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# HMA

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HEALTH MANAGEMENT ASSOCIATES

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

**IN FOCUS:** ALABAMA COMMISSION MAKES MEDICAID REDESIGN RECOMMENDATIONS

**HMA ROUNDUP:** ARKANSAS PROPOSES MEDICAID EXPANSION VIA EXCHANGE; NEW JERSEY OPTS FOR MEDICAID EXPANSION; ILLINOIS FINALIZES DUAL ELIGIBLE MOU; CALIFORNIA RURAL COUNTY MCO AWARDS EXPECTED IN NEXT TWO WEEKS; CALIFORNIA DUAL ELIGIBLE MOU PENDING FINAL RATE NEGOTIATIONS; LOUISIANA LTC RFI RESPONDENTS DISCLOSED; HAWAII ANNOUNCES BEHAVIORAL HEALTH AWARD; HHS ANNOUNCES RECIPIENTS OF STATE INNOVATION AWARDS

**OTHER HEADLINES:** MEDICAID EXPANSION DISCUSSIONS CONTINUE IN NORTH CAROLINA, IOWA, MISSOURI, INDIANA, KANSAS, TEXAS, AND WYOMING; MAXIMUS AWARDED CONNECTICUT CUSTOMER SERVICE CONTRACT; D.C. REJECTS CHARTERED HEALTH PLAN RFP PROTEST

**FEBRUARY 27, 2013**

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

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## Contents

<b>In Focus: Alabama Commission Makes Medicaid Redesign Recommendations</b>	<b>2</b>
<b>HMA Medicaid Roundup</b>	<b>4</b>
<b>Other Headlines</b>	<b>15</b>
<b>Company News</b>	<b>18</b>
<b>RFP Calendar</b>	<b>19</b>
<b>Dual Integration Proposal Status</b>	<b>20</b>
<b>HMA Recent Publications</b>	<b>21</b>

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## IN FOCUS: ALABAMA COMMISSION MAKES MEDICAID REDESIGN RECOMMENDATIONS

This week, our *In Focus* section reviews the Alabama Medicaid redesign recommendations made by the Alabama Medicaid Advisory Commission (the Commission) in its January 2013 report. The Commission was charged with reporting to the Governor by January 31, 2013, its recommendations on redesign efforts that would make the Medicaid program more financially sustainable and more focused on quality care and cost control. The report details the current pressures on the Medicaid system as well as outlines the nine recommendations made by the Commission. The Commission recommends :

- statewide expansion of the limited patient care network fee-for-service (FFS) care management program;
- the transition from FFS to full-risk capitation; and
- the establishment of several regions, to be led by regional community care networks;
- however, an individual region may elect to contract with a traditional Medicaid managed care organization.

### Medicaid Background

Alabama Medicaid covers roughly 940,000 beneficiaries, or one-third of the state's population. This is in spite of the fact that the state has some of the most restrictive eligibility standards in the nation. The Commission's report cites limited eligibility, combined with similarly restrictive benefit packages, as contributing to Alabama's Medicaid program having the third lowest per eligible spending in the nation – behind only California and Georgia.

Alabama's state share of the \$5.6 billion Medicaid program amounts to a little over \$1.8 billion. A significant portion of state funding for Medicaid comes from provider tax arrangements with the state's hospitals, nursing homes, and pharmacies, generating nearly 20 percent of funds on an annual basis.

Currently, four markets in the state are served by patient care networks – Mobile, Opelika, Tuscaloosa, and Huntsville. Although still a FFS program design, the patient care networks have implemented case management for higher risk beneficiaries. Patient care networks cover children and the ABD populations, but do not enroll maternity patients or dual eligibles, and do not offer pharmacy or long-term care benefits.

### Redesign Recommendations

The Commission heard from United Healthcare, representing the managed care industry, on how Medicaid MCOs could save Alabama money while improving health outcomes. The regional care organization option was presented by Manatt Consulting, developed on behalf of the Alabama Hospital Association. The Mannatt alternative expands the current patient care networks, described above, into regional care organizations. The Commission also heard from pharmacy and hospital representatives, who indicated that

support for renewal of the pharmacy and hospital provider taxes would be limited if the state were placed into commercial managed care and pharmacy benefit management.

The full recommendations of the Commission follow:

1. Alabama should be divided into regions with a community led network coordinating Medicaid services in that region.
2. Expanded regional patient care networks are to become risk-bearing organizations.
3. Regions may opt to contract with a commercial MCO for care, risk management, or other services.
4. The state shall set an implementation timeline and benchmarks for regions, with a process for state intervention in the case of failure to meet benchmarks.
5. Alabama Medicaid should apply for an 1115 Waiver from CMS for to implement and provide funding for the transition to managed care.
6. The legislature should develop a Medicaid spending cap with flexibility around federal rules and regulations, economic uncertainty, and other unforeseen spending impacts.
7. The Commission recommends the renewal of both the hospital and nursing home provider taxes.
8. The state should convert certified public expenditures (CPEs), currently used to prospectively cover estimated uncompensated hospital care, to intergovernmental transfers (IGTs) with greater transparency and reduced potential for future liability.
9. Alabama Medicaid is encouraged to explore transitioning hospital payment methodology away from per diem/per encounter and toward a payment methodology that pay for outcomes, such as the APR-DRG system.

### **Takeaways from Commission Report**

While the Commission's report stops short of calling for a statewide MCO expansion, the amendment allowing for regions to contract with a commercial MCO presents an opportunity for traditional Medicaid MCO presence in Alabama. There may be additional opportunity for third-party administration (TPA) roles in regions that opt for a community or provider-based managed care lead. The final decision from the state and a timeline, potentially with regional benchmarks, will be key in determining the structure of Alabama Medicaid's shift to managed care going forward.

Link to Alabama Medicaid Advisory Commission Report: [\(PDF\)](#)

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## HMA MEDICAID ROUNDUP

### *Arkansas*

#### HMA Roundup

**Innovative Medicaid Expansion option pursued by Gov. Beebe.** On Tuesday, February 26, 2013, Governor Beebe unveiled an innovative plan, which he asserted had the blessing of HHS, that may allow Medicaid eligible Arkansans (i.e. below 138% FPL) to receive private health coverage on the state's exchanges with premiums 100% federally financed for the first three years. This arrangement would be the first in the nation allowing for a state's use of federal Medicaid funds to pay for exchange plan premiums below the 100% FPL level. At this time, the full details of the arrangement are not public and it is unclear if HHS would pay the Medicaid equivalent cost (per capita) or the full cost of an exchange plan which would presumably be higher.

The state Department of Human Services Director confirmed that the proposed plan would involve covering the entire expansion population through the exchange, contingent on a partnership exchange model. Should that partnership model not be possible, then this arrangement would be subject to another HHS review. Republican leaders in the legislature offered positive initial responses to proposed arrangement, but also stipulated that any agreement would sunset in three years.

#### In the news

- **"Mike Beebe Strikes a Good Deal for Arkansas Health Care Providers"**

"Arkansas governor Mike Beebe, a Democrat in a state that's become extremely conservative in national politics, struck a deal with the Department of Health and Human Services yesterday that could pave the way for future further Medicaid expansions in red states. The basic arrangement is that Arkansas will take the federal money on offer to drastically expand its Medicaid program, and use it not to expand Medicaid but instead to offer coverage to low-income Arkansas via the Obamacare exchange process." ([Slate.com](#))

### *California*

#### HMA Roundup - Jennifer Kent

**MRMIB Shortfall Grows.** The Managed Risk Medical Insurance Board (MRMIB) executive director Janette Casillas defended the board against criticisms of poor forecasting, in light of a \$116 million general fund deficit in the Healthy Families (HF) program. Taken together with an additional \$216 million in forfeited federal funds due to the shortfall, the HF program deficit totals \$332 million in FY 2013. Casillas pointed to the expiration of a managed care tax as the root cause of the shortfall. The Legislature appropriated \$15 million to chip away at the deficit. MRMIB has been unable to pay health plans in the program for services provided since the end of December 2012.

**Stakeholders Voice Opinions on Medi-Cal Expansion, Enrollment, Waivers, and Grants.** Last Friday, the DHCS Director Toby Douglas offered a variety of updates on

Medi-Cal concerns at a Stakeholder Advisory Committee meeting. Below, we feature some of the highlights:

- The Administration wants to move ahead with the optional Medi-Cal expansion, but cannot separate the expansion from the need to reach a deal on county realignment funds. There will be a separate stakeholder process for the “optional” Medi-Cal expansion discussion occurring between the Administration and counties.
- The first phase of the Healthy Families transition has gone “smoothly” with 180,000 children transferred and data indicating that almost 100% have stayed with their primary care provider. The Department has released its first transition report to CMS and anticipates starting Phase II on March 1, 2013.
- The rural county Medi-Cal managed care procurement is expected to be announced in the next 1-2 weeks. The release will be for the 26 Northern California counties and will be split amongst bidders – there were six applicants. Imperial is slated to become a Geographic Managed Care county and San Benito will join the Central California Alliance County Organized Health System.
- The state’s memorandum of understanding (MOU) with CMS on the dual demonstration pilot is nearly ready for signing, but Jane Ogle (Deputy Director, Health Care Delivery Systems) acknowledged that it’s “all about the money” at this point. If the dual demo plans are unable to come to agreement with the state on savings targets (in order to build the rates), then the MOU will not be signed. The September 1, 2013 start date remains intact, although it may not be feasible with the MOU still hanging in abeyance.

### Upcoming Meetings

**February 28:** Joint Hearing of Budget Subcommittee-1 on Health and Human Services and Assembly Health committees upon Adjournment of Session. Informational hearing on Healthy Families Transition, Community Based Adult Services Transition, and the New Medi-Cal Hearing Aids Reimbursement Policy

**March 6:** Assembly Budget Subcommittee on Health at 1:30 p.m. Department of Health Care Services: Affordable Care Act Medi-Cal Expansion.

**March 13:** Joint hearing for Health and Business Committees at 1:30 p.m. focused on “Increasing Access to Care Under the Affordable Care Act: Utilizing the Health Care Continuum to Increase Patient Access”

**Medi-Cal Expansion Reviewed by Assembly.** Last week, the Assembly Health Committee reviewed a presentation from UC Berkeley’s Ken Jacobs on the various fiscal and caseload implications of Medi-Cal expansion, followed by a hearing for the Speaker’s bill (ABX1 1) to expand Medi-Cal in California in line with ACA provisions. The speaker’s personal involvement highlights the importance of this legislation to him. At this point, the Administration has not yet taken a position on the legislation, although it has released proposed amendments to Senate Bill 28.

## In the news

- **“States Can Cut Back on Medicaid Payments, Administration Says”**

“The Obama administration said Monday that states could cut Medicaid payments to many doctors and other health care providers to hold down costs in the program, which insures 60 million low-income people and will soon cover many more under the new health care law. The administration’s position, set forth in a federal appeals court in California, has broad national implications as it comes as the White House is trying to persuade states to expand Medicaid as part of the new law.” ([New York Times](#))

- **“Healthcare overhaul may threaten California's safety net”**

“An estimated 3 million to 4 million Californians – about 10% of the state's population – could remain uninsured even after the healthcare overhaul law takes full effect. The burden of their care will fall to public hospitals, county health centers and community clinics. And those institutions may be in jeopardy. County health leaders and others say the national health law has had the unintended consequence of threatening the financial stability of the state's safety net.” ([Los Angeles Times](#))

- **“Individual Market Reforms Called 'Historic'”**

“Two health reform bills working their way through the state Legislature still contain question marks about some of the details, but overall they represent a major milestone for Californians who buy their own health insurance, according to consumer advocates.... The two companion bills, ABx1 2 and SBx1 2, retool the laws governing California's individual insurance market to align with new regulations in the Affordable Care Act. Similar legislation was proposed and passed by the Legislature last year but vetoed by Gov. Jerry Brown (D). The governor didn't want the state to make new laws based on a federal law that could be repealed if a Republican moved into the White House. The bills, moving through committees now, are expected to be approved in both houses and signed by the governor.” ([California Healthline](#))

## Colorado

### HMA Roundup – Joan Henneberry

**Colorado HBEX Request for Application for Outreach and Education.** The Colorado Health Benefit Exchange issued a request for applications for organizations that want to be engaged with outreach and education for the health insurance exchange. The Connect for Health Assistance Network will select and certify individuals to be Health Coverage Guides (navigators). The announcement can be found here: [Funding Opportunity Announcement](#). Grants are due April 8, 2013 and grantees are expected to be chosen in May with training held this summer.

**Bill to Repeal High Risk Pool with Transition Period.** HB 13-1115 is on its way to becoming the law that will repeal the current high risk pool, CoverColorado, and terminating coverage for all participants effective April 1, 2014. With the ACA requiring companies to offer coverage even with pre-existing conditions the need for CoverColorado goes away next year. To prevent gaps in coverage for the over 11,000 enrollees who will most-



ly get coverage through the new health insurance exchange, there is a lengthy transition period. The bill also provides for any leftover funds from CoverColorado to be transferred to a foundation that helps those with high health needs, and for 25 percent of leftover funds to be donated to the Colorado Health Benefit Exchange.

### **In the news**

- **“Colorado Medicaid will add 9,250 adults to coverage, wipe out wait”**

“Colorado Medicaid will add 9,250 of the neediest adults to health insurance coverage this year, doubling a program paid for by hospital fees and wiping out much of a waiting list. Poor adults without dependent children were one of the few groups left out of Medicaid until last year, when the state used the hospital funds to open rolls to the first 10,000 applicants. They were among the most impoverished in the state, with income of less than \$90 a month and often with chronic, debilitating illnesses.” (Denver Post)

## **Florida**

### **HMA Roundup – Gary Crayton and Elaine Peters**

Following last week’s decision by Governor Scott to support Medicaid expansion following HHS’ approval of the statewide Medicaid managed care waiver, it still remains that the legislature must act to approve budget appropriations for the expansion. The Senate appears to be on-board with the decision, although House support is not as apparent. The estimating conference, originally scheduled for Friday March 1, 2013, has been rolled into a more comprehensive estimating conference meeting on Thursday March 7, 2013, covering Medicaid long term expenditures, the Affordable Care Act, and Medicaid impact.

### **In the news**

- **“Medicaid fraud trial starts for former WellCare executives”**

“Four former WellCare executives accused of defrauding the Medicaid program of more than \$30 million put up their first courtroom defense Tuesday. Far from breaking the law, they argued, they did their best to cope with a lack of guidance from state bureaucrats. Lawyers for the former executives at the Tampa-based health care plan company blamed Florida's Agency for Health Care Administration for misreading state law, failing to specify what it wanted on WellCare's expense reports and even concealing information on how it calculated what the firm was paid to handle care for Medicaid recipients.” (Tampa Bay Times)

## **Georgia**

### **HMA Roundup – Mark Trail**

**Georgia Medicaid Redesign Presented to Medical Care Advisory Committee.** Last week, the Department of Community Health presented Medicaid redesign initiatives to the Medical Care Advisory Committee. With regard to the transition of foster care and adoption assistance to Georgia Families, the state is undertaking the selection of a single care management organization (CMO) from amongst the three incumbents for a January



2014 implementation. The interview process will likely commence by late March 2013, with a selection decision targeted for April, and implementation activities to begin by June 2013.

With regard to the aged, blind, and disabled (ABD) population, DCH is designing an automatic intensive medical care coordination model for all ABD populations that features navigators, improved care coordination for duals, and medical homes. A single state-wide vendor would identify high-risk “impactable” candidates for intensive care management, with the option for individuals to decline such services. The model anticipates a fee-for-service model with vendor “shared savings” and provider incentives. RFP requirements are being developed with an expected late first quarter 2013 issuance, vendor selection in the second quarter of 2013, and a targeted implementation date of January 2014.

**Georgia Senate Approves Revised 2013 Budget.** Last Friday, the Georgia Senate approved a revised 2013 \$19.3 billion budget, which features minor differences with the House version, but maintaining the bulk of Governor Deal’s recommendations. The revised budget would transfer nearly \$100 million from Georgia’s National Mortgage settlement to the Medicaid program. The House-Senate conference committee should meet to forge a compromise bill for final approval within the next week.

**Senate Bill Proposes a Pilot Program for Medicaid Smart Card.** Senate Bill 220 was recently introduced in the Senate to establish a pilot program using “smart card” technology in the Medicaid program. The bill would require the establishment of a 6-12 month pilot to test cost-effectiveness of the smart card to authenticate recipients at the point of service, authenticate providers, and reduce fraud and costs. The bill aims to protect personal information and use biometrics to validate identity.

### **In the news**

- **“Deal: Still ‘No’ On Medicaid”**

“Florida’s Governor has changed his mind about Medicaid expansion, which is part of the federal healthcare reform law, known as Obamacare. Governor Nathan Deal said Thursday he intends to stand firm on his decision not to expand Medicaid.”  
(GPB News)

## ***Hawaii***

### **HMA Roundup**

The Med-QUEST announced that it has awarded its contract for the Community Care Services (CCS) program, which provides Behavioral Health services To Medicaid eligible adults who have a serious mental illness, to WellCare’s ‘Ohana Health Plan. ‘Ohana will be providing behavioral health services to CCS members Statewide. ‘Ohana will start the provision of services to CCS members on March 1, 2013. Other bidders included APS Healthcare, Beacon Health Strategies, and ValueOptions. (Link to award)

## *Illinois*

### **HMA Roundup – Matt Powers and Jane Longo**

**CMS Approves Illinois Dual Eligibles Demonstration.** On February 22, 2013, the Illinois Department of Healthcare and Family Services (HFS) received approval from CMS to implement the Medicare-Medicaid Alignment Initiative (MMAI) for dual eligible. The MMAI demonstration project will coordinate care for 135,000 Medicare-Medicaid enrollees in the Chicagoland area and throughout central Illinois beginning in October 2013, subject to readiness review.

Under the Demonstration, health plans will assess the medical, behavioral health, long-term services and supports, and social needs of dual eligible, who will then be stratified into three risk groups based on needs. Quality measures have been established including experience of care, care coordination, and fostering and supporting community living. Enrollees will have access to a care coordinator who will work with an interdisciplinary care team responsible for their comprehensive care management.

Eligible beneficiaries will be able to select a health plan and opt into the demonstration in October 2013. Starting on January 1, 2014, enrollees who did not already make a selection or opt out of the demonstration will be auto-assigned over a six month period. The Illinois MOU is available at [Link](#)

## *Indiana*

### **HMA Roundup – Cathy Rudd**

**Medicaid Expansion Bill Passes Overwhelmingly in the Senate.** The Indiana Senate voted 44-6 to expand Medicaid using the Healthy Indiana Plan as the vehicle for expansion. HIP is slated to sunset at the end of 2013 without approval from CMS. Efforts by Democrats to expand the traditional Medicaid program have not been successful in the legislature. Unlike last week's stalled House bill, which had aimed to implement managed care for the Aged, Blind, and Disabled (ABD) population on October 1, 2013, the Senate bill merely calls for a report by August 1, 2013, without a firm date for ABD managed care enrollment.

### **In the news**

- **“Indiana Senate approves Medicaid expansion”**

“The Indiana Senate voted Tuesday to expand Medicaid using a state-run program, as lawmakers and Gov. Mike Pence continue negotiating how the state should cover an estimated 400,000 low-income residents. Pence and the Republican-led General Assembly have beat back efforts by Democrats to expand coverage using the traditional federal-state Medicaid program for the poor. Instead, they say, expansion should be done either through the Healthy Indiana Plan or a similar state-run program, giving the state more control over costs.” ([Indiana Business Journal](#))

## *Louisiana*

### **HMA Roundup**

**Medicaid Provider Re-Enrollment to Commence February 28.** Contractors CNSI and Noridian Administrative Services will handle all Louisiana Medicaid Provider Enrollment activity (i.e. new enrollments, changes, re-enrollment of all existing providers) starting on Thursday, February 28, 2013. The new Medicaid claims processing system, dubbed PRISM (Provider Recipient Integrated System for Medicaid), will replace the current system—operated by Molina—in the fall of 2014. Provider enrollment (and re-enrollment of all current providers) is the first step toward PRISM implementation. All current providers must re-enroll by December 31, 2013.

**Bayou Health Program Hits One-Year Anniversary.** February 2013 marks the one-year anniversary of the transition from Louisiana’s fee-for-service Medicaid program to a managed care system. Starting in October 2012, DHH began auto-enrollment of expectant mothers into a Bayou Health Plan during their first month of eligibility to immediately access coordinated care and wellness benefits. In November 2012, members of the three prepaid Bayou Health Plans (Amerigroup, LaCare and Louisiana Healthcare Connections) received pharmacy benefits as part of their coordinated benefits package. Members of Community Health Solutions and United Healthcare Community Plan maintain their pharmacy benefits through legacy Medicaid. On January 1, 2013, LaCHIP Affordable Plan enrollees became bayou Health members.

**State Health Secretary Selected for National Commission on Long-Term Care.** Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein was named by Senate Minority Leader Mitch McConnell to be a member of the National Commission on Long-Term Care. The Commission will look at long-term care delivery, in both home and institutional settings; funding mechanisms; and the respective roles of Medicare, Medicaid, and private insurance. Prior to becoming Louisiana’s DHH Secretary in 2010, he was Microsoft’s managing director of worldwide health and had, previously, served in the Federal Department of Health and Human Services overseeing state Medicaid programs.

**RFI on Long Term Services and Supports Generates Strong Response.** On November 29, 2012, the DHH issued a Request for Information (RFI) on strategies that would restructure and enhance the Medicaid-funded delivery of Long Term Services and Supports (LTSS). Within two months, DHH had received sixteen responses from the following organizations:

- Aetna Better Health
- Amerigroup Louisiana, Inc.
- Alere
- AmeriHealth Mercy
- Community Health Solutions of Louisiana
- The Council on Quality and Leadership
- Humana
- Louisiana Healthcare Connections
- Louisiana Nursing Home Association
- Magellan Health Services
- Maximus
- Peoples Health
- Seniorlink
- UnitedHealthcare Community Plan
- WellCare Health Plans, Inc.
- Louisiana Health Care Quality Forum

The responses can be viewed at [www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com), under Medicaid News. No commitment to issuing an RFP has yet been made.

### **In the news**

- **“Jindal's \$24.7 billion budget relies heavily on privatization of LSU hospitals”**

“Gov. Bobby Jindal's \$24.7 billion spending plan for the coming fiscal year will plug a \$1 billion-plus hole with a mix of so-called "one-time money," assumptions of large savings from the privatization of public hospitals, and anticipated money from the sale of state property and proceeds from lawsuits filed by the state.” ([NOLA.com](http://NOLA.com))

## *Massachusetts*

### **HMA Roundup – Tom Dehner**

**New HHS Secretary Addresses Welfare Controversy.** The newly appointed Health and Human Services secretary, John W. Polanowicz, brings a heavy provider background to his position. Mr. Polanowicz most recently served as president of St. Elizabeth’s Medical Center in Brighton, the largest hospital in the Steward Health Care System. Prior to St. Elizabeth’s, Polanowicz was president and CEO at Marlborough Hospital for eight years and, previously, VP of operations at UMass Memorial Medical Center.

Mr. Polanowicz already has taken on a controversy by working with the Federal Government on a settlement to address \$27 million in food-stamp overpayments in the state. He is emphasizing investing in resources to ensure program integrity and to prevent future abuse of the welfare system. Polanowicz asked for DTA (Department of Transitional Assistance) Commissioner Curley’s resignation earlier this month upon the discovery of the overpayments to ineligible recipients.

## *Michigan*

### **HMA Roundup – Esther Reagan**

**Michigan Medicaid Managed Care Enrollment Increases.** As of February 1, 2013, there were 1,237,864 Medicaid beneficiaries enrolled in 13 Medicaid Health Plans (HMOs), an increase of 2,897 since January 1, 2013. The number of Medicaid beneficiaries eligible for managed care enrollment also increased in February – there were 1,303,574 eligible beneficiaries, up from 1,294,560 in January.

The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow – there were 34,701 duals enrolled in February, up from 32,065 in January, an increase of 2,636. The number of Medicaid children dually eligible for the Children’s Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs also continues to grow – there were 13,067 CSHCS/Medicaid children enrolled in February, up from 9,474 in January. [Read more](#)

The number of Medicaid-only HMO enrollees continues to decline. The sum of the increases in the number of enrollees dually eligible for Medicare and the enrollees dually eligible for CSHCS – 6,229 – is more than twice the total enrollment increase of 2,897.

As the enrollment reports reflect, every county in the state is served by at least one Medicaid Health Plan. Auto-assignment of beneficiaries into the HMOs is now in place in every county of the state and there are at least two HMOs serving every county in the Lower Peninsula. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned through federal "Rural Exception" authority to the one HMO serving the counties, Upper Peninsula Health Plan.

**Health Insurance Exchange Funding Approved by House Committee.** Michigan recently received a \$30.67 million Level One Establishment Grant from the US Department of Health and Human Services to support planning and implementation of the state's State-Federal Partnership Health Insurance Exchange. Michigan is one of seven states, along with Arkansas, Delaware, Illinois, Iowa, New Hampshire and West Virginia, opting for a partnership exchange rather than either a state-operated or federally-facilitated exchange. (Governor Rick Snyder had called for Michigan to create a state-operated exchange; however the Legislature did not support that strategy.) Legislative approval is required before the new grant funds can be used, and on February 27, 2013 the vehicle bill for the funding (House Bill 411) received approval by the House Appropriations Committee. The bill will now advance for review by the full House of Representatives; if approved, it will then be forwarded to the Senate for action.

**Blue Cross Blue Shield of Michigan Reform Bills Passed by Senate and House Committee.** Governor Rick Snyder released a proposal in September 2012 to reform how Blue Cross Blue Shield of Michigan (BCBSM) is structured and regulated in the state. The Legislature approved bills in late 2012 but the Governor vetoed them because of language added late in the process related to coverage of abortion services. Legislation was re-introduced (Senate Bills 61 and 62) in mid-January 2013, without the language prompting the Governor's previous veto. The bills were passed by the Senate without delay and referred to the House of Representatives. They were approved by the House Insurance Committee on February 21, 2013 but have yet to be voted on by the full House.

**Two New Mental Health Boards Created by Executive Orders.** On February 20, 2013, Governor Rick Snyder issued Executive Orders creating two new boards charged with recommending improvements to the state's mental health system. Executive Order 2013-6 creates the Mental Health and Wellness Commission, a six-member advisory board to the Department of Community Health (DCH), chaired by the Lieutenant Governor. The Commission's charge includes but is not limited to identifying ways to address gaps in the delivery of mental health services and proposing new service models to strengthen the entire delivery spectrum of mental health services throughout the state. A report of findings and recommendations is due in December 2013 and the commission will cease to exist by mid-2014.

Executive Order 2013-7 creates the Mental Health Diversion Council, a 14-member advisory body to both the Governor and DCH, also chaired by the Lieutenant Governor. The Council's charge includes but is not limited to adopting and implementing a diversion action plan to improve efforts to divert individuals with mental illness, intellectual disabilities and developmental disabilities, including co morbid substance use disorders from criminal justice involvement to appropriate treatment. The Council is not term-limited.

## *New Jersey*

### **HMA Roundup - Eliot Fishman**

**Governor Christie Supports Medicaid Expansion.** On Tuesday, February 26, 2013, Gov. Chris Christie announced his support for Medicaid expansion in New Jersey. The governor expressed reservations with the Affordable Care Act, but expressed his views that the state could not afford to refuse Federal dollars that would otherwise be spent elsewhere. Christie believes that 104,000 may be added to Medicaid rolls, although other studies indicate as many as 300,000 uninsured will be newly covered in 2014.

## *Pennsylvania*

### **HMA Roundup - Izanne Leonard-Haak and Matt Roan**

**Families USA Report Touts Economic Benefits of Medicaid Expansion in PA.** The Pennsylvania Health Access Network and Families USA have released a report arguing that Medicaid expansion would be a benefit to Pennsylvania's economy. The report concludes that by providing coverage to over 600,000 additional Pennsylvanians, approximately 41,200 new jobs will be created.

**Lottery Discussions Continue to Fund Senior Services.** The Corbett Administration and the Legislature continue discussions on how to maintain \$50 million in funding committed to senior services, emanating from the Governor's stalled lottery privatization deal. The Governor's budget provides for a "reserve" fund of \$200 million to support senior programs in the event that lottery revenues decline. House Democrats have introduced legislation that would mandate the use of the surplus lottery funds to cover Corbett's proposed \$50 million in new spending and add another \$70 million for such programs.

**Medical Assistance Enrollment on the Decline.** Medical assistance enrollment fell by 55,000 in the last 6 months of 2012, which has led some advocacy groups to question whether this result is by design. The drop was primarily in the "General Assistance" category which consists of adults who do not qualify for Medicaid under current Federal rules. The elimination of supplemental cash assistance—funded entirely with state funds—which had been offered to many beneficiaries receiving Medical Assistance coincided with a drop in renewals for medical assistance.

### **In the news**

- **"Pa. Democrats build Medicaid pressure on Corbett"**

"Pressure on Gov. Tom Corbett grew Tuesday to accept the federal government's offer to fund the lion's share of a massive Medicaid expansion now that Pennsylvania is virtually surrounded by states that are getting in line, including states run by Corbett's fellow Republican governors." ([York Daily Record](#))

## *National*

### **HMA Roundup**

**HHS Announces 25 States to Receive State Innovation Model Awards.** Health and Human Services (HHS) Secretary Sebelius announced the first recipients of State Innovation Model awards, which will allow states to implement new plans to lower cost, improve



quality, and enhance Medicaid efficiency. Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont will test multi-payer payment and delivery models on a broader scale. In addition, 19 other states will receive awards to further develop proposals for comprehensive reforms. More information can be found at [Link](#)

### In the news

- **“Medicaid physician pay boost stalled”**

“No states appear to have implemented a temporary Medicaid physician pay boost more than eight weeks after it was supposed to have gone into effect, according to provider groups tracking the issue.” ([Modern Healthcare](#))

- **“AARP presses governors to accept Medicaid expansion”**

“The nation's largest seniors' lobby is stepping up its effort to sell governors on the Medicaid expansion in President Obama's healthcare law. AARP said Monday it's "ramping up" an advocacy push to persuade governors to take part in the Medicaid expansion. The lobbying effort includes advertising and in-person lobbying in more than 40 states, AARP said.” ([The Hill](#))

- **“Remaining Health Care Law Regs Won't Solve Affordability Problem, Insurers Say”**

“Insurers are still waiting for some federal regulations before they file applications to sell coverage under the health care law next year. But two big final rules Health and Human Services officials released last week have left companies with little doubt that a significant number of people will find it difficult to find affordable coverage next year.” ([CQ HealthBeat](#))

- **“States Work to Smooth Transition from Medicaid to Health Exchanges”**

Governing Magazine's Dylan Scott highlights concerns related to the “churn” effect between Medicaid and the Exchanges and what states like Nevada are doing to combat this effect. ([Governing Magazine](#))

- **“HHS: Most states on track with health law's technical demands”**

“Thirty-five states will be ready with new healthcare eligibility and enrollment systems by Jan. 1 of next year, according to a new federal report. The Health and Human Services (HHS) Inspector General surveyed states in March and April 2012 about their readiness to comply with a variety of technical requirements under President Obama's healthcare law. These requirements include simple, streamlined application systems for Medicaid, CHIP and the healthcare law's new insurance exchanges.” ([The Hill](#))



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## OTHER HEADLINES

### District of Columbia

- **“Jeffrey Thompson loses bid to derail D.C. Medicaid contracts”**

“[The Washington Post] reported Tuesday that lawyers for Jeffrey Thompson’s D.C. Healthcare Systems Inc. – the corporate parent of Chartered Health Plan, now under city receivership – had moved to stop the sale of Chartered’s most valuable assets. Today, Thompson’s company lost a separate bid to cancel the city’s ongoing effort to award new Medicaid contracts worth hundreds of millions of dollars.” ([Washington Post](#))

### Iowa

- **“Branstad Affirms No Medicaid Expansion”**

“Gov. Terry Branstad said Saturday that he has told U.S. Health and Human Services Secretary Kathleen Sebelius that he will not expand Medicaid in Iowa. Branstad met with Sebelius Friday in Washington, and in an interview Saturday with The Associated Press the governor said he again rejected an expansion of Medicaid in Iowa. Branstad said he pressed Sebelius for a federal waiver to continue IowaCare, a health care program that provides limited benefits to 70,000 low income adults in the state. That program is set to expire later this year.” ([KCRG News](#))

### Kansas

- **“Hospital association poll shows most Kansans support Medicaid expansion”**

“A majority of Kansans support expanding Medicaid to help low-income people gain health coverage, according to a poll done in December for the Kansas Hospital Association and released this week. According to the survey results, 60 percent of the state's residents would support expanding Medicaid to include persons earning up to 138 percent of the federal poverty level – \$15,420. Expansion was opposed by 24 percent of those surveyed and 16 percent said they weren’t sure.” ([Kansas Health Institute](#))

- **“Large assisted-living chain curtails Medicaid participation”**

“One of the state’s largest assisted-living chains has curtailed its participation in the Kansas Medicaid program. ‘Of our 18 facilities, 15 are no longer taking any new Medicaid clients,’ said Denise German, senior vice president of Vintage Park, which is headquartered here. The decision, German said, was driven by a 2012 reduction in Medicaid reimbursements and by concerns that payments would be cut more under KanCare. The three Vintage Park facilities that still accept Medicaid clients are in towns with no other facilities. The company’s local administrators there chose to continue so there would be local options for residents.” ([Kansas Health Institute](#))

## Kentucky

- **“Senate Committee Backs Bill Requiring Kentucky Medicaid Providers to Publish Prescription Prices”**

“A bill requiring Kentucky Medicaid managed care operators publish a list of prescriptions and reimbursement prices on Wednesday passed a state Senate committee, following prodding from independent pharmacists asking for access to pricing standards before they fill prescriptions.” ([WKMS.org](#))

## New York

- **“EmblemHealth pulls small business plans”**

“EmblemHealth announced major changes to its small-group market product offerings—a move, say brokers, that mirrors actions taken by Empire BCBS. In 2011, Empire cut its business in the small-group market by about two-thirds because the plans had become so unprofitable.” ([Crain's Health Pulse](#))

- **“Sequestration cuts darken hospitals' horizons”**

“It wasn't enough that New York's hospitals endured Medicaid cuts, lost revenue from the economic downturn, and then got hit by Superstorm Sandy. Now the state's battle-weary health care industry faces a loss of \$2.13 billion in federal funds over the next 10 years if Congress fails to reduce the federal deficit by March 1. That's when the mandated cuts in domestic and military programs will automatically take effect to reduce \$1 trillion in federal spending over the coming decade. Of that, \$5 billion is at stake in New York, according to the state budget office.” ([Crain's Health Pulse](#))

- **“Judge orders Brooklyn hospital to stay open”**

“Nurses unions and a doctors group have won a round in their fight to keep money-losing Long Island College Hospital in Brooklyn open. The hospital, one of three run by State University of New York Downstate Medical Center, bleeds about \$4 million a month and on Feb. 7 SUNY trustees voted to shutter the Cobble Hill facility. But lawyers for the unions and doctors persuaded a Kings County Supreme Court judge on Wednesday that the vote may have violated the state's open meetings law because it was done in executive session.” ([Crain's New York](#))

## North Carolina

- **“Medicaid bill headed to McCrory”**

“Gov. Pat McCrory is poised to sign legislation that rejects major parts of the federal health care law after Republican lawmakers gave final approval to the measure Tuesday. The Republican governor supports the effort to block a state-sponsored insurance exchange and the expansion of Medicaid coverage to 500,000 low-income residents.” ([Raleigh News Observer](#))

## Oregon

- **“Oregon governor touts new Medicaid model”**

“Oregon Gov. John Kitzhaber used the just-completed National Governors Association winter meeting to try to get his colleagues to think not just about cutting or expanding Medicaid – but about reinventing it.” ([Politico](#))

## South Carolina

- **“SC Medicaid agency hopes home visits cut costs”**

“South Carolina's Medicaid agency hopes home visits steer patients away from frequent and expensive trips to the emergency room. The idea involves training trusted community representatives, such as church leaders, to help Medicaid patients navigate the health care system. Their tasks would range from setting up doctors' appointments to making sure prescriptions are filled and medications taken properly.” ([Associated Press](#))

## Tennessee

- **“Bill Haslam unmoved by Florida's Medicaid expansion”**

“An abrupt move by Florida Gov. Rick Scott, a prominent critic of Obamacare, to reverse course and support Medicaid expansion hasn't been enough to bump fellow Republican Gov. Bill Haslam of Tennessee off the fence.” ([Times Free Press](#))

## Texas

- **“Senate Panel Discusses Reforms to Curb Medicaid Costs”**

“SB 7 aims to curb costs by expanding managed care services, establishing pilot programs to try capping costs and to monitor services more efficiently. It would also set up an “intellectual and developmental disability system redesign advisory committee” – made up of stakeholders from disability rights groups – to advise the Health and Human Services Commission on ways to efficiently redesign Medicaid acute care services. Health care providers, intellectually and developmentally disabled Texans and their family members had a long list of concerns.” ([Texas Tribune](#))

- **“Perry Not Backing Off Opposition to Medicaid Expansion”**

“Gov. Rick Perry, who authored the memorably titled book “Fed Up!” before launching a presidential run in 2011, is again demonstrating his skeptical view of a federal government that comes bearing gifts for his state -- even as many of his Republican colleagues have changed their tune.” ([RealClearPolitics](#))

## Wyoming

- **“House defeats new attempt at Medicaid expansion in Wyoming”**

“The latest attempt to extend state Medicaid coverage to nearly 18,000 low-income adults died quickly in the Wyoming House on Friday. Advocates tried to include expansion as an amendment to a Medicaid reform bill, but House members beat back the effort by a 47-11 vote. The vote means there is little chance Wyoming will participate in optional parts of Medicaid expansion when much of the federal health reform law goes into effect in January.” ([Billings Gazette](#))

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## COMPANY NEWS

- **“MAXIMUS Awarded Contract for Connecticut’s Health Insurance Exchange Customer Contact Center Operations”**

“MAXIMUS, a leading provider of government services worldwide, announced that it has signed a new contract with the state of Connecticut to operate the customer contact center operations for Access Health CT, the state’s Health Insurance Exchange. The three-year, five-month base contract is valued at \$15 million, commences on March 1, 2013, and runs through August 31, 2016. Thereafter, the contract also has a two-year option period that the state may exercise following the completion of the base contract.” (MAXIMUS News Release)

## 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
TBD	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Virginia Duals	RFP Released	65,400
March, 2013	Idaho Duals	RFP Released	17,700
March, 2013	California Rural	Application Approvals	280,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	South Carolina Duals	RFP Released	68,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	California Duals	Implementation	500,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	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	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		9/1/2013
Colorado	MFFS	62,982					6/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	10/1/2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	70,000	TBD	TBD	TBD		1/1/2014
Missouri	MFFS†	6,380					10/1/2012
Minnesota		93,165	Not pursuing Financial Alignment Model				
New Mexico		40,000	Not pursuing Financial Alignment Model				
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					TBD
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon		68,000	Not pursuing Financial Alignment Model				
Rhode Island	Capitated	22,737		Apr-May 2013			9/1/2013
South Carolina	Capitated	68,000	May-June 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	78,596	March 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	TBD	TBD	TBD		1/1/2014
Washington	Capitated/MFFS	115,000	TBD	TBD	TBD	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		4/1/2013
<b>Totals</b>	<b>15 Capitated 7 MFFS</b>	<b>1.7M Capitated 485K FFS</b>	<b>5</b>			<b>4</b>	

\*\* 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.

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## HMA RECENT PUBLICATIONS

### *“State Levers for Improving Managed Care for Vulnerable Populations: Strategies with Medicaid MCOs and ACOs”*

#### **The Commonwealth Fund**

**Sharon Silow-Carroll, MSW, MBA – Contributor**

**Jennifer N. Edwards, DrPH, MHS – Contributor**

**Diana Rodin, MPH – Contributor**

HMA recently published a report detailing the 10 leading states’ strategies for using managed care to promote quality, cost-effectiveness, and better health outcomes for vulnerable Medicaid populations. The authors also concluded there’s plenty of room for MCOs and ACOs to not only co-exist in serving Medicaid populations, but interface as they’re moving in similar directions toward greater accountability among health care providers for quality and cost. ([Link - PDF](#))

### *“Finance: A Guide to Safety Net Provider Reimbursement”*

#### **HMA Accountable Care Institute (ACI)**

**Doug Elwell, MSA – Contributor**

**Art Jones, MD – Contributor**

**Gaylee Morgan, MPP – Contributor**

**Steven M. Perlin, MBA – Contributor**

The prevailing healthcare reimbursement system in the United States has failed to create effective incentives for providers to improve quality and contain costs. The current system has rewarded volume over value and has discouraged providers from working together toward improved health for the populations they serve. These issues are even more acute within the safety net, which faces stronger incentives to increase volumes to compensate for reimbursement rates that are often well below the cost of providing care. This paper describes key concepts that must be part of a value-based reimbursement system and describes how value-based reimbursement creates strong incentives for the development of effective, accountable delivery systems. ([Link - PDF](#))

### *“Empanelment in an Accountable Care Environment”*

#### **HMA Accountable Care Institute (ACI)**

**Greg Vachon, MD – Contributor**

**Lori Weiselberg, MPH – Contributor**

A foundation of both the Patient Centered Medical Home (PCMH) model of care and accountable care, “empanelment” is the process of creating and maintaining a relationship between each patient and a primary care provider. This document is a guide to implementing this foundational process in organizations that deliver primary care and are seeking to deliver on the triple aim of accountable care: improved health, better experience, and lower cost. ([Link - PDF](#))