid	381,569	382,143	384,279	383,397	380,304	371,437
Total CHIP	46,426	46,430	44,726	44,986	44,695	42,301
Total Missouri	**427,995**	**428,573**	**429,005**	**428,383**	**424,999**	**413,738**
+/- m/m	*(189)*	*578*	*432*	*(622)*	*(3,384)*	*(11,261)*
% y/y	*-0.3%*	*-1.0%*	*-0.8%*	*-1.1%*	*-1.2%*	*-2.7%*

Texas

As of December 2011, Texas had enrolled more than 2.6 million lives in MCO plans. By June 2012, the number of enrolled lives exceeds 3.4 million. In March and April 2012, Texas added more than 800,000 managed care lives through expansions in the STAR and STAR+PLUS managed care programs into several new regions in the state. As of June 2012, year-over-year managed care enrollment is up 44 percent. In February 2012, prior to the expansion, year-over-year enrollment was up more than 12 percent.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
STAR	1,730,605	1,738,488	2,276,008	2,481,041	2,486,461	2,494,801
STAR+PLUS	273,372	271,383	369,728	375,900	361,622	363,136
STAR HEALTH	31,791	31,789	31,506	31,508	30,041	28,859
CHIP	561,462	565,660	548,867	556,953	557,794	556,193
Total Texas	**2,597,230**	**2,607,320**	**3,226,109**	**3,445,402**	**3,435,918**	**3,442,989**
+/- m/m	*(25,890)*	*10,090*	*618,789*	*219,293*	*(9,484)*	*7,071*
% y/y	*15.0%*	*12.3%*	*39.0%*	*48.1%*	*46.7%*	*44.0%*

Washington

Managed care enrollments have declined in each of the six months of 2012 so far. In all, managed care enrollment is down more than 18,000 lives, or 2.4 percent on a year-over-year basis. On July 1, 2012, newly procured managed care plans will begin to serve both the Basic Health and Healthy Options programs.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total Washington	**699,936**	**699,222**	**699,147**	**697,885**	**696,257**	**685,349**
+/- m/m	*(3,909)*	*(714)*	*(75)*	*(1,262)*	*(1,628)*	*(10,908)*
% y/y	*0.0%*	*-1.0%*	*-0.2%*	*-0.1%*	*-0.3%*	*-2.4%*

West Virginia

West Virginia managed care enrollments have varied month to month but remain steady on a year-over-year basis. As of June 2012, nearly 170,000 lives were enrolled in managed care plans, up just 0.7 percent from the prior year.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Total West Virginia	**168,104**	**171,215**	**170,370**	**170,174**	**167,520**	**169,735**
+/- m/m	*(3,734)*	*3,111*	*(845)*	*(196)*	*(2,654)*	*2,215*
% y/y	*0.5%*	*1.5%*	*2.3%*	*1.4%*	*-0.4%*	*0.7%*

Wisconsin

Enrollment growth trends in Wisconsin have continued to slow over the past six months. Although March 2012 enrollment was up roughly 1 percent from a year earlier, by June 2012, enrollment had fallen below 2011 levels. The rate of year-over-year enrollment growth has steadily fallen from more than 16 percent in early 2011, to just under 1 percent in June 2012.

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
BadgerCare+	674,174	675,071	672,535	670,354	673,789	672,561
SSI	33,046	33,190	33,328	33,381	33,509	33,634
Total Wisconsin	**707,220**	**708,261**	**705,863**	**703,735**	**707,298**	**706,195**
+/- m/m	*(3,303)*	*1,041*	*(2,398)*	*(2,128)*	*3,563*	*(1,103)*
% y/y	*3.5%*	*1.4%*	*1.1%*	*0.5%*	*0.3%*	*-0.4%*

Select Company Analysis

Where available, we have included total Medicaid enrollments as reported in company financial statements. So far, Centene, United, and WellPoint have announced Q2 financial results. All other companies will include Q1 total enrollment unless otherwise noted.

Aetna

We track monthly enrollment data in four states where Aetna operates. Aetna lost nearly 100,000 managed care lives on January 1, 2012, when Connecticut discontinued its managed care program. With the losses in Connecticut and Arizona's consistent enrollment decline, Aetna's total risk-based covered lives were down more than 20 percent on a year-over-year basis in June 2012 to 422,000 lives. Aetna reported 1.17 million total Medicaid lives reported in Q1 2012 financial statements.

Aetna	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Arizona	306,463	304,475	301,637	298,745	297,180	295,783
+/- m/m	(2,364)	(1,988)	(2,838)	(2,892)	(1,565)	(1,397)
% y/y	-1.6%	-2.2%	-2.7%	-3.3%	-4.3%	-5.6%
Connectictut	0	0	0	0	0	0
+/- m/m	(97,396)	0	0	0	0	0
% y/y	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missouri	52,997	53,526	53,768	54,726	55,886	53,582
+/- m/m	(49)	529	242	958	1,160	(2,304)
% y/y	5.1%	4.9%	5.3%	6.3%	8.3%	4.3%
Pennsylvania	54,763	55,858				
+/- m/m	N/A	1,095	N/A	N/A	N/A	N/A
% y/y	32.0%	34.6%				
Texas	72,161	73,037	71,323	72,826	73,251	73,322
+/- m/m	(335)	876	(1,714)	1,503	425	71
% y/y	13.9%	19.0%	16.7%	18.0%	16.4%	11.7%
Total Aetna	**486,384**	**486,896**	**426,728**	**426,297**	**426,317**	**422,687**
+/- m/m	(100,144)	512	(4,310)	(431)	20	(3,630)
% y/y	-17.4%	-17.3%	-18.0%	-18.1%	-18.6%	-20.2%

Source: State Medicaid Enrollment data

Notes: Totals, month/month, and year/year changes adjusted for missing PA data

Amerigroup

We track monthly enrollment data in six of the eleven states where Amerigroup operates. Unfortunately, Georgia, Ohio, and Tennessee have not updated enrollment reports with any Q2 2012 data at this time. Within the three states that have reported monthly enrollment through June, Amerigroup covers over 1 million lives, up nearly 40 percent year-over-year. This growth comes in the newly implemented Louisiana managed care program, as well as in managed care expansions in Texas. In Q1 2012 financial statements, Amerigroup reported total Medicaid enrollments of more than 2.1 million across all states.

Amerigroup	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Florida	180,100	182,421	181,893	184,565	186,437	187,277
+/- m/m	1,294	2,321	(528)	2,672	1,872	840
% y/y	3.0%	2.9%	2.2%	3.4%	4.1%	4.0%
Louisiana		44,715	44,283	95,593	143,590	141,283
+/- m/m			(432)	51,310	47,997	(2,307)
% y/y						
Texas	606,736	607,365	676,262	723,209	716,554	721,076
+/- m/m	(5,323)	629	68,897	46,947	(6,655)	4,522
% y/y	10.9%	7.6%	20.0%	28.3%	26.7%	25.6%
Total Amerigroup	**786,836**	**834,501**	**902,438**	**1,003,367**	**1,046,581**	**1,049,636**
+/- m/m	(4,029)	47,665	67,937	100,929	43,214	3,055
% y/y	9.0%	12.5%	21.7%	35.2%	40.6%	39.1%

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 Q2 2012, Centene covers nearly 1.3 million lives, up 75 percent over the previous year. These states cover just over 50 percent of Centene's nationwide Medicaid enrollment of 1.8 million, as reported in Q2 2012 financial statements. Across these states, Centene has experienced sequential monthly enrollment growth in five of the last six months, with major gains in enrolled lives from February through May 2012, as a result of managed care expansions in Louisiana and Texas.

Centene	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Arizona	21,876	21,841	21,750	21,766	22,773	22,629
+/- m/m	(194)	(35)	(91)	16	1,007	(144)
% y/y	6.1%	5.4%	4.9%	4.6%	8.9%	8.3%
Florida	196,976	199,500	196,713	198,631	200,171	200,888
+/- m/m	1,566	2,524	(2,787)	1,918	1,540	717
% y/y	6.1%	6.6%	5.3%	6.4%	7.1%	6.8%
Louisiana		51,158	51,217	107,656	168,736	166,497
+/- m/m		51,158	59	56,439	61,080	(2,239)
% y/y		N/A	N/A	N/A	N/A	N/A
South Carolina	83,856	85,342	85,732	86,891		
+/- m/m	1,952	1,486	390	1,159	N/A	N/A
% y/y	-5.8%	-2.9%	2.6%	5.3%		
Texas	488,971	491,545	780,501	864,825	858,374	862,926
+/- m/m	(2,099)	2,574	288,956	84,324	(6,451)	4,552
% y/y	16.3%	11.0%	76.1%	94.7%	91.8%	88.9%
Wisconsin	40,005	40,080	39,745	39,373	39,891	39,671
+/- m/m	(530)	75	(335)	(372)	518	(220)
% y/y	-1.3%	-2.5%	-3.2%	-3.5%	-2.3%	-3.1%
Total Centene	**831,684**	**889,466**	**1,175,658**	**1,319,142**	**1,289,945**	**1,292,611**
+/- m/m	695	57,782	286,192	143,484	57,694	2,666
% y/y	9.9%	14.1%	51.6%	70.2%	76.7%	75.0%

Source: State Medicaid Enrollment data
Notes: Totals, month/month, and year/year changes adjusted for missing SC data

Coventry

We track monthly enrollment data in five states where Coventry operates risk-based health plans. Across these five states, Coventry experienced strong enrollment growth in February 2012, driven almost entirely by enrollment growth in Missouri. June 2012 total covered lives for these five states were up more than 14 percent on a year-over-year basis. Across all states, Coventry enrolls 924,000 Medicaid lives, as reported in Q1 2012 financial statements.

Coventry	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Florida	43,794	43,915	43,500	44,170	44,933	45,716
+/- m/m	825	121	(415)	670	763	783
% y/y	2.5%	3.0%	3.0%	5.7%	7.7%	9.5%
Michigan	45,475	45,381	45,221	45,025	44,560	44,171
+/- m/m	(163)	(94)	(160)	(196)	(465)	(389)
% y/y	-9.4%	-9.5%	-8.8%	-9.5%	-8.3%	-7.1%
Missouri	193,004	246,217	245,948	252,898	255,155	238,900
+/- m/m	1,123	53,213	(269)	6,950	2,257	(16,255)
% y/y	-0.7%	25.9%	26.0%	29.2%	30.9%	24.1%
Pennsylvania	15,693	16,043				
+/- m/m	N/A	350	N/A	N/A	N/A	N/A
% y/y	29.7%	32.6%				
West Virginia	61,109	61,109	61,240	61,240	61,543	61,543
+/- m/m	1,648	1,648	221	221	1,346	1,346
% y/y	5.8%	5.8%	6.5%	6.5%	5.9%	5.9%
Total Coventry	**359,075**	**412,665**	**395,909**	**403,333**	**406,191**	**390,330**
+/- m/m	3,220	53,590	(713)	7,424	2,858	(15,861)
% y/y	-0.3%	14.6%	15.1%	17.0%	18.3%	14.8%

Source: State Medicaid Enrollment data

Notes: Totals, month/month, and year/year changes adjusted for missing PA data

Health Net

We track Health Net's monthly enrollment data in California where the company covered more than 760,000 Medicaid members through June 2012, an increase of 21 percent from the previous year. The figures listed below do not include enrollment in the state's Healthy Families program, which is operated separately and for which monthly enrollment data is not available. We note that Health Net's Fresno contract (123,000 lives) was awarded in March to a local plan called CalViva for whom Health Net is serving as a subcontractor.

Health Net	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
California	676,674	684,316	697,641	755,406	756,802	762,615
+/- m/m	7,167	7,642	13,325	57,765	1,396	5,813
% y/y	-8.2%	-7.3%	13.4%	22.1%	21.8%	21.1%

Source: State Medicaid Enrollment data

Humana

We track Humana's monthly enrollment data in Florida where the company covered 45,000 Medicaid members through June 2012. Humana reported an enrollment of 621,500 Medicaid lives in the third quarter of 2011, most of which is in Puerto Rico. In Florida, Humana enrollment losses appear to be slowing from month to month. However, enrollment is down 8 percent year over year.

Humana	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Florida	44,943	44,910	44,200	44,363	44,699	45,270
+/- m/m	849	(33)	(710)	163	336	571
% y/y	-13.3%	-12.7%	-13.2%	-11.2%	-10.0%	-8.0%

Source: State Medicaid Enrollment data

Molina

We track monthly enrollment data in seven of the ten states where Molina operates risk-based health plans. Across these states, Molina has experienced healthy enrollment growth the last six months, driven by contract wins in Texas (rural CHIP, Dallas STAR+PLUS) and the acquisition of Abri Health Plan in Wisconsin. However, year-over-year enrollment is down in California, Michigan, and Missouri. The expansion MC contracts in Texas added more than 130,000 covered lives in a March and April, bringing Texas enrollment up roughly 130 percent in the last year.

Molina	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
California	201,796	201,222	201,434	177,118	178,399	177,574
+/- m/m	1,825	(574)	212	(24,316)	1,281	(825)
% y/y	6.5%	6.4%	6.5%	-6.5%	-6.1%	-7.4%
Florida	68,044	68,719	68,473	68,949	69,402	69,373
+/- m/m	279	675	(246)	476	453	(29)
% y/y	10.9%	8.6%	5.5%	6.3%	6.7%	5.8%
Michigan	211,791	211,289	211,173	211,210	209,846	208,666
+/- m/m	(181)	(502)	(116)	37	(1,364)	(1,180)
% y/y	-2.9%	-3.1%	-2.6%	-2.9%	-1.8%	-1.1%
Missouri	81,114	81,716	81,716	76,175	81,716	77,096
+/- m/m	18	602	602	(5,889)	602	5,687
% y/y	-0.3%	-1.0%	-1.0%	-7.1%	99.0%	-2.3%
Texas	149,396	150,360	262,818	284,652	283,981	283,759
+/- m/m	736	964	112,458	21,834	(671)	(222)
% y/y	68.3%	24.3%	114.7%	131.7%	130.8%	128.0%
Washington	339,756	339,936	340,370	339,805	340,523	339,149
+/- m/m	(1,216)	180	434	(565)	718	(1,374)
% y/y	1.8%	2.4%	3.7%	3.8%	3.5%	2.1%
Wisconsin	41,594	41,863	41,622	41,576	41,597	41,741
+/- m/m	121	269	(241)	(46)	21	144
% y/y	5.8%	5.2%	4.7%	4.0%	2.3%	2.6%
Total Molina	**1,093,491**	**1,095,105**	**1,207,606**	**1,199,485**	**1,205,464**	**1,197,358**
+/- m/m	1,582	1,614	112,501	(8,121)	5,979	(8,106)
% y/y	8.0%	4.7%	15.7%	14.9%	15.7%	14.6%

Source: State Medicaid Enrollment data

UnitedHealth

We track monthly enrollment data in seven of nine states where UnitedHealth operates risk-based health plans. Within these seven states, UnitedHealth covers more than 1.3 million lives, or approximately one-third of UnitedHealth's reported 3.8 million total covered lives (Q2 2012). In this subset of markets, UnitedHealth saw several months of consistent declines in total enrollment until expansion and new business contracts went live in Texas and Louisiana, adding roughly 270,000 lives during February through May 2012 and bringing year-over-year enrollment in these states up 26.5 percent.

UnitedHealth	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Arizona	252,845	250,938	248,733	246,778	246,484	245,640
+/- m/m	(2,210)	(1,907)	(2,205)	(1,955)	(294)	(844)
% y/y	0.2%	-0.4%	-0.9%	-1.4%	-2.3%	-3.8%
Florida	113,111	111,607	108,363	106,187	106,101	109,331
+/- m/m	(1,192)	(1,504)	(3,244)	(2,176)	(86)	3,230
% y/y	-1.0%	-4.3%	-7.8%	-9.7%	-10.1%	-7.9%
Louisiana		59,736	63,656	146,920	222,010	225,561
+/- m/m		59,736	3,920	83,264	75,090	3,551
% y/y		N/A	N/A	N/A	N/A	N/A
Michigan	242,040	241,829	240,980	240,907	239,314	238,413
+/- m/m	41	(211)	(849)	(73)	(1,593)	(901)
% y/y	2.9%	2.0%	1.7%	0.7%	1.1%	0.4%
Pennsylvania	211,865	210,827				
+/- m/m	N/A	(1,038)	N/A	N/A	N/A	N/A
% y/y	-6.5%	-7.0%				
South Carolina	70,313	69,610	68,307	67,934		
+/- m/m	(521)	(703)	(1,303)	(373)	N/A	N/A
% y/y	-3.5%	-5.3%	-7.6%	-9.4%		
Texas	105,331	104,726	158,769	170,009	168,087	168,151
+/- m/m	(197)	(605)	54,043	11,240	(1,922)	64
% y/y	18.4%	16.9%	76.5%	88.0%	84.7%	82.3%
Wisconsin	294,607	295,369	295,801	296,203	297,414	297,509
+/- m/m	(988)	762	432	402	1,211	95
% y/y	7.1%	4.2%	4.3%	3.7%	2.6%	2.3%
Total UnitedHealth	**1,290,112**	**1,344,642**	**1,184,609**	**1,274,938**	**1,279,410**	**1,284,605**
+/- m/m	(5,067)	54,530	50,794	90,329	72,406	5,195
% y/y	3.8%	7.7%	12.5%	20.5%	26.7%	26.5%

Source: State Medicaid Enrollment data
Notes: Totals, month/month, and year/year changes adjusted for missing SC data

WellCare

We track monthly enrollment data in five of the six states where WellCare operates risk-based Medicaid health plans (New York excluded). However, Georgia and Ohio have not reported enrollment numbers for 2012 at this time. Within the three states below, WellCare covers more than 523,000 Medicaid lives, as of June 2012, which is approximately 35 percent of WellCare's reported enrollment across all states of 1.48 million (Q1 2012). After year-over-year declines in enrollment for much of the latter part of 2011, WellCare has experienced stronger enrollment growth in the first half of 2012, with June 2012 enrollment up more than 6 percent annually.

WellCare	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Florida	353,970	358,465	356,792	362,463	372,727	374,685
+/- m/m	10,091	4,495	(1,673)	5,671	10,264	1,958
% y/y	2.4%	3.4%	3.3%	5.3%	8.9%	9.6%
Illinois	133,610	133,484	133,046	132,303	132,908	133,682
+/- m/m	542	(126)	(438)	(743)	605	774
% y/y	-4.7%	-3.9%	-3.8%	-3.8%	-2.8%	-1.2%
Missouri	16,361	16,374	16,318	15,217	14,572	15,359
+/- m/m	(102)	13	(56)	(1,101)	(645)	787
% y/y	0.6%	-0.5%	-0.4%	-8.2%	-11.9%	-5.2%
Total WellCare	**503,941**	**508,323**	**506,156**	**509,983**	**520,207**	**523,726**
+/- m/m	10,531	4,382	(2,167)	3,827	10,224	3,519
% y/y	0.6%	1.4%	1.4%	2.5%	5.3%	6.4%

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, or approximately 30 percent of the company's 1.88 million total reported lives (Q2 2012). In this subset of markets, WellPoint has experienced monthly enrollment growth in four of the last six months, with March posting a net loss in covered lives of more than 16,000 due to a lost contract in Texas. Prior to March 2012, WellPoint had shown consistent monthly increases in year-over-year enrollment growth in these four markets.

WellPoint	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
California	436,295	436,349	442,947	448,273	451,226	450,642
+/- m/m	1,174	54	6,598	5,326	2,953	(584)
% y/y	6.6%	7.5%	4.9%	6.2%	6.4%	5.3%
Texas	22,621	22,448	0	0	0	0
+/- m/m	(262)	(173)	(22,448)	0	0	0
% y/y	11.4%	33.8%	-100.0%	-100.0%	-100.0%	-100.0%
Wisconsin	22,641	22,625	22,407	22,100	22,402	22,450
+/- m/m	(357)	(16)	(218)	(307)	302	48
% y/y	-7.3%	-8.7%	-9.2%	-10.0%	-6.6%	-7.4%
West Virginia	82,008	83,312	82,695	82,317	81,174	81,849
+/- m/m	(1,117)	1,304	(617)	(378)	(1,143)	675
% y/y	-0.6%	0.2%	0.5%	-0.5%	-1.9%	-1.3%
Total WellPoint	**563,565**	**564,734**	**548,049**	**552,690**	**554,802**	**554,941**
+/- m/m	(562)	1,169	(16,685)	4,641	2,112	139
% y/y	5.1%	6.4%	0.3%	1.0%	1.0%	0.0%

Source: State Medicaid Enrollment data

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

The California Department of Health Care Services (DHCS) released an updated timeline for implementation of its dual eligible demonstration program. The state is currently negotiating the terms of its memorandum of understanding with CMS. That process is expected to be completed in August after which three-way contracting with the health plans is scheduled to begin (September/October). Readiness reviews are scheduled to be completed during the October/November time period with notifications to be mailed in December. The state is considering two enrollment options:

1. Staggered enrollment
    - March: Mandatory managed care enrollment for Medi-Cal benefits (full and partial duals)
    - June: Start dual demo enrollment for Medicare and Medi-Cal benefits (full duals only)
2. Simultaneous enrollment:
    - March – June: Begin passive enrollment process for demonstration at the same time as mandatory enrollment for Medi-Cal

The updated timeline is available here.

California's Health Benefit Exchange Update: With the US Supreme Court decision upholding the provisions of the Affordable Care Act, California's Health Benefit Exchange continues to press ahead with its aggressive operational plan. On July 19, the Board held a full day meeting to discuss staff recommendations for Qualified Health Plan (QHP) criteria. As a selective contracting entity, the Exchange will be taking an active role in the purchasing and selection of plans in California. Some of the criteria include:

- Standardizing benefit packages in each metallic tier. (Under California law, QHPs must affirmatively market, offer and sell products in each tier. Catastrophic plans may only be sold by QHPs that participate in the Exchange.)
- Limiting the number of QHP bids/products to 2-3 for each geographic region.
- Standardizing rate tiers, tier composition and tier ratios for all QHPs.
- Standardizing age factors for rate development.
- Allowing plans to do a limited rate-up for tobacco use (e.g., 5%).
- Standardizing major cost-sharing components and allowing only limited customization for ancillary benefits.
- Standardizing major benefit limits and exclusions.
- Requiring formularies to meet Medicare Part D minimum standards rather than ACA minimum standard.

- Allowing choice only between bronze/silver plans for individuals between 100% and 250% of FPL (prohibiting purchase of gold/platinum products).
- Adopting provider network adequacy requirements as dictated by state regulatory agency (Department of Managed Health Care or California Department of Insurance).
- Broadening the definition of "Essential Community Providers" to include private physicians, clinics and hospitals that serve Medi-Cal and other low-income populations.
- Allowing QHPs to determine contract terms and rates for Federally-Qualified Health Clinics.
- Requiring all QHPs to have "Commendable" NQCA rating by 2015.

The Health Exchange is actively seeking public comment on these recommendations through August 6. They are expected to adopt these standards at their August 23 board meeting in order to release a QHP procurement in September 2012.

In the news

- **Timeline Delineates Duals Project Tasks**

  The state Department of Health Care Services has released a timeline of deadlines and target dates for its Coordinated Care Initiative, also known as the duals demonstration project. The pilot program in eight counties, beginning in March, 2013, will serve about 700,000 of the state's dual eligibles. Link to CADuals Draft Timeline. (California Healthline)

Florida

HMA Roundup – Gary Crayton

On July 19, the Agency for Health Care Administration (AHCA) hosted a vendor's conference bidder's meeting for the LTC Managed Care ITN that is underway. AHCA responded to initial questions over the three-hour session, and responses to those questions as well as new questions that have been submitted will be posted July 26.

Also related to the LTC Managed Care ITN, the state published the rate ranges in the data book and updated the roll-out schedule for MCO's participating in the program, which we have reproduced below. We note that the "margin load" assumption built into the rates is a fairly tight range of 1.5% to 1.75%.

HCBS Population			
Region	Contract Payment Period	Bottom of Range	Top of the Range
1	November 1, 2013 - August 31, 2014	$1,095.71	$1,129.50
2	November 1, 2013 - August 31, 2014	$760.27	$780.01
3	March 1, 2014 – August 31, 2014	$1,098.74	$1,134.09
4	March 1, 2014 – August 31, 2014	$1,098.74	$1,134.09
5	February 1, 2014 – August 31, 2014	$1,234.72	$1,277.66
6	February 1, 2014 – August 31, 2014	$1,234.72	$1,277.66
7	August 1, 2013 – August 31, 2014	$1,228.95	$1,268.85

HCBS Population			
Region	Contract Payment Period	Bottom of Range	Top of the Range
8	September 1, 2013 – August 31, 2014	$1,358.17	$1,401.37
9	September 1, 2013 – August 31, 2014	$1,454.57	$1,500.28
10	November 1, 2013 – August 31, 2014	$1,360.24	$1,404.49
11	December 1, 2013 – August 31, 2014	$1,361.28	$1,406.06

Non-HCBS Population			
Region	Contract Payment Period	Bottom of Range	Top of the Range
1	November 1, 2013 - August 31, 2014	$4,619.89	$4,721.61
2	November 1, 2013 - August 31, 2014	$4,619.89	$4,721.61
3	March 1, 2014 – August 31, 2014	$4,619.90	$4,726.18
4	March 1, 2014 – August 31, 2014	$4,619.90	$4,726.18
5	February 1, 2014 – August 31, 2014	$4,714.38	$4,821.87
6	February 1, 2014 – August 31, 2014	$4,619.90	$4,725.27
7	August 1, 2013 – August 31, 2014	$4,714.35	$4,814.65
8	September 1, 2013 – August 31, 2014	$4,948.21	$5,054.68
9	September 1, 2013 – August 31, 2014	$4,948.21	$5,054.68
10	November 1, 2013 – August 31, 2014	$5,166.61	$5,273.67
11	December 1, 2013 – August 31, 2014	$5,166.61	$5,274.95

Georgia

HMA Roundup – Mark Trail

With respect to the state's decision to halt its Medicaid redesign initiatives, the Georgia Department of Community Health (DCH) is presently considering options either to proceed with a re-procurement of the existing CMO program or to approach CMS about an extension of the current CMO contracts. While extending coverage to the ABD population and other elements of the redesign are on hold, DCH does want to pursue certain improvements in the existing CMO program including:

- Carving in the foster care population
- Incorporating value based purchasing strategies
- Creating a centralized enrollment and eligibility website
- Other administrative efficiencies.

In the news

- **Georgia's Top Public Health Official Against Medicaid Expansion**

  Georgia's top public health official says she's against a proposed expansion of the state Medicaid system. Since last month's Supreme Court ruling on the Affordable Care Act, there's been much speculation about whether Georgia will opt out of the law's Medicaid expansion. If state leaders decide to expand, more than 600,000 Georgians will be newly eligible. Despite the promise of billions in federal funds, Public Health Commissioner Brenda Fitzgerald says the state would still need to come up with money it doesn't have, not to mention additional doctors and nurses. (PBA.org)

Illinois

HMA Roundup – Jane Longo and Matt Powers

At the State's Medicaid Advisory Committee meeting last Friday, July 20, HFS announced that the dual integration plans will also serve Medicaid-only aged, blind, and disabled Medicaid enrollees (ABDs). These individuals will be mandatorily enrolled in managed care plans in the Greater Chicago and Central Illinois regions. Aetna and Centene currently serve Medicaid-only ABDs in the Chicago suburbs. The state has not established a timeline for enrolling this population, however, the duals integration demonstration will begin on April 1, 2013.

Illinois released an RFP for an Illinois Health Insurance Exchange. The state is seeking a partner to "provide business services, technology infrastructure setup and operation, accompanying systems application development, and systems operation services associated with the establishment, ongoing operations, and maintenance of the Illinois Health Insurance Exchange (HIX)."

New York

HMA Roundup – Denise Soffel

The NYS Office for People With Developmental Disabilities (OPWDD) is in the process of developing a combined Section 1915 b/c waiver called People First. Section 1915(b) is the Medicaid managed care waiver; Section 1915(c) is the home and community based care waiver. CMS allows states to apply for a concurrent waiver to provide traditional long-term care benefits (like home health, personal care, and institutional services), as well as non-traditional home and community-based services (like homemaker services, adult day health services, and respite care) using a managed care delivery system rather than fee-for-service. With the People First Waiver, OPWDD's service system will be moving to a care management structure in which fee-for-service delivery will eventually be replaced by some form of a capitated/global payment model of service provider reimbursement. The waiver design and implementation process will allow New York State to develop and test care management methods that are carefully planned, designed and evaluated for their effectiveness at delivering person-centered services that are appropriate to each individual's needs with enhanced degrees of personal choice and control over the services received.

OPWDD currently serves 126,000 New Yorkers with developmental disabilities. It has an annual budget of $7 billion, of which 95 percent comes from Medicaid. Almost half its clients are dual eligible. A growing number of clients have dual diagnoses of developmental disability and a behavioral health diagnosis. Over the last year the agency has undertaken a planning process to redesign the system, which is largely a provider-centered delivery system, to a more person-centered system. OPWDD has been working with CMS in developing its waiver and expects to submit the waiver this fall. Implementation will be very gradual, beginning with pilot demonstrations in the spring of 2013. OPWDD is also participating in New York's duals demonstration initiative with a 10,000-person demonstration program that will enroll individuals with developmental disabilities into Fully-Integrated Duals Advantage (FIDA) programs.

The delivery system funded through OPWDD is made up largely of small providers without experience in taking on risk and without the capacity to do so. Managed Long Term Care Plans have significant reserve requirements, which are beyond the reach of most providers. The state envisions provider collaboratives coming together over the course of the waiver. With the intent of maintaining the current provider base, the state is not looking for large providers from out of state to come in, but is committed to strengthening its home-grown provider system. The list of services and benefits to be covered is comprehensive, including institutional as well as home and community-based services, habilitative services, behavioral health and respite care.

Texas

HMA Roundup – Gary Young

The Texas Health and Human Services Commission (HHSC) has adjusted capitation rates for the STAR and STAR+PLUS Medicaid programs in the ten-county Hidalgo Service Area. The revised rates are effective for the State Fiscal Year beginning September 1, 2012. STAR serves mainly the TANF population and STAR+PLUS the aged, blind and disabled. About half of those enrolled in STAR+PLUS are also enrolled in Medicare. STAR+PLUS includes both acute care services and long-term services and supports (LTSS).

Capitated managed care was implemented in the Hidalgo Service Area on March 1, 2012. As part of the general statewide expansion of managed care, inpatient services were added to STAR+PLUS, and pharmacy services were carved into both Medicaid managed care programs. Initial managed care rates were for the period March 1, 2012, to August 31, 2012.

Because of the historically high Medicaid fee-for-service utilization in the Hidalgo Service Area, particularly of LTSS, the state used an aggressive managed care discount factor for STAR+PLUS. Following a review of the STAR and STAR+PLUS Hidalgo managed care plan experience, the state has significantly increased the SFY 2013 rates for all four STAR+PLUS risk groups and reduced rates for two of the TANF risk groups, Pregnant Women and Newborns. Most other TANF children risk group rates were increased.

The state has committed to continuing to review the situation in Hidalgo and may make further adjustments to the rates during the coming months if warranted.

In the news

- **In Medicaid Fraud Investigations, a Controversial Tool**

  HHSC's Office of Inspector General (OIG) has dramatically increased both its caseload and the potential monetary returns associated with it over the last fiscal year, a spike that has won rave reviews from budget-weary state lawmakers and has cast Texas' innovative enforcement team into the national spotlight. But OIG's dollar-recovery strategy has enraged doctors who treat Medicaid patients. They say an anonymous call to a fraud hotline or a computer-generated analysis of a handful of billing codes is enough to halt their financing without so much as a hearing, jeopardizing their practices and employees and leaving thousands of needy patients in a lurch while the state works to prove — or rule out — abuse. (Texas Tribune)

OTHER HEADLINES

Alabama

- **Bentley says health care exchange decision will wait until after election**

  Republican Gov. Robert Bentley said he will wait until after the November presidential election to decide whether to set up a state health care exchange as required by the Affordable Care Act. (AL.com)

Arizona

- **AZ's handling of 'dual eligible' health-care recipients gets high marks**

  Arizona's system for providing medical care for "dual eligible" people – those who qualify for both Medicare and Medicaid services – was praised as a promising model for other states at a U.S. Senate hearing Wednesday. Tom Betlach, director of the Arizona Health Care Cost Containment System, told lawmakers in Washington, D.C., that the state's system of Medicaid managed care for dual-eligibles has saved money and improved care for the "frailest members most in need of care coordination." (Tucson Sentinel)

Connecticut

- **Proposed cutbacks in health care for poor hang in political limbo**

  A controversial plan that could end state health assistance for more than 13,000 of Connecticut's poorest residents fell into political limbo late Tuesday afternoon. After a day-long meeting, two panels of state lawmakers balked -- at least for now -- at giving Gov. Dannel P. Malloy's administration the go-ahead to set into motion a plan that could limit who in Connecticut can receive Medicaid, government's health program for the poor. The administration wants the federal government to allow Connecticut to impose two temporary restrictions on the Medicaid for Low Income Adults program, known as LIA. But the administration needs the approval of the Appropriations and Human Services committees to make the request. The committees have until Aug. 18 to act. Under the state law governing such applications, unless the panels vote to block the move within 30 days of receiving the proposed application, the administration can ask Washington to proceed without their permission. (CT Mirror)

Kansas

- **Group aims to reduce Medicaid waiting lists for developmentally disabled services**

  A Kansas group campaigning to reduce the waiting list for services for the developmentally disabled is holding meetings and trying to build grassroots support for its effort statewide. Launched in January, the campaign aims to persuade Kansas officials to eliminate a backlog for Medicaid-funded services that currently has about 4,915 developmentally disabled people on a waiting list. About 3,225 people are waiting for any services and about 1,690 are on the list to receive additional services. The much-sought services include home help during the workday and slots in group homes. Those on the list can wait years before receiving services, said some of the people who attended the meeting Thursday. The average wait is about 30 months. (Kansas Health Institute)

Kentucky

- **Judge orders Medicaid deal to continue temporarily**

  The CEO of one of the three Medicaid managed care companies says his company is losing money because the state failed to provide accurate utilization data and doesn't account for the company's higher costs in managing care for high risk patients. Michael Murphy, CEO of CoventryCares of Kentucky, faced tough questioning from state lawmakers Wednesday about the company's termination of contracts with several hospitals in eastern Kentucky, principally Appalachian Regional Healthcare which has eight hospitals in the region. ARH sued Coventry after the managed care company served notice that it intended to terminate its contract with ARH. While Murphy answered the committee's questions Wednesday, the federal judge in the case, Karl Forester, issued a ruling that Coventry must continue Medicaid payments to ARH through Nov. 1 in order to protect the health of 25,000 patients in the region covered by Coventry. He said Coventry may terminate its contract with ARH after Nov. 1. (The Times Tribune)

- **Beshear says he will expand Medicaid if state can afford it**

  Gov. Steve Beshear said on Wednesday that he would expand Kentucky's Medicaid program under the federal health-reform law if the state can afford the cost. "If there is a way that we can afford that will get more coverage for more Kentuckians, I'm for it, because if we've got a healthier Kentucky, we're all better off. Our economy's better off, and of course the individuals are better off," Beshear told Jack Pattie of WVLK Radio in an interview on Pattie's mid-morning show. (Hazard Herald)

Michigan

- **State to block preferential hospital pricing by insurers**

  Michigan Insurance Commissioner Kevin Clinton issued an order saying the state will prohibit the use of preferential hospital pricing policies by insurers unless he approves them. The decision is effective February 1. It applies to all health insurance companies operating in Michigan. These preferential pricing policies -- known in the hospital and insurance industries as most favored nation clauses -- go to the heart of a 2010 landmark suit filed by the United State Justice Department against Blue Cross Blue Shield of Michigan. The federal government contends the policies unfairly cause hospitals to charge other insurance companies more to offset big discounts they give to the Blues. Aetna, one of the nation's largest health insurers, also filed a lawsuit last year with similar allegations. Both cases are pending in Detroit's Federal Court. (Detroit Free Press)

- **State is taking bids to privatize prison health care**

  The State of Michigan has called for bids in what could be the largest privatization of state government services in Michigan history. Proposals are due Aug. 29 for a massive deal to provide medical services -- physical and mental -- to all 43,000 inmates held in Michigan prisons. Services include wound care, treatment of heart disease and diabetes, dental care, optometry and sex offender treatment. Prison medical and mental health services cost the state $306 million in 2011, and the state wants to test the waters through competitive bidding to determine how much or whether it can reduce that, he said. (Detroit Free Press)

- **Michigan health reform group wants Gov. Rick Snyder to issue executive order**

  A health care reform organization Wednesday called on Michigan Gov. Rick Snyder to issue an executive order to create a state health insurance exchange, one day after a top Republican leader said the state needs more time to set up the program. Michigan Consumers for Healthcare, a Lansing nonprofit with 155 member groups, issued a statement encouraging Snyder to give his own go-ahead for an exchange -- a largely Web-based program for comparing and buying insurance. (Detroit Free Press)

Minnesota

- **Minnesota Medicaid program: Independent audit sought; federal probes under way**

  The Minnesota Department of Human Services is commissioning an independent audit to respond to lingering questions about the state Medicaid program's past practices in paying private HMOs. The Medicaid rate-setting process also is the subject of several federal investigations. The new audit contract will go out for a competitive bid, so officials could not say what the work will cost. (Twin Cities Pioneer Press)

Nebraska

- **Lawmaker questions governor's authority on health insurance exchange**

  A state lawmaker said Thursday that a special session might be needed to give Republican Gov. Dave Heineman authority to decide whether Nebraska will establish a so-called insurance exchange under the federal health care law. States have until Nov. 16 to say whether they will establish exchanges or let the federal government step in and run them. Insurance Department officials told a legislative committee Thursday that Heineman can do so by executive order. Heineman's office later said the state constitution gives him that authority. But Sen. Paul Schumacher of Columbus said the Legislature must give the governor authority to make the decision and noted the tight deadlines. (Journal Star)

Oregon

- **Trillium, a health plan provider in Eugene, is spearheading reform efforts in Oregon**

  As Oregon launches a statewide effort to reform health care, there's a lot riding locally on the shoulders of one company, Trillium Community Health Plan. Oregon recently received the go-ahead from the federal government to come up with its own plan to help low-income Oregonians stay healthy and to treat them when they are sick or injured, while keeping a lid on costs. Trillium, which is owned by a group of 300 doctors, has stepped up to partner with Lane County in establishing a new way to provide health care to people covered by the Oregon Health Plan — Oregon's version of Medicaid, the government insurance that is mainly for low-income residents. Trillium is spearheading the new coordinated care organization, or CCO, in Lane County, which plans to provide better health care at lower cost by focusing on prevention; by getting patients' doctors, dentists and therapists talking more to each other; and by using people such as community health workers to work with patients and help motivate them to meet their health goals. CCO supporters say that all of these efforts should cut down on expensive trips to the Emergency Room and the hospital, and help avoid duplication of services, such as lab tests. (The Register-Guard)

Virginia

- **Inmates at Va women's prison allege shoddy health care amounts to cruel and unusual punishment**

Medical care at a Virginia women's prison is so deficient that it violates the U.S. Constitution's ban on cruel and unusual punishment, five inmates claim in a lawsuit filed Tuesday. The prisoners filed the complaint in U.S. District Court in Charlottesville against several prison officials and Armor Correctional Health Services Inc. The Miami-based company has a contract with the Virginia Department of Corrections to provide medical care at Fluvanna Correctional Center for Women. (Washington Post)

West Virginia

- **State delays plan to transfer Medicaid patients**

The state has delayed plans to turn over the care of 57,000 elderly or disabled Medicaid patients to three health insurance companies. The Department of Health and Human Resources said in May it would move patients who receive Supplemental Security Income into managed care insurance plans starting December. The three companies - Carelink, The Health Plan and Unicare - would get money from the state to insure SSI patients for whom the state currently handles claims. The three companies already manage care for 170,000 Medicaid recipients. Nancy Atkins, the head of the state Medicaid program, told lawmakers Monday the rollout had been delayed until next summer. She said the switch was delayed while officials look at the complex formula they use to reimburse some hospitals. Now the state is aiming to begin on July 1, 2013. (Charleston Daily Mail)

Wisconsin

- **Wisconsin's Family Care waiver granted**

Wisconsin's request to renew the popular Family Care program designed to help keep poor elderly people in their homes has been granted. But the federal Centers for Medicare and Medicaid Services says in Friday's letter anyone eligible for the program who had been put on a waiting list during an enrollment cap last year should be reimbursed for their health care costs during that time. The CMS letter says that waiting list violated terms of the state's approved waiver. State Department of Health Services Secretary Dennis Smith says DHS was not aware of anyone who was improperly placed on the waiting list and everyone who was eligible for services got them. (LaCrosse Tribune)

Wyoming

- **Mead expresses grave concerns over Medicaid expansion**

Gov. Matt Mead has "grave concerns" about the financial impact of expanding Medicaid in Wyoming, he wrote in a letter sent Thursday to the Obama administration's top health official. In the letter, Mead asks U.S. Health and Human Services Secretary Kathleen Sebelius for more details related to the federal health reform law and Wyoming. Wyoming leaders haven't decided whether to participate in the expansion. Mead has questioned how the expansion would be paid for and whether it is sustainable. Over the past decade, the state's Medicaid budget has increased more than six-fold, he noted. (Billings Gazette)

National

- **13 States Cut Medicaid To Balance Budgets**

Thirteen states are moving to cut Medicaid by reducing benefits, paying health providers less or tightening eligibility, even as the federal government prepares to expand the insurance program for the poor to as many as 17 million more people.

- Illinois cut enrollees to four prescriptions a month; imposed a copay for prescriptions for non-pregnant adults; raised eligibility to eliminate more than 25,000 adults and eliminated non-emergency dental care for adults.
- Alabama cut pay for doctors and dentists 10 percent and eliminated coverage for eyeglasses.
- Florida cut funding to hospitals that treat Medicaid patients by 5.6 percent – following a 12.5 percent cut a year ago. The state is also seeking permission to limit non-pregnant adults to two primary care visits a month unless they are pregnant, and to cap emergency room coverage at six visits a year.
- California added a $15 fee for those who go to the emergency room for routine care and cut reimbursements to private hospitals by $150 million.
- Wisconsin added or increased monthly premiums for most non-pregnant adults with incomes above $14,856 for an individual.
- South Dakota, Maryland, Colorado, Louisiana, New Hampshire, Hawaii and Maine also are making reductions to their programs. Connecticut is weighing cuts likely to go into effect this fall.

A few states have increased Medicaid benefits, including Arizona, which will boost pay for mental health providers next April. And some are looking at restoring cuts made during the worst of the recession, said Vernon Smith, managing principal with consulting firm Health Management Associates and a former Michigan Medicaid director. (Kaiser Health News)

- **CBO: Court ruling cuts cost of health-care law, but leaves 3 million more uninsured**

In its June 28 ruling, the court upheld the bulk of the Affordable Care Act but struck down a plan to require states to expand their Medicaid programs to cover residents who earn as much as 138 percent of the federal poverty level. As a result, analysts at the nonpartisan Congressional Budget Office expect that some states will refuse to expand their Medicaid programs or will delay expansion until after 2014, when most other provisions of the law are scheduled to take effect. In a separate report released Tuesday, the CBO said the Affordable Care Act would retain its powers of deficit reduction, a critical goal of the legislation during a time of record budget deficits. (Washington Post)

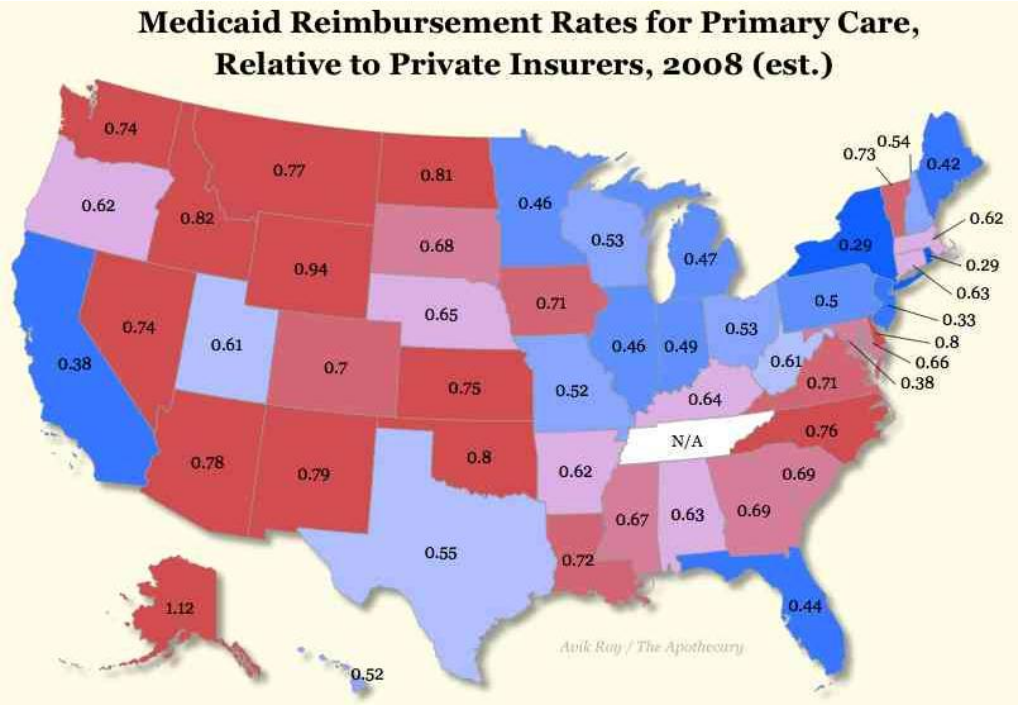
- **States Efforts To Outsource Prison Health Care Come Under Scrutiny**

States, in an attempt to cut costs, are increasingly outsourcing health care for inmates to for-profit companies, but the trend is raising concerns among unions and prisoners' rights groups. About 20 states, including Arizona, Illinois and Maryland, have shifted all or portions of their prison health care operations to private firms. Officials in these

states maintain that the companies, which provide physical, dental, mental and pharmaceutical services, are less expensive than employing state workers — partially because using the companies saves benefits and pension costs. (Kaiser Health News)

- **California pays Medicaid doctors half as much as North Dakota**

The map below looks at Medicaid's reimbursement rates for primary care doctors as a percent of payments to private carriers:



The takeaway seems to be that states that have maintained more expansive Medicaid programs — places like California and New York — tend to get there by paying doctors less to see patients. States who cover fewer people, meanwhile, look to reimburse providers at a higher rate. (Washington Post)

- **Working poor stand at center of Medicaid debate**

Nowhere did Obama's health care law hold more promise than in Texas, which leads the nation in the portion of its population that is uninsured. A quarter of Texans have no coverage, many of them families like the Gallegos who are considered the working poor. Perry was not alone in his decision. Several other GOP governors made the same move or are contemplating doing so, saying they can't afford to expand the joint state-federal program that provides care for the poor and disabled, or that they disagree with it philosophically. Texas already has one of the nation's most restrictive Medicaid programs, offering coverage only to the disabled, children and parents who earn less than $2,256 a year for a family of three. Without a Medicaid expansion, the state's working poor will continue relying on emergency rooms — the most costly treatment option — instead of primary care doctors. The Texas Hospital Association estimates that care for uninsured patients cost hospitals in the state $4.5 billion in 2010. (Yahoo News)

- **Government Looks to Managed Care as Cost Saver for Medicaid**

  Federal officials are planning a widespread test next year to see whether moving as many as 2 million low-income people into managed-care health plans can save money without undercutting the quality of the care patients get. On July 18, the official in charge of the effort said at a Senate Special Committee on Aging hearing that federal regulators do not intend to significantly reduce the number of people who would be shifted from fee-for-service plans, where they see the doctor of their choice, into managed care, which sometimes has access restrictions. The patients are part of the so-called dual eligibles, 9 million low-income people who qualify for Medicaid and Medicare. CMS officials will begin announcing as soon as August which states will get the green light to start shifting patients into managed care next year. According to guidelines CMS sent to states, the agency will work with individual states to determine payment rates based on spending and on expected savings. If the switch to managed care does not produce savings for both CMS and the state, "the demonstration will not go forward." Twenty-six states applied, hoping to save on Medicaid. Federal officials don't expect to approve all the applications, so the number of beneficiaries could be fewer than 2 million. (CQ Healthbeat)

- **CRS Analysts Say Supreme Court Decision Didn't Strike Down 'MOE' Rule**

  Contrary to arguments by Maine Governor Paul R. LePage, the Supreme Court's June 28 health care law ruling did not strike down the measure's "maintenance of effort" requirement that blocks states from reducing Medicaid eligibility before coverage expands in 2014. That's the finding of a July 16 Congressional Research Service memo that analyzes some of the practical implications of the high court's ruling for Medicaid officials. Nor does the ruling mean that states aren't required to comply with health care law provisions that determine income eligibility for the expanded Medicaid coverage based on "modified adjusted gross income," known as the MAGI standard, the analysis says. (CQ Healthbeat)

- **How Would a Block Grant Model Change Medicaid?**

  Five Republican governors -- from Virginia, Nebraska, Utah, Wyoming and Tennessee -- have said they would consider expanding Medicaid in exchange for block grant funding, which provides more flexibility in the way states spend federal dollars, according to *Politico*. The biggest change, some policy analysts say, would be a loss of accountability. Current federal Medicaid support for states, which accounts for between 50 percent and 75 percent of the program's spending, is subject to a variety of minimum federal requirements on coverage and eligibility. According to an April 2011 issue brief from the Kaiser Family Foundation, a block grant could potentially remove those requirements and result in fewer people being eligible for and covered by the program. A separate concern from critics is that Medicaid would be unable to quickly adapt to evolving economic conditions under a block grant because federal funding would be fixed rather than depend on state enrollment as it does now. Supporters of a Medicaid block grant counter that the proposal would make the program more fiscally responsible. The Kaiser Family Foundation estimated that the Ryan plan would save the United States a combined $750 billion. Florida and Texas would save $31 billion and $49 billion each. (GOVERNING)

PRIVATE COMPANY NEWS

- **Two insurers see new markets beyond Mass.**

  Tufts Health Plan and Harvard Pilgrim Health Care, which already operate in some nearby states, are strategizing on how they can boost their market share outside Massachusetts as about 30 million Americans who do not have insurance buy subsidized private coverage or become eligible for Medicaid under the law upheld by the Supreme Court last month. Their competitive advantage, they say, is experience in doing business under the 2006 Massachusetts health care overhaul, which made the state the first in the county to bring coverage to most uninsured residents. (Boston Globe)

- **Centene Swings To 2nd Quarter Loss on Impairment Charge; Revenue Up**

  Centene Corp. swung to a second-quarter loss as a large impairment charge masked the Medicaid insurer's stronger-than-expected revenue growth. Centene was one of three insurers that won contracts last year to cover Kentucky's Medicaid population. Revenue from new markets can be substantial, but it takes time to build up profitability due to new business costs and high initial medical expenses for patients. Last month Centene, which also operates specialty-based programs, lowered its full-year guidance and said it would post an unexpected second-quarter loss, due to high costs in Kentucky and Texas and in an individual health-care business. (Wall Street Journal)

- **Fidelis CEO's death stuns health execs**

  The sudden death of Fidelis Care President and CEO Mark Lane shocked local insurance executives who knew him as a staunch defender of the right of every New Yorker to access health care and health insurance. Mr. Lane died Sunday at age 60. Fidelis said the cause was a brief illness but did not provide additional details. (Crain's New York)

- **After Health Care Ruling, Centene Is Cast as Takeover Target**

  Since the Supreme Court upheld President Obama's transformative health care law last month, Wall Street has been wondering whether the decision would set off a fresh round of consolidation in the industry. One analyst says the Centene Corporation, a health care services company focused on Medicaid, could be a takeover target. "Centene could make a lot of sense to a strategic acquirer, given its large scale, margin upside and favorable growth prospects," Michael Wiederhorn, a managing director and senior analyst at Oppenheimer, wrote in a research note. (New York Times)

- **Magellan Health Said To Explore Company's Sale In Talks**

  Magellan Health Services Inc., a manager of behavioral, radiology and specialty drug services, is exploring the company's sale and has held talks with possible bidders, said a person with knowledge of the matter. Magellan is working with Credit Suisse Group AG, said the person, who declined to be identified because the discussions are private. The market value of the company as of yesterday was $1.44 billion, after DealReporter said Magellan had been working on a possible sale. Magellan also administers plans for Medicaid, the joint state-federal health program for the poor, according to its website. The company doesn't comment on rumors and speculation, David Carter, a spokesman for Magellan, said in a telephone interview. (Bloomberg)

RFP Calendar

Below is an updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
July 24, 2012	Kentucky - Region 3	Proposals Due	170,000
July 30, 2012	Massachusetts Duals	Proposals Due	115,000
Early August 2012	Illinois Duals	Contract awards	136,000
August 13, 2012	Ohio Duals	Contract awards finalized	122,000
September 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
Late 2012	New Hampshire	Implementation (delayed)	130,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 1, 2013	Florida LTC	Contract Awards	90,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	136,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
October 1, 2013	Florida LTC	Implementation	90,000
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
October 1, 2014	Florida acute care	Implementation	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

Below is a summary table of the progression of states toward implementing dual eligible integration demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	N/A	1/1/2014
California	Capitated	685,000*	X	4/4/2012	X	6/30/2012	X	3/1/2012	4/4/2012	3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012				1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012				12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012				1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	Early Aug. 2012	4/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012				1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012		Q2 2013	July 2013	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012	X	8/20/2012	9/21/2012	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012		Feb. 2013	March 2013	7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012				10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012				1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012		Q3 2012	Dec. 2012	1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012				1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012				1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	Scoring: 6/28/12	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012				7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012		Certification process		1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012		Apr-May 2013	6/1/2013	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012			7/30/2013	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012				1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012		Late 2012	Early 2013	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012			July 2013	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012		1/1/2013	2/28/2013	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012		Feb. 2013	July 2013	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012				1/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***4***			

**Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

[+] Acute Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

[‡] Capitated duals integration model for health homes population.

HMA Recently Published Research

Financing County Medi-Cal Eligibility and Enrollment in California

Stan Rosenstein, Principal Advisor
Caroline Davis, Senior Consultant
David Fosdick, Consultant

Prepared for the California Health Care Foundation, this report examines how the state finances county administration of these programs and explores the potential impacts of several changes underway and on the horizon, such as budget cuts, a new methodology for determining Medi-Cal administrative payments to counties, and the transition of children from Healthy Families to Medi-Cal. Several implications of the Affordable Care Act (ACA) are also discussed, including:

- **Medicaid expansion and eligibility simplification.** Medi-Cal enrollment could grow by 1.8 million or more people beginning in 2014. At the same time, the ACA requires simplification of the enrollment and redetermination processes.
- **Role of California's Health Benefit Exchange.** Federal regulations will let California decide whether eligibility for most Medi-Cal applicants will be determined by the Exchange or Medi-Cal.
- **Eligibility determination systems.** Federal funding is available through 2015 to upgrade Medi-Cal eligibility determination systems to streamline eligibility across Medi-Cal and the Exchange.
- **Adoption of a Basic Health Program.** County workload may increase if the state elects to create a Basic Health Program for individuals with incomes up to 200% of the federal poverty level who do not qualify for Medi-Cal.
- **Realignment of health care programs.** The governor's proposed budget discussed changing responsibilities for the funding and delivery of certain health care services in response to low-income, uninsured Californians moving out of county programs and into Medi-Cal or the Health Benefit Exchange.

Taken together, these programmatic changes will alter the landscape of funding for county administration of eligibility for public assistance benefits and provide an opportunity to rethink the role of counties. **(Link to Report – California Health Care Foundation)**

Comprehensive Hospital EHRs Improve Quality and Efficiency

Sharon Silow-Carroll, Managing Principal
Jennifer Edwards, Managing Principal
Diana Rodin, Consultant

HMA prepared a report for the Commonwealth Fund examining the experiences of nine hospitals with comprehensive electronic health record (EHR) systems. The report describes ways that the systems facilitate patient safety, quality improvement, and efficiency. The EHRs have contributed to faster, more accurate communication and streamlined processes, which improve patient flow, minimize duplicative tests, enable faster responses to patient inquiries, improve capture of charges, and generate federal incentive payments. The report presents challenges to EHR implementation and ways to alleviate them, and lessons for other hospitals and policymakers. **(Link to Report - The Commonwealth Fund)**

Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

Mike Nardone, Principal

The Medicaid expansion under the Affordable Care Act will provide coverage to most of the estimated 1.2 million people who are homeless, including the roughly 110,000 individuals who are chronically homeless and more likely to suffer chronic, complex health conditions. This policy brief makes a case for states to explore the use of new Medicaid financing options available under ACA (e.g., health homes), as well as flexibilities afforded through Medicaid managed care, to support the funding of housing-based care management services in supportive housing for formerly homeless individuals. The research suggests that such an approach can improve care for these beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services. **(Link to Policy Brief - Center for Health Care Strategies)**

Public and Private Insurance Coverage for Chronic Hepatitis B Patients: Health Reform Will Facilitate Early Investments Providing Long-Term Benefits

Jack Meyer, Managing Principal
Gaylee Morgan, Senior Consultant
Vern K. Smith, Managing Principal

The implementation of national health reform in the U.S. provides important opportunities to increase the awareness, routine screening, and treatment of viral hepatitis. An estimated 2.2 million Americans are infected with chronic hepatitis B (HBV), yet nearly two-thirds of these people are unaware of their disease until they have developed liver cancer, cirrhosis, or liver failure many years later. A growing body of evidence indicates that when HBV is detected early and properly treated, these highly adverse outcomes can be delayed or avoided altogether.

Enrollment in health coverage is absolutely vital to this early detection and treatment. In fact, our research shows that liver transplants can be reduced by 58 percent and the death rate can be reduced by 20 percent when lower-income people are enrolled in insurance coverage and treated early in the course of their disease. This study projects that over 70,000 people with HBV will newly enroll in Medicaid under the Patient Protection and Affordable Care Act and about 75,000 more people with HBV will newly enroll in Health Insurance Exchanges. We find that a 5 percent reduction in liver transplants for HBV patients could finance more than 420,00 screenings. **(Link to Report - Center for Health Care Strategies)**