HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MACPAC REPORT ON MEDICAID PROGRAM INTEGRITY

HMA ROUNDUP: OHIO MEDICAID MCO AWARDS ANNOUNCED; UPDATED TIMELINE FOR ILLINOIS DELIVERY SYSTEM REFORMS; GEORGIA EXPECTS TO RELEASE A DRAFT RFP FOR ELIGIBILITY SYSTEM REDESIGN; NEW YORK RELEASES SUCCESSFUL HEALTH HOME APPLICANTS

OTHER HEADLINES: TEXAS PROVIDERS PUSH BACK AGAINST DUAL ELIGIBLES IN MCOS; MARYLAND EXCHANGE BILL SENT TO GOVERNOR; FEDS APPROVE ARIZONA SAFETY NET CARE POOL; CALIFORNIA ESSENTIAL HEALTH BENEFITS BILL CLEARS COMMITTEE; HHS ANNOUNCES SHARED-SAVINGS ACOS; MEDPAC DEBATES MANDATORY MCO ENROLLMENT FOR DUAL ELIGIBLES

DUALS INTEGRATION CALENDAR: ADDED TO WEEKLY ROUNDUP

APRIL 11, 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
OAKLAND, 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: MACPAC REPORTS ON MEDICAID PROGRAM INTEGRITY

This week, our *In Focus* section addresses Medicaid program integrity, highlighting two recent Federal commission recommendations on the topic. In the March 2012 report from the Medicaid and CHIP Payment and Access Commission (MACPAC), the Commission dedicated a chapter to Medicaid program integrity, or those initiatives designed to detect and deter fraud, waste, and abuse and improve program administration. In this report, we provide a quick overview of Medicaid program integrity and examine the two MACPAC recommendations.

Medicaid Program Integrity Overview

Program integrity efforts are growing increasingly important as a cost-control tool for states' to employ in an environment where traditional levers for reducing cost growth, restricting enrollment and reducing provider payment levels, have been constrained by federal legislation and the courts. Targeting fraud, abuse, and waste are commonly discussed in efforts to derive Medicaid savings at both the state and federal level. The goal of these efforts is the proper and effective use of Medicaid funding, both state and federal. The MACPAC report identifies four key observations across the broad range of program integrity efforts in the Medicaid program:

- A variety of program integrity statutory provisions and administration initiatives have been implemented over time. Yet, identification of provisions and initiatives that may no longer be effective is necessary given some fundamental changes to Medicaid programs over time like the expansion of risk based managed care.
- More than a dozen agencies at the federal and state levels are involved in program integrity. With so many involved in these activities, success and efficiency depend on effective coordination.
- Balance between program integrity activities and other management responsibilities is an important consideration. Initiatives that are not effective or timely may lead to federal and state funds being spent on services that may be unnecessary or were never delivered, while those that are too aggressive may place an undue burden on providers.
- The availability, timeliness, and accuracy of data used in program integrity activities may make it difficult to quantify and compare the value, success, and cost-effectiveness of these initiatives.

State Efforts and Federal Matching Funds

States utilize a variety of efforts to attempt to reduce fraud, abuse, and waste. The MACPAC report highlights several examples of these efforts:

- Data mining to identify possible fraud and abuse for further examination.
- Identifying improper payments (both underpayments and overpayments). Many states have already implemented Recovery Audit Contractor (RAC) programs

through a contracted RAC entity to identify underpayments and overpayments to providers.

- Audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse.
- Enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud.
- Technical assistance and education for state staff so they are able to prevent and identify fraud and abuse.
- Outreach to and education of the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements).

While general administration of a state Medicaid program is funded with a 50 percent federal matching rate, there are significant incentives in place in federal matching funding for states to aggressively pursue program integrity efforts.

State Program Integrity Activities	Federal Matching Rate
Medicaid Fraud Control Unit	
First Three Years	90 percent
After Three Years	75 percent
Medicaid Management Information System	
Design, development, upgrade	90 percent
Operation	75 percent
Medical Professionals	75 percent
Medical and Utilization Review	75 percent

Source: MACPAC Report to the Congress on Medicaid and CHIP, March 2012

MACPAC Recommendations

The March 2012 MACPAC report includes two recommendations:

1. **Simplify and streamline regulation, and determine program effectiveness**

   Providers have identified undue complications created by multiple rounds of audits by multiple agencies, both state and federal. In addition to the burden this creates for providers, there is likely significant resource waste at both the state and federal levels. Additionally, providers have reported unintentional errors from complex claims processing requirements. As part of this simplification, evaluation of the broad range of programs is critical. Those providing effective program integrity efforts should be enhanced or expanded, while those contributing little to program integrity efforts, and causing inefficiencies, should be done away with. Providers should benefit significantly, and the report suggests that new providers may be incentivized to enter the Medicaid market, increasing patient access.

2. **Quantify impact of program integrity, disseminate best practices, enhance training**

   While states track and calculate the value of program integrity, these efforts are varied and lack standardization. The MACPAC recommends CMS take a lead in developing analytic tools to better quantify the impact of both recovery and prevention of fraud,

abuse, and waste. Allocating resources to program integrity efforts can only be done effectively if states can determine the value of a given program integrity effort. The Medicaid Integrity Group reviews state program integrity options every three years. The MACPAC recommends broad dissemination of these reviews. Finally, training of federal and state staff presents a significant opportunity for improvement of program integrity. The MACPAC particularly notes that with the increasing majority of Medicaid enrollees enrolled in some form of managed care, training and focus on evaluation program integrity in managed care will be key in moving forward.

HMA Takeaways

Low provider reimbursement rates and the challenge of ensuring adequate provider participation adds another wrinkle to fraud and abuse efforts in Medicaid. Safety net providers – those the treat a high portion of Medicaid recipients and uninsured patients - often lack the resources to dedicate to sophisticated fraud detection efforts. Medicaid programs have to be mindful of maintaining the appropriate balance of program integrity while promoting access with a resource-constrained set of safety net providers.

Medicaid programs in a majority of states are steadily shifting lives from a fee-for-service (FFS) structure to managed care plans. MCOs have significant incentive to reduce fraud and abuse on the provider side. As a state shifts to greater MCO enrollment, program integrity efforts will shift more toward proper and prompt enrollment and eligibility verification, ensuring capitation payments are made only for those individuals eligible and enrolled in Medicaid. However, though lives have shifted significant away from FFS and into MCOs, Medicaid claims and spending have not. In 2008, only 21 percent of Medicaid spending was paid under an MCO structure, according to the MACPAC June 2011 report on Medicaid Managed Care. While recent MCO expansion into the aged, blind and disabled (ABD) population, along with the dual eligible population in the next two years, will shift more of this spending to MCOs, addressing fraud and abuse in the FFS population will still be a significant task.

States are implementing Medicaid Recovery Audit Contractor (RAC) programs under requirements in ACA, although many states already had existing contracts with RAC entities in their Medicaid programs. Many states with significant managed care enrollments have filed exemptions to the RAC requirement, although none have been granted. We note that states are not required to include MCOs in RAC review, but may do so if they choose. The RAC program is designed to identify overpayments and underpayments to Medicaid providers. Several companies offer RAC services, with the most significant being HMS, a subsidiary of HMS Holdings Corp. HMS holds contracts, or has been given a notice of intent to award, in over seventeen states. In most of these states, HMS is the sole contractor, serving as a subcontractor in only a few. Other RAC contracts are held by CGI, Cognosante, Goold Health Systems, HealthDataInsights, Myers & Stauffer, PRGX, and Recovery Audit Specialists, LLC. Several states have outstanding RFPs for RAC services, while Oklahoma has issued an RFI that includes RAC services.

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

The Medical Services Board has approved a state plan amendment that will allow Medicaid clients to receive hospice services for individuals with a terminal illness and medical prognosis of life expectancy of nine months or less, should the illness run its normal course. This is a change from a longstanding rule that individuals had to have a life expectancy of six months or less.

In the news

- **Colorado pharmacy board denies Medicaid, insurer access to Rx drug registry**

  Colorado Medicaid officials and a private insurer have quietly sought access to the state's prescription drug registry to help stop doctor-shopping and pharmacy-hopping for pain pills, but a state board denied them. The State Board of Pharmacy said the law allows access only to those providing direct care or dispensing direct prescriptions, and told state Medicaid and Rocky Mountain Health Plans they could not conduct wider reviews. (Denver Post)

Georgia

HMA Roundup – Mark Trail

A draft RFP for eligibility system redesign is expected to be released later in April. As mentioned in previous weeks, a decision on the direction of the Medicaid redesign should be out later this month as well.

In budget news, Georgia March 2012 revenues were up five percent compared to March 2011 and revenues for FY 2012 were up 4.7 percent overall.

Illinois

HMA Roundup – Jane Longo / Matt Powers

With a growing list of ongoing changes and key upcoming milestones with significant impact to the Illinois Medicaid program, we present the timeline below. The timeline provides key dates in the state's transition to 50 percent Medicaid care coordination by 2015, including provider-based networks of care coordination entities for adults and children with complex health needs, a dual eligible integration demonstration, and a broader Medicaid Managed Care RFP coming down the road. Additionally, with a call for as much as $2.7 billion in cuts to the state Medicaid program, we have highlighted some key milestones and upcoming dates in the budget process. This timeline does not include at least two other significant happenings: the state is continuing to pursue a hospital Medicaid payment redesign, shifting away from fixed payment streams to providers; and the Cook County Health and Hospitals System is pursuing an early Medicaid expansion through an 1115 waiver to bring coverage to a substantial number of uninsured lives in the Chicago area..

NOTE – all elements in the table are estimates and subject to change

Date	Care Coordination	Budget/Medicaid Cuts
January 2012	***Phase I RFP Released*** Complex Adults, no MCOs	
February 2012	75 LOIs received	***Gov. Address, Feb. 22.*** Call for $2.7B in Medicaid cuts.
March 2012		HFS released menu of possible cuts and associated savings.
April 2012	***Dual Integration RFP*** To be released April 30 (tentative) ***Phase II RFP Release*** Complex Children	***Gov. Budget Proposal*** Possible week of April 9-13?
May 2012	***Phase I RFP Due May 25, 2012***	Legislative Scheduled Sessions ends May 31, 2012
June 2012 through August 2012	***Dual Integration RFP Winners*** To be announced July 1, 2012 ***Medicaid MCO RFP*** Summer 2012, may be delayed	If nothing passes, Legislature moves to extended session with two-thirds majority required to pass a law..
January 2013	***Phase I, Phase II, Duals*** Go live January 1, 2013 ***Medicaid MCOs*** Depends on possible delay	

New York

HMA Roundup – Denise Soffel

The New York State Department of Health (NYSDOH) received 42 Health Home applications to serve the thirteen counties in Phase II of the state's Health Homes implementation. The state announced 18 awarded sites this week, however, each must meet specified contingencies before receiving final approval. Health Home designees in the Manhattan region are to be announced soon. The Health Homes by region are available on the NYSDOH website: (Phase II Designated Health Homes)

Implementation of Health Homes for Medicaid enrollees with chronic conditions was recommended by the Governor Cuomo's Medicaid Redesign Team. As a result, this initiative was included in the Governor's SFY11/12 Budget and was adopted into law effective April 1, 2011.

In the news

- **VNSNY's managed long-term care plan expands**

  VNSNY Choice, the managed care arm of the Visiting Nurse Service of New York, received New York state approval to expand its managed long-term care health plan to Nassau, Suffolk and Westchester counties beginning May 1. State officials are awaiting approval by CMS of a federal waiver that will allow New York to make managed long-term care mandatory for most adult Medicaid beneficiaries and dual eligibles who

need home and community-based care services for more than 120 days. The state officials had wanted to get approval in time for an April 1 enrollment date for New York City residents, but that has been pushed back to July. The hope is to expand mandatory enrollment in the rest of the state as health plan capacity becomes available.

Ohio

HMA Roundup – Alicia Smith

The big news this week were the surprising Medicaid managed care awards to serve the states CFC and ABD beneficiaries. On Friday, April 6, the Ohio Department of Job and Family Services (ODJFS) announced that five plans were selected to provide services to non-dual eligible Medicaid beneficiaries statewide beginning January 1, 2013:

- Aetna Better Health of Ohio
- CareSource
- Meridian Health Plan
- Paramount Advantage
- United Healthcare Community Plan of Ohio

Left off the list were four of the current Medicaid managed care contractors in the state – Amerigroup, Centene, Molina and WellCare. The announcement took these plans by surprise and all are considering protesting the results based on what they have described as inconsistent scoring criteria across plan applications. The plans have until Friday April 13th to file protests if they decide to do so. HMA has requested the scoring detail and will provide additional insight into the results as that becomes publicly available.

In the news

- **Molina Healthcare, Centene Plunge, Lose Ohio Medicaid**

  Ohio opted not to renew Medicaid contracts with four managed care operators, including Molina Healthcare and Centene. The state instead awarded the new contract to cover more than 2.1 million low-income Ohioans to five companies, including Aetna and UnitedHealth Group. Contracts with Amerigroup and WellCare also were not renewed. On Monday, Centene said the selection process was flawed and that it planned to file a protest within the required seven days. Molina said it's considering an appeal. In addition to Aetna and UnitedHealth, the contract that begins Jan. 1, 2013, also includes privately held CareSource, Meridian Health Plan and Paramount Advantage. (Investor's Business Daily)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

A Democratic response to Gov. Corbett's budget is expected in the coming days. The budget proposal is expected to contain less cuts to the Medicaid program than the Governor's budget proposal. This scenario is supported by higher revenue assumptions in the coming fiscal year.

On April 1, Coventry's CoventryCares plan has gone live serving Medicaid managed care lives in Southwest Zone - Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties. There are approximately 300,000 Medicaid managed care lives in the Southwest Zone. CoventryCares currently serves 17,000 lives in other managed care counties in the state. Also serving these Southwest Zone counties are Gateway, United, and UPMC.

In the news

- **Lawsuit Challenges Administration's DPW Budget Proposal**

  The Disabilities Rights Network (DRN) and attorney Stephen Gold, on behalf of six mental health and intellectual disability organizations, filed a lawsuit against Governor Corbett, the Office of the Budget and the Department of Public Welfare (DPW). The lawsuit, filed in state court, claims that the 20% funding cut along with the proposal to transfer mental health and intellectual disability funds to a block grant violates the Mental Health and Intellectual Disability Act of 1966, which mandates that Pennsylvanians with mental illness and intellectual disabilities have access to adequate services and that the executive branch request sufficient appropriations from the legislature to fund those services. DRN petitions the court to require the Governor, the Budget Office and DPW to request sufficient funds from the legislature to fully fund the service needs of Pennsylvanians with mental health and intellectual disabilities.

OTHER HEADLINES

Arizona

- **Feds approve Gov. Brewer's requests for Medicaid changes**

  The federal government last Friday approved a handful of changes to Arizona's Medicaid program that state officials said could help extend health coverage to more than 20,000 low-income children. The so-called Safety Net Care Pool program that was given the green light Friday by CMS was approved by state lawmakers in spring 2011. The program is designed to help hospitals cope with the growing level of uncompensated care they provide to Medicaid patients. Brewer spokesman Matt Benson said the program will funnel $332 million a year in local government funds to Phoenix Children's Hospital, Maricopa Medical Center and University Medical Center, until Jan. 1, 2014. (DC Courier)

- **7 Arizona doctors lose Medicaid contracts**

  The state's Medicaid program said it has terminated the contracts of seven doctors who were top prescribers of powerful pain pills and mental-health prescription drugs. Their dismissals were made public as the result of an ongoing probe by U.S. Sen. Charles Grassley, R-Iowa, of drug-prescribing patterns in Medicaid programs across the country. Medicaid programs, which provide health care to the nation's poor, reimburse doctors and practitioners. Grassley's probe centers on health-care professionals who prescribe large amounts of pain pills and psychiatric drugs. (AZ Central)

Arkansas

- **Insurance chief denied OK to spend fed funds on health insurance exchange**

  A legislative panel today failed to endorse state spending from a multimillion-dollar federal grant to implement a key component of the national health care reform law. State Insurance Commissioner Jay Bradford had sought an endorsement from the Performance Evaluation and Expenditure Review Subcommittee for the state Insurance Department's use of a $7.7 million federal grant to fund various aspects of planning for a federally mandated health insurance exchange in Arkansas. The subcommittee voted 10-4 on the request, with 11 votes needed for a favorable review from the 20-member panel. (Arkansas News)

California

- **Essential Health Benefit Bill Clears Committee**

  The Assembly Committee on Health cleared AB 1453, which laid out a plan for what essential benefits will be covered in California under the Affordable Care Act. The proposed set of benefits is modeled on the Kaiser small group HMO plan. The federal government requires states to choose essential benefits in 10 broad categories. In California, that process looked daunting because of the many health care mandates passed by the Legislature, including coverage of autism. This package includes all current California mandates -- including autism coverage -- and everything in the package fits the federal profile as well, which means there would be no extra mandate costs to the state. (CaliforniaHealthline)

- **New claims format blamed for Medi-Cal payment problems**

  Some of the slow payment problems blamed on a local Medi-Cal plan are caused by billing middlemen still adapting to new claims requirements, said the plan's claims officials. The staff at Gold Coast Health Plan and the company it contracts to process claims, ACS, are reaching out to billing companies to try to resolve lingering complaints about payments that appear to be months behind. Some of the problems have been triggered by the federal government's mandate that electronic claims be submitted on a new format called 5010. Clinics, nursing homes and other providers were asked to start using the new format Jan. 1, although government enforcement has been pushed back to July. ACS, an arm of Xerox, started using the new system earlier this year and will transition to it completely on May 1. (Ventura County Star)

Connecticut

- **Connecticut revisits old-school Medicaid financing**

  State officials say the system was no longer saving the state money and patients were not getting the care they need — just the opposite of what managed care organizations promise. So to regain control of its health care programs, the state cut its ties with managed care organizations and started over. On January 1, Connecticut began directly reimbursing health care providers, while a non-profit organization provides care coordination and customer service for all of the state's Medicaid and Children's Health Insurance Program beneficiaries, plus members of a state-funded program for low-income adults — about 600,000 people in all. Not only does the state expect to save money under the new arrangement, but it is adding case management services for the state's most vulnerable beneficiaries, the aged, blind and disabled, who were not covered by the old managed care plans. (Stateline)

Maine

- **Another 5,300 mistakenly left eligible for MaineCare benefits, report says**

  The Department of Health and Human Services originally estimated that the error led the state's Medicaid program, known as MaineCare, to continue paying medical bills for up to 19,000 beneficiaries after they lost eligibility through the end of last year. A March 30 report by a working group looking into the bad payments refers to an additional 5,300 people who mistakenly received coverage from Jan. 2 to March 10 of this year. The computer system that pays MaineCare claims doesn't communicate properly with a separate system that tracks eligibility, according to DHHS officials. (Bangor Daily News)

Maryland

- **Md. General Assembly finishes work on health exchange bill, sends to governor for signature**

  The Maryland General Assembly has finished work on legislation to create the framework for a public marketplace to provide health care to the uninsured. The state Senate gave final approval to the bill Thursday, sending it to Gov. Martin O'Malley for his signature. (Washington Post)

Massachusetts

- **Mass. immigrants begin to join health care plan**

State lawmakers voted in 2009 to cut funding for low-income immigrants enrolled in Commonwealth Care because the federal government does not reimburse states for dental, hospice, skilled-nursing care and other costs incurred by foreign-born residents living in the country for less than five years. The immigrants were transferred to another state program that offered limited coverage, while thousands of others were put on a waiting list. The action, intended to help plug a $1.9 billion budget deficit, marked the first significant rollback to the health care law that was signed in 2006. The Supreme Judicial Court, however, ruled unanimously in January that preventing immigrants from enrolling was unconstitutional because it violated their rights to equal protection under the Massachusetts Constitution. Judges said state officials couldn't justify their exclusion on the basis of fiscal concerns alone. About 26,000 immigrants who were on the waiting list have begun receiving letters telling them that they are eligible to enroll into the Commonwealth Care and MassHealth. (Boston Globe)

Michigan

- **Michigan health officials seek to create long-term care system for elderly**

The state of Michigan plans to seek federal approval this month to create a managed care system for elderly patients needing long-term medical care who are eligible for both Medicare and Medicaid insurance coverage. The Department of Community Health is finalizing a proposal that would better coordinate care by determining whether individuals need skilled nursing in a 24-hour facility or can live independently at home with the assistance of daytime aides, officials said. A comment period on the proposal ended Wednesday, a day before the American Association of Retired Persons called on policymakers to spend more on in-home health care and less on institutional nursing homes. Thirty-five states spend fewer tax dollars on Medicaid for nursing home care than Michigan, in part because of policies that put a greater emphasis on home or community-based medical care, according to a new AARP Michigan report. One study estimates Michigan could save more than $57,000 per patient with home-based health care. (Detroit News)

New Jersey

- **Fate of Medicaid Waiver Faces Budget Review**

New Jersey's fate in its Medicaid waiver application was the center of attention in the Statehouse yesterday, as the state's top human services official testified before the Assembly to the cost and the policy benefits of the state winning approval in the lengthy process. New Jersey could receive millions in new federal matching funds for Medicaid as the state implements major changes planned for the $11 billion, state/federal funded healthcare program for 1.3 million low-income residents, who include children, frail elderly, and those with behavioral health and substance abuse problems. A key – and controversial -- DHS initiative in the application is moving the state's 28,000 Medicaid nursing home residents into managed care, a change designed to improve the coordination of home and community-based services to help seniors avoid moving to a nursing home for as long as possible. (NJ Spotlight)

North Carolina

- **NC Medicaid program averts a pair of fiscal crises**

  North Carolina's Medicaid program will dodge two immediate fiscal crises because federal regulators agreed Wednesday to extend the deadline to carry out new personal care service requirements and state officials outlined ways to close a projected $150 million shortfall. State budget director Andy Willis told legislators that to up to $45 million for the gap can be found in the Health and Human Services department to pay the bills until the Legislature returns to its budget-adjusting session in May. The General Assembly then would have to act to grant the executive branch authority to spend unused money from other parts of state government, which Republicans on the commission sounded willing to do. (NECN.com)

Oregon

- **Medicaid Collaborative Emerges to Create Coordinated Care Organization in Tri-County**

  Last, the Tri-County Medicaid Collaborative - CareOregon, FamilyCare, Kaiser Permanente, Providence Health Plans and Tuality Health Alliance - filed its letter of intent with the Oregon Health Authority to become a coordinated care organization and provide physical and mental healthcare to more than 200,000 people on the Oregon Health Plan starting August 1. But it's likely to face competition from at least two health insurers – ODS Health Plan, which wants to expand into the Portland market and UnitedHealth, which has never participated in Medicaid, but is attempting to have a statewide presence. Whether this new collaborative leads to a single health plan in the tri-county area is still unknown. If a single health plan does emerge, the collaborative would create a new organization representing all the participating organizations. (The Lund Report)

South Dakota

- **No easy cure for struggling Medicaid**

  At a time when Medicaid enrollments are rising because of a bad economy, the number of doctors and dentists accepting Medicaid patients is declining in South Dakota. One in seven South Dakotans is already a Medicaid recipient and nearly 70 percent of those are children. The Affordable Care Act, new federal health care legislation aimed at reducing the number of uninsured people, is expected to add another 54,000 South Dakotans to Medicaid rolls between 2014 and 2019. Ninety percent of the state's approximately 2,000 physicians say Medicaid reimbursement rates already don't cover their overhead costs to provide the care, much less allow them to make a profit, and future cuts to provider payments promise to make that situation worse. (Rapid City Journal)

Texas

- **Resistance builds to managed care for dual eligibles**

  Texas is one of many states where physicians are wrestling with the effects of — and fighting back against — the expansion of managed care into the poorest, oldest and often sickest population of patients. By moving dual eligibles to managed care, states hope to save money on what Medicaid covers, which mostly are the out-of-pocket expenses associated with Medicare deductibles. Texas, for example, hopes to save $475 million over two years with the changes it has made to dual-eligible coverage. Texas requires anyone on Medicaid older than 21 to be in the state's managed care program, Star-Plus. Dual eligibles moved into the program in full as of March 1. That was only two months after the state cut coverage to dual eligibles. The start of a new year of Medicare deductibles, the state's payment rate cuts and a technical glitch in claims processing meant that some Texas physicians have been paid nothing for caring for some of their neediest patients since the beginning of 2012. (American Medical News)

- **Interactive: Mapping Medicaid Patients' Pharmacy Access**

  State lawmakers expect to save more than $100 million by including pharmaceutical reimbursements in Medicaid managed care, which was rolled out across the state this year. But pharmacists and small-business owners are crying foul, saying the lowered rates could run independent pharmacists out of business and greatly reduce Medicaid patients' access to medication. The interactive map (link below) shows Medicaid patients' access to pharmacies across the state by comparing the location of pharmacies serving Medicaid patients as of March 2012 to the percentage of the county population enrolled in Medicaid as of August 2011 — the most current available enrollment data. The Tribune calculated the percentage of the county population enrolled in Medicaid by combining enrollment data with 2011 county population estimates* from the Texas Department of State Health Services. (Texas Tribune)

Utah

- **Scope of Utah Medicaid data breach explodes**

  A data breach initially thought to be limited to 24,000 Utahns on public health insurance is now believed to have put nearly 800,000 Utahns at risk. The Social Security numbers of up to 280,000 Utahns were exposed to hackers in the breach last week while less sensitive information — such as names and birth dates — from 500,000 others was released. Utah could face federal penalties or fines. How the state is judged to have handled the breach will factor into any decision by the Centers for Medicare and Medicaid. (Salt Lake Tribune)

National

- **HHS Proposes One-Year Delay of ICD-10 Compliance Date**

  The Department of Health and Human Services (HHS) today announced a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). The proposed rule may be viewed at: www.ofr.gov/inspection.aspx

- **Over 1.1 Million Beneficiaries Now Served By Accountable Care Organizations**

  Under the new Medicare Shared Savings Program (Shared Savings Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The first 27 Shared Savings Program ACOs will serve an estimated 375,000 beneficiaries in 18 States. This brings the total number of organizations participating Medicare shared savings initiatives on April 1 to 65, including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January 2011. In all, as of April 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives. To learn more about the ACOs announced today, visit: (ACO Fact Sheets). For more information on the Advanced Payment ACO Model, including the participating ACOs, visit: (CMS Innovations - ACOs).

  List of Accountable Care Organizations Starting April 1, 2012:

  - Accountable Care Coalition of Caldwell County, LLC Lenoir, NC
  - Accountable Care Coalition of Coastal Georgia Ormond, FL (Serving beneficiaries in GA and SC)
  - Accountable Care Coalition of Eastern North Carolina, LLC New Bern, NC
  - Accountable Care Coalition of Greater Athens Georgia Athens, GA
  - Accountable Care Coalition of Mount Kisco, LLC Mount Kisco, NY
  - Accountable Care Coalition of the Mississippi Gulf Coast, LLC Clearwater, FL (Serving beneficiaries in the Mississippi Gulf Coast area)
  - Accountable Care Coalition of the North Country, LLC Canton, NY
  - Accountable Care Coalition of Southeast Wisconsin, LLC Milwaukee, WI
  - Accountable Care Coalition of Texas, Inc. Houston, TX
  - *AHS ACO, LLC* Morristown, NJ (Serving beneficiaries in NJ and PA)
  - *AppleCare Medical ACO, LLC* Buena Park, CA
  - *Arizona Connected Care, LLC* Tucson, AZ
  - *Chinese Community Accountable Care Organization* New York, NY
  - *CIPA Western New York IPA, doing business as Catholic Medical Partners* Buffalo, NY
  - *Coastal Carolina Quality Care, Inc.* New Bern, NC
  - *Crystal Run Healthcare ACO, LLC* Middletown, NY (Serving beneficiaries in NY and PA)
  - *Florida Physicians Trust, LLC* Winter Park, FL
  - *Hackensack Physician-Hospital Alliance ACO, LLC* Hackensack, NJ (Serving beneficiaries in NJ and NY)

- *Jackson Purchase Medical Associates, PSC* Paducah, KY
- *Jordan Community ACO* Plymouth, MA
- *North Country ACO* Littleton, NH (Serving beneficiaries in NH and VT)
- *Optimus Healthcare Partners, LLC* Summit, NJ
- *Physicians of Cape Cod ACO Description of Organization* Hyannis, MA
- *Premier ACO Physician Network* Lakewood, CA
- *Primary Partners, LLC* Clermont, FL
- *RGV ACO Health Providers, LLC* Donna, TX
- *West Florida ACO, LLC* Trinity, FL

- **Outlook still grim for US state, local budgets-GAO**

  U.S. state and local governments' fiscal situations have improved recently but will still deteriorate through 2060, the Government Accountability Office said on Thursday. Each year, the federal auditing agency releases a long-term outlook for state and local budget conditions. Last year, it warned that rising healthcare costs and low revenue would create extraordinary pressures on public sector budgets for decades to come. This year, the outlook improved for the near term, mostly due to an "increase in tax receipts following the decline during 2008 and into 2009," GAO said. But the outlook remains gloomy for the future, with healthcare costs, both for public employees and for the Medicaid insurance program for the poor, swelling and weighing on budgets, GAO said. (Reuters)

- **Automatic Enrollment of 'Duals' in Managed Care Plans Stirs Anxiety at MedPAC**

  Members of the Medicare Payment Advisory Commission expressed concern Thursday about automatically enrolling "dual eligibles" in managed care plans as part of a series of health law demonstration programs to be launched next year. MedPAC Chairman Glenn Hackbarth said the programs could entail moving people into care delivery arrangements that may or may not be a good match for a dual given such a patient's particular medical needs. CMS says the demos will enroll up to two million of the nation's 10 million duals. Twelve states have said they will conduct demonstration programs to better coordinate care of the duals. Uneasiness about the demonstration programs dominated the early part of Thursday's discussion but then the tide turned, with a number of commissioners emphasizing the importance of moving ahead with the programs. (CQ Healthbeat)

COMPANY NEWS

- **Molina Healthcare of California Selected to Participate in Dual Eligible Demonstration Project**

  Molina Healthcare, Inc. announced that its wholly owned subsidiary, Molina Healthcare of California (MHC), has been selected by the California Department of Health Care Services (DHCS) to participate as an integrated health plan in California's proposed demonstration project to provide healthcare services for beneficiaries who are eligible for both Medi-Cal and Medicare (dual-eligible beneficiaries) in San Diego County. In addition to San Diego County, Los Angeles County was also selected by DHCS for a dual-eligible demonstration project. MHC will participate in the Los Angeles County dual-eligible pilot program as a subcontracted health plan. (Molina News Release)

- **California DHCS Selects Health Net for Dual Eligibles Pilot in Los Angeles and San Diego Counties**

  The California Department of Health Care Services selected Health Net, Inc. to participate in its proposed dual eligibles demonstration pilot for both Los Angeles County and San Diego County. The state of California is pursuing new approaches to service the "dual eligibles" population – beneficiaries that are eligible for both Medicare and Medicaid. Following a period for stakeholder input, California will submit this proposal to the Centers for Medicare & Medicaid Services for approval. (Health Net news release)

RFP CALENDAR

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

Date	State	Event	Beneficiaries
Early April	Pennsylvania	Contract awards	465,000
April, 2012	Arizona Duals	Demo Proposal released	120,000
April 18, 2012	Ohio Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 27, 2012	Massachusetts Duals	RFP Released	115,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 18, 2012	Kansas	Contract awards	313,000
May 25, 2012	Ohio Duals	Proposals due	115,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 15, 2012	Illinois Duals	Proposals due	172,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	New York LTC	Implementation	200,000
June 4, 2012	Massachusetts Duals	Proposals due	115,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	90,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	172,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
September 20, 2012	Ohio Duals	Contracts finalized	115,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	172,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
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	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
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida	LTC enrollment complete	90,000
January 1, 2014	New York Dual	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
February 1, 2014	Georgia	Implementation	1,500,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

Below we provide an ongoing look at states as they progress toward implementation dual eligible integration demonstrations in 2013. The table does not include those states pursuing dual integration demonstrations in 2014.

State	Released by State	Date	Submitted to CMS	Date	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
California	X	4/4/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Illinois	X	2/17/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Massachusetts	X	12/7/2011	X	2/16/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan*	X	3/5/2012			5/24/2012	9/20/2012	TBD	7/1/2013
Minnesota	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Ohio	X	2/27/2012	X	4/2/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Washington	X	3/12/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Wisconsin	X	3/16/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013

**Michigan proposed an enrollment effective data of 7/1/13*

HMA RECENTLY PUBLISHED RESEARCH

Webcast: Proven Steps To Clinical Efficiency

Sharon Silow-Carroll, Managing Principal

April 9, 2012: When hospitals seek to enhance value in care delivery, their goal is two-fold: improve quality while using resources as effectively as possible. Bill Santamour of Hospitals & Health Networks (H&HN) talks with Sharon Silow-Carroll of Health Management Associates (HMA) about four hospitals that have successfully done just that by better managing service lines, harnessing data and technology and rethinking clinical staffing. **(H&HN Magazine - Link to Webcast)**

Webcast: Medicaid Budgets and California's Dual Eligible RFS

Vernon Smith, Managing Principal

Jennifer Kent, Principal

On Friday, March 2, 2012 HMA Principals Vernon Smith and Jennifer Kent hosted a conference call in conjunction with the Gerson Lehrman Group (GLG). On the call, Vernon provided an update on state Medicaid budgets and the expansion of Medicaid managed care while Jennifer led a discussion of California's request for solutions (RFS) for an integrated delivery model for Medicare-Medicaid eligibles. A webcast replay of the call is available at: **(GLG Research - Link to Webcast)**

UPCOMING HMA APPEARANCES

The Women's College of the University of Denver's Leadership Salon - Is consensus possible? A conversation on health care policy.

Joan Henneberry, Panelist

April 19, 2012

Denver, Colorado

Venture Behavioral Health Regional Integrated Care Summit - Pathways to Medicaid Health Homes and Safety Net ACOs

Alicia Smith, Presenter

Pat Terrell, Presenter

Terry Conway, MD, Presenter

April 19, 2012

Kalamazoo, Michigan

2012 Spring State of the State - State Health Reform: Implications of the Supreme Court Decision

Joan Henneberry, Keynote Speaker

April 24, 2012

Denver, Colorado

19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – How are States Progressing in Setting Up State-Based Exchanges?

Jennifer Kent, Presenter

May 24, 2012

Princeton, New Jersey

AcademyHealth Annual Research Meeting – The Impact of the ACA on State Policy: Early Findings

Jennifer Edwards, Panel Facilitator

June 25, 2012

Orlando, Florida

AcademyHealth Annual Research Meeting – Health Insurance Exchanges: Progress to Date

Joan Henneberry, Panel Facilitator

June 25, 2012

Orlando, Florida