HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: COMMUNITY HEALTH CENTERS AWARDED $128.6M THROUGH ACA

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

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IN FOCUS: COMMUNITY HEALTH CENTERS AWARDED $128.6 MILLION THROUGH THE AFFORDABLE CARE ACT

This week, our *In Focus* section is provided by Deborah Zahn, a Principal in HMA's New York office. On June 20, 2012 Health and Human Services (HHS) Secretary Kathleen Sebelius announced awards of $128.6 million in new grants for 219 community health centers to expand their service delivery sites and serve 1.25 million additional patients. Made possible through the Affordable Care Act, the grants—called New Access Points (NAPs)—will support the establishment of new health center sites in 41 states, the District of Columbia, Puerto Rico, and the Northern Mariana Islands and provide annual grants to the health centers to provide care to underserved populations.

This was the second round of awards from a competitive funding opportunity announcement released in fiscal year (FY) 2011 by the Health Resources and Services Administration (HRSA), the federal agency that oversees the Health Center Program. HRSA received over 800 NAP applications but, due to federal funding constraints and uncertainties, initially only awarded $28.8 million for 67 health centers. This was significantly less than approximately $250 million for 350 awards it had anticipated funding in FY 2011.

The grants are awarded under the Health Center Program, which is authorized by section 330 of the Public Health Service Act and are for existing or new federally qualified health centers (FQHCs). An FQHC is a community health center that is designated by the federal government and receives federal funding under Section 330 of the Public Health Services Act to provide essential primary and preventive health care services and related enabling services to medically underserved communities and vulnerable populations. FQHCs must be located in and/or serve high-need areas, serve the full "life cycle" of care (e.g., prenatal, pediatrics, adolescent, adult, geriatric) through a core staff of primary care providers, provide services available to all with fees adjusted based on ability to pay, and be governed by a community board with a majority of members who are users of the health center. In addition, FQHCs must maintain systems that can produce accurate, auditable financial and utilization information as well as a variety of demographic and other data required by the federal government. In exchange for meeting rigorous federal requirements, FQHCs are entitled

HMA Clients Awarded More Than $2.5 Million

HMA assisted six health center clients in developing applications for the grants. Five of those received awards totally more than $2.5 million. Four of the health centers are in upstate New York and one is in Illinois. The grants will be paid annually to the health centers and range from $379,167 to $650,000 per health center. In New York, the Community Health Care Association of New York State, New York's Primary Care Association, provided funding for technical assistance and consultant services in historically underfunded regions of the State with support from the New York State Health Foundation and the Health Foundation of Western and Central New York.

to a range of benefits, including an annual grant to offset the cost of caring for the uninsured, reimbursement by Medicaid and Medicare under a Prospective Payment System, free tort protection under the Federal Tort Claims Act, discounted drug prices through the federal 340(b) program, "first-dollar" Medicare coverage, and access to other programs and resources. There are currently 1,100 FQHCs operating over 8,500 service sites. They provide care to approximately 20.2 million patients.

Although it has not yet been confirmed by HRSA, there may be another NAP application opportunity in January 2013.

A listing of the New Access Point grants is available at: http://www.hrsa.gov

Service Area Competition Funding

HRSA has also just announced the availability of $346 million in funding for an estimated 220 applicants through its Service Area Competition (SAC). SAC awards support FQHCs in providing services for defined underserved areas and/or populations. The opportunity is for current grantees applying to continue serving their current service area and whose project periods are ending in FY 2013, current grantees applying to serve a new service area, and new applicants. The project period is up to five years for current grantees and up to two years for new applicants.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

On July 9, the California Department of Health Care Services (DHCS) released a revised list of Letter of Intent (LOI) respondents to 28-county Medicaid managed care expansion. The revised list corrects an error in the previous LOI table. The Governor's budget proposes expanding Medi-Cal, the state's Medicaid managed care program into 28 counties currently only served by the fee-for-service (FFS) program in June 2013. The expansion would bring more than 300,000 FFS Medi-Cal lives into managed care plans. The revised LOI list below:

Plan Name	26 Contiguous	Imperial	San Benito	Northern	Central	Border	Other Specific Counties	Other
Anthem Blue Cross	X	X	X	X	X	X		
Care1st	X	X	X	X	X	X		
Blue Shield	X	X	X	X	X	X		
Centene	X	X	X	X	X	X		
Humana	X	X	X					
United Health Plan	X	X	X					
Meridian Health Plan	X			X	X			
Wellcare Health Plan	X							
Community Health Group		X						
Molina Health Care		X					El Dorado, Placer	
Central California Alliance for Health			X					
Partnership Health Plan							Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity	
Molina Pathways								Coordinated Health Care in Fee-For-Service
Quantum Health								Coordinated Health Care in Fee-For-Service

Source: http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPMMCDrfiHOME.aspx

In the news

- **California health exchange seeks to make buying insurance a breeze**

  Peter V. Lee wants to make buying health insurance "as easy as buying a book on Amazon." He heads the nascent California Health Benefit Exchange, the cornerstone of the state's effort to put in place the federal health care overhaul. Lee envisions that 15 months from now, uninsured California residents will log onto any computer to shop for health care the same way they purchase novels. The exchange must tackle three major areas in the coming months: attracting potential subscribers, building the enrollment system and selecting the health insurers and the plans they will provide. (Sacramento Bee)

Colorado

HMA Roundup – Joan Henneberry

The Colorado Health Benefits Exchange (COHBE) continues to move forward in its development and implementation. The COHBE is applying for a second round of Level 1 federal grant funding and will apply for Level 2 grant funding in February 2013. The state scheduled two public webinars on the essential health benefits package on July 18 and July 30, 2012. The COHBE has established standard comparative information for available plans in the Exchange, to include premiums and cost sharing, benefits covered, limitations and exclusions, prescription drug co-pays, and plan tier rating or catastrophic coverage. Issues to be resolved in the coming months include the open enrollment period and mid-year plan changes.

Governor John Hickenlooper signed an Executive Order creating the Office of Community Living (Office), designed to help meet the growing need for long-term services and supports by people with disabilities and aging adults and be housed in the Department of Health Care Policy and Financing. By 2021, the number of older adults in Colorado is expected to increase by 54 percent. This Office will help prepare the state to meet the needs for long-term services and supports and focus attention and resources on meeting the unique needs of aging Coloradans and individuals with disabilities. The Office will align services and supports so that individuals, and their families do not have to navigate a complicated and fragmented system. The goal of the Office is to provide strategic direction on the redesign of all aspects of the long-term services and supports delivery system, including service models, payment structures and data systems to create efficient and person-centered community-based care. State agencies and divisions working on community living will work collaboratively with the Office.

In the news

- **Colorado hospitals want Medicaid expansion**

  Burdened with providing $1.5 billion in care for the uninsured a year, Colorado hospitals support an expansion of Medicaid to help reduce health care costs. "As of now, the Medicaid expansion is the best solution we know of to get health insurance for the people who need it most," said Julian Kesner, spokesman for the Colorado Hospital Association. Kesner said the association's financial analysts are calculating how much a failure to expand Medicaid would cost hospitals, but he doesn't have an estimate yet. Hospitals cannot turn away uninsured people who show up sick in emergency rooms. Hospitals absorb some of these costs while taxpayers and individuals and businesses — who foot the bill for ever-more expensive private health insurance premiums — are paying the rest of the tab for the uninsured. Gov. John Hickenlooper, a Democrat, and his aides have made no commitments on whether they'll support adding more people to Colorado's already expanding Medicaid rolls. (Health Policy Solutions)

Florida

HMA Roundup – Gary Crayton

The state announced contract awards in response to the Florida Healthy Kids RFP. Healthy Kids is the state's Medicaid CHIP program, and services for more than 225,000 CHIP enrollees were reprocured under the RFP. Contracts were awarded in each of Florida's 67 counties. WellCare and United were awarded 65 and 40 counties, respectively. Coventry was awarded 16 counties, Amerigroup won 11 counties, while Centene was awarded one county and Blue Cross Blue Shield (BCBS) was awarded two counties. United and BCBS both saw significant drops in number of counties as compared to existing contracts. New contracts go live on October 1, 2012. A link to county-specific awards is available at: https://www.healthykids.org/

In the news

- **Fla. moving ahead with prison health privatization**

  Gov. Rick Scott's administration announced Tuesday that it was moving ahead with privatizing health care services in Florida's prisons, two weeks after a Tallahassee judge refused to rule on a legal challenge by unions representing nurses and other state employees. Circuit Judge Kevin Carroll on July 2 said it was a moot issue because a state budget provision authorizing the privatization had expired at midnight June 30. Gov. Scott's administration said it intends to award contracts to Corizon Inc. of Brentwood, Tenn., for services in northwest and central Florida and Pittsburgh-based Wexford Health Sources in the southern part of the state. They are among four companies that submitted responses to requests to provide services. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The Georgia Department of Community Health (DCH) announced last week that it was putting on hold plans to overhaul the state's Medicaid program, details of which were expected to be announced any day. Based on a report from the state's consultant on the redesign, Navigant, it was anticipated that more of the Medicaid program would have been brought under managed care contracts, including the aged, blind and disabled population. Sources from DCH have indicated that the tabling of the Medicaid redesign is due to political uncertainty over the future of Medicaid and the Medicaid expansion until after the fall elections. Procurements for the current low-income Medicaid and CHIP programs may be delayed as well, but could be seen as early as Spring 2013.

Gov. Nathan Deal's administration reported that the State of Georgia's net tax collections for the month of June totaled $1.54 billion, an increase of $39 million, or 2.6 percent, compared to June 2011. For fiscal year 2012, which ended June 30, net revenue collections totaled $16.1 billion, which is an increase of $742 million, or 4.8 percent, compared to the previous fiscal year.

Indiana

HMA Roundup – Catherine Rudd

The Indiana Family and Social Services Administration hosted a dual eligible integration Advisory Council Meeting on July 13 at 1pm during which it explained that it has expanded the scope of its approach to integration to include the Aged, Blind and Disabled Medicaid population. The State plans to take an outcomes based approach in the design of its program, determining what the desired outcomes will be for various populations and then designing a program to achieve them. Some non-traditional outcomes are expected to be included, such as improving employment status, functioning in school and decreased involvement in the criminal justice system. While no further meetings are currently scheduled for the Advisory Council, the State plans to work directly with various stakeholder groups to select and define outcomes and encouraged comments from interested parties, which can be submitted through the State's Integrated Care website at http://www.in.gov/fssa/ompp/4347.htm.

A timeline will be issued at a later date, but tentatively the State's goal is to have a program in place by July 1, 2013.

The State will be submitting a State Plan amendment this week for a PACE program but anticipates that enrollment will not occur until next year.

New York

HMA Roundup – Denise Soffel

Supportive Housing RFP

As part of the Medicaid Redesign Team activity, the state set aside $75 million to expand supportive housing for high need and high cost Medicaid beneficiaries. The Housing Trust Fund Corporation (HTFC), an agency within the NYS Homes and Community Renewal, recently released an RFP for supportive housing projects. The HTFC is making available $25 million of capital for supportive rental housing development. The RFP requires that 30 percent of units be set aside for individuals eligible under the NY/NY III program, a joint city-state initiative to expand supportive housing. Eligible populations include chronically homeless individuals with a serious mental illness or substance abuse disorder, chronically homeless families where the head of household has a serious mental illness or substance abuse disorder, individuals currently residing in state psychiatric facilities, and chronically homeless adults with HIV and a co-occurring behavioral health disorder. http://www.nyshcr.org/Funding/MRTRFP.pdf

NYS Exchange Establishment Level 1 Funding

New York has submitted its third application for Level 1 funding. The $95 million request focuses on IT systems, program integration, consumer assistance and business operations. New York has already received $59.2 million in Level 1 funding. Governor Cuomo established the NY Health Benefit Exchange through an executive order in April 2012. Funding is now being requested to support hiring executive level staff for the exchange, as well as a number of functional staff. The state is also requesting funding for expansion of the enrollment center, operated by MAXIMUS, to take on broader functions

related to the ACA. MAXIMUS currently provides call center services related to eligibility and renewal for the state's Medicaid and CHP programs. They will be providing back-end operations for the Exchange Eligibility and Enrollment functions. The state also seeks funds to continue work on its all payer database, which will support the business operations of the exchange. Finally, New York is seeking additional funding for the Consumer Health Advocates initiative, to continue to provide consumer assistance to individuals and small businesses through a state-wide network of community-based organizations. Available at: http://www.healthcarereform.ny.gov/

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The Pennsylvania Department of Public Welfare (DPW) announced a one-month delay in the rollout of the New West region Medicaid managed care expansion. Implementation will begin on October 1, 2012 instead of September 1, 2012 as originally planned. The four plans selected to serve the New West are AmeriHealth Mercy, Coventry, Gateway, and University of Pittsburgh Medical Center (UPMC). The state has not commented whether the delay in the New West implementation will impact the New East implementation, set for March, 1, 2013. Awards in the New East are currently being protested.

OTHER HEADLINES

Alaska

- **Alaska governor says state won't set up health-insurance exchange**

  Alaska will not set up a program allowing residents to buy health insurance across state lines as envisioned under the Obama administration's new healthcare law, leaving that task to the U.S. government, Governor Sean Parnell announced Tuesday. It is too expensive for the state to set up an insurance-exchange program, as required by the Patient Protection and Affordable Care Act, said Parnell, a Republican who has been a critic of the Obama administration's new healthcare law. Instead, the federal government should bear the responsibility of creating and running the exchange, Parnell said. (Reuters)

Kentucky

- **Ky. governor creates health insurance exchange**

  Kentucky Gov. Steve Beshear has issued an executive order creating a statewide health insurance exchange, following up on his promise to do so once the U.S. Supreme Court upheld the federal health care overhaul. Beshear's office said Tuesday the exchange will begin operation Jan. 1, 2014. The federal government will create exchanges starting in 2014 for states that don't develop their own. The order establishes the Office of the Kentucky Health Benefit Exchange and establishes an 11-member Exchange Advisory Board. Carrie Banahan, executive director of the Office of Health Policy, will be executive director of the new office. (CBS News)

Louisiana

- **Louisiana Announces SFY 2013 Reimbursement Rate Reductions**

  In order to avoid a SFY 2013 budget deficit in the Medicaid Program, the Department of Health and Hospitals has reduced reimbursement rates for various Medicaid services with dates of service on or after July 1, 2012. Emergency Rules on the reductions will be published in the July 20, 2012 edition of the Louisiana Register. While the rate changes are effective July 1st, it will take some time-potentially as long as a couple of months-before the necessary system configuration changes to reflect the new rates have been completed by Molina, Amerigroup, LaCare, Louisiana Healthcare Connections and Magellan. Providers can anticipate that, once the configuration changes have been completed, claims for dates of service 7/1/12 and after will be systematically adjusted.

  Changes impacting Bayou Health (Louisiana's managed Medicaid and CHIP program):

  - Prepaid Plans will see Per Member Per Month premiums reduced by 3.7 percent
  - Shared Savings Plans will see Monthly Management Fees reduced by 3.7 percent (from $18.16 to $17.49 and from $12.81 to $12.37). Additionally, pass through payment of $1.50 intended for primary care providers PCPs has been eliminated with termination of CommunityCARE on June 1, 2012.

  For details, see the Emergency Rule section of the July 2012 Louisiana Register at: http://www.doa.louisiana.gov/osr/reg/register.htm.

Massachusetts

- **Mass. Lawmakers Face Scramble As Session Nears End**

  The two-year legislative session on Beacon Hill is heading into the homestretch. With formal sessions set to end on July 31, a number of major bills await final action by lawmakers. Atop that list is a health care cost containment measure. Both the House and Senate have passed versions of the bill that seeks to reduce health care expenditures by $150 billion to $160 billion over 15 years. A conference committee has been working to reconcile differences between the two versions. (WBUR.org)

Michigan

- **Health care on agenda when Michigan lawmakers return**

  Michigan Gov. Rick Snyder and his fellow Republicans could find themselves knee-deep in health care issues Wednesday when lawmakers briefly return after a five-week break. Snyder needs to get reluctant House Republicans on board with his efforts to create an online site where individuals and small businesses can comparison shop for private health insurance. Snyder spokeswoman Sara Wurfel says the governor would like the House on Thursday to follow the lead of the GOP-controlled Senate and approve setting up the exchange. Lawmakers aren't scheduled to be in session again until mid-August. State officials are scrambling to get a state-run exchange in place by 2014. They're running out of time to show they've done enough initial planning and may have to partner with the federal government on an exchange. (Detroit Free Press)

Minnesota

- **Minnesota announces $41 million contract to set up health exchange**

  Minnesota announced a $41 million contract on Monday with the Virginia-based Maximus firm to design and maintain a state-run health insurance exchange mandated in the federal health insurance reform law. The state is one of at least 15 to move forward with a health insurance exchange using executive branch authority, and Gov. Mark Dayton has been a strong proponent for a state-run exchange rather than the more rigid federal option. The contract announced Monday is the first major movement on health insurance exchanges since the Supreme Court ruling in late June, according to the company. The agreement involves three state departments — Commerce, Health and Human Services. (MinnPost)

Texas

- **Businesses Will Push Perry to Rethink Medicaid Expansion**

  Texas Gov. Rick Perry says he rejects the "Obamacare power grab" and will block measures expanding health insurance to millions in his state. The country's second-biggest health insurer is betting he won't succeed. The same day last week that Perry said expanding Medicaid would be like "adding a thousand people to the Titanic," WellPoint Inc. disclosed an agreement to buy Texas's biggest Medicaid managed care company for $4.9 billion. The purchase of Amerigroup, which operates in 12 other states besides Texas, is WellPoint's attempt to cash in on the health act's addition of 17 million Americans to Medicaid. Quiet for now, insurers are expected to join hospitals and patient advocates to fight for Medicaid expansion and what are enormous amounts of money, even by Washington standards. Nowhere are the dollars bigger than in Perry's state, where one in four lacks health coverage. (Kaiser Health News)

- **State sharply lowers estimate of Medicaid expansion cost**

  On the heels of Gov. Rick Perry's declaration that Texas will not expand Medicaid because it is too costly, his health and human services commissioner said Thursday that fully implementing health care reform would cost the state about $11 billion less over 10 years than previously estimated. Executive Commissioner Thomas Suehs told a Texas House subcommittee that the new estimate is between $15 billion and $16 billion in state costs over a decade, compared to the previous estimate of $26 billion to $27 billion. The state would get an additional $100.1 billion in federal money over that time, according to the Texas Health and Human Services Commission. (Houston Chronicle)

Virginia

- **Cuccinelli: Va. should opt out of Medicaid expansion**

  Attorney General Ken Cuccinelli wants Virginia to opt of the new federal health law's Medicaid expansion. Gov. McDonnell told legislators last week that he was considering opting out, but he needed more information from the federal government. He said the same thing while hosting the National Governors Association this weekend in Williamsburg, where other governors expressed similar reservations. (Washington Post)

National

- **Thirteen states affirm intention to establish Exchanges**

  HHS has posted letters from twelve states stating their intention to establish a state-based health insurance exchange. Those states are: California, Colorado, Connecticut, Hawaii, Massachusetts, Maryland, Minnesota, New York, Oregon, Rhode Island, Vermont, and Washington. Additionally, Kentucky's governor has affirmed that they will also establish a state-based exchange. Governors' letters to HHS are available at: (www.healthcare.gov)

- **Bill Frist To GOP Governors: Get Cracking On Exchanges**

  Bill Frist, a former Republican Senate majority leader and a heart transplant surgeon, today argued in a column that state officials should not pass up the opportunity to build the insurance exchanges that are right for them. "State exchanges are the solution," he wrote. "They represent the federalist ideal of states as 'laboratories for democracy.' We are seeing 50 states each designing a model that is right for them, empowered to take into account their individual cultures, politics, economies, and demographics. While much planning has yet to be done, we are already seeing a huge range in state models. I love the diversity and the innovation." (Kaiser Health News)

- **Report: US states' financial woes eroding services**

  U.S. states face long-term budget burdens that are already limiting their ability to pay for basic services such as law enforcement, local schools and transportation, a report released Tuesday said. Aging populations and rising health care costs are inflating Medicaid and pension expenses. At the same time, revenue from sales and gas taxes is shrinking. And grants from the federal government, which provide about a third of state revenue, are likely to shrink, the report said. Those challenges are made worse by a lack of planning by many states and the repeated use of one-time accounting gimmicks to cut costs, the report added. The report was issued by the State Budget Crisis Task Force, a non-profit co-chaired by former Federal Reserve Chairman Paul Volcker and former New York Lieutenant Governor Richard Ravitch. It focused on six states that encompass about a third of the U.S. population: California, Illinois, New Jersey, New York, Texas, and Virginia. The states' financial problems aren't just a result of the recession and slow recovery, the report said. They have built up over years. (Wall Street Journal)

- **Groups to CMS: Slow down**

  Health care providers and policy analysts broadly agree that the current care environment for dual eligible beneficiaries needs to change — and fast. The approximately 9 million people on both Medicare and Medicaid tend to have multiple health problems, and their care is both highly fragmented and very expensive. There's general agreement on what has to change: improve care coordination among the doctors, physicians and nursing homes — and make sure they share in any resulting savings. But criticism toward a Centers for Medicare & Medicaid Services-led effort to do just that has been rising. MedPAC recently raised a number of concerns over the size, scope and rapid pace of the program. Sen. Jay Rockefeller (D-W.Va.), who helped shape the effort, has

called for its immediate halt. Critics of the CMS demonstration for dual eligibles say it's a classic example of the right idea but the wrong execution. (Politico)

- **Feds to states: No pressure on Medicaid**

  In a letter to Republican governors Friday, the administration says there's no deadline for states to decide on Medicaid. And states can receive federal funding to explore their options without having to pay it back if they later decline. Marilyn Tavenner, administrator of Medicare and Medicaid, says in the letter she expects states "will recognize that this is a good deal," since federal taxpayers are covering the lion's share of costs. (Newsday)

- **ACA opponents want to kill law via subsidies**

  The next shot in the legal war over the health reform law isn't another lawsuit but an academic paper that says federal exchanges can't give people subsidies to help pay for their coverage. The paper, authored by Case Western Reserve University's Jonathan Adler and the Cato Institute's Michael Cannon, puts intellectual heft behind an argument that has been percolating among the law's opponents. If the courts were to accept Adler's and Cannon's argument, that could effectively enable states to kill federal exchanges by empowering them to cut off the subsidies. Without subsidies, the federal exchanges would not be economically viable because they couldn't get as many people to sign up for coverage. Any challenge to the exchange subsidies would have to target the Internal Revenue Service's interpretation of the law's premium subsidies provisions. In a rule published in May, the IRS specifically said both federal and state exchanges can administer the subsidies. (Politico)

- **Charity care remains pressing even if federal health law is implemented**

  One question left unanswered by the health-reform law is how much charity care nonprofit hospitals must provide in exchange for numerous tax breaks. These hospitals pay no federal income and capital gains taxes, no state and local property taxes and no taxes on purchases. The issue of whether communities get enough in return for this generosity used to be hotly debated, but it isn't given much ink in the 2,400-page Affordable Care Act. Even so, hospitals will still need relatively robust charity-care budgets because of the number who will remain uninsured in spite of the ACA. A report by the Robert Woods Johnson Foundation estimates that the law will fail to cover 23 million uninsured people. Although hospitals say they are prepared to continue serving those left uninsured, some regret that the health law did not specify what percentage of resources nonprofit hospitals must devote to this care. The law did add new tax rules requiring hospitals to spell out more fully how they are meeting a community's health needs. (St. Louis Beacon)

COMPANY NEWS

- **Molina's Medicaid Claims Processing System Receives Full Federal Certification in Idaho**

  Molina Healthcare, Inc. announced today that the Medicaid Management Information System (MMIS) implemented in Idaho by its wholly owned subsidiary, Molina Medicaid Solutions, has received full federal certification from the Centers for Medicare and Medicaid Services (CMS). The certification follows a week of rigorous on-site testing of the system, as well as a subsequent evaluation by CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75 percent of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims. The claims payment system serves over 230,000 participants and handles more than 140,000 claims per week. The federal government required the system upgrade, with conversion to Molina's system occurring in June 2010. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50 percent of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75 percent of costs, reducing the state's share. (Molina News Release)

- **MAXIMUS Awarded Contract for Minnesota Health Insurance Exchange**

  MAXIMUS (NYSE: MMS), a leading provider of government services worldwide, today announced that it has been awarded a $41 million contract by the State of Minnesota to design and develop the technical solution, including a consumer-friendly website, for Minnesota's statewide health insurance exchange and Medicaid modernization. Following a competitive bid process, MAXIMUS was selected as the prime contractor to design and develop the Minnesota health insurance exchange, and to deliver major technology improvements to Minnesota's Medicaid systems to provide streamlined eligibility determinations, enhance customer service, allow for timely eligibility changes, and promote ongoing program integrity. The Minnesota health insurance exchange development will include the deployment of StateAdvantage, a complete health insurance exchange solution developed through an alliance between Connecture, Inc. and MAXIMUS. Other MAXIMUS subcontractors include IBM, utilizing the IBM Curam solution for healthcare reform, and EngagePoint (formerly known as Consumer Health Technologies). (Maximus News Release)

- **Aetna, N.J. group to launch ACO**

  Hunterdon HealthCare Partners, of Flemington, N.J., will launch an accountable care organization this summer with the insurer Aetna. The deal will tie payment to the Hunterdon Medical Center and its 225 affiliated doctors to performance on certain metrics, such as reduced hospital readmissions and emergency room visits and other quality, efficiency or patient-satisfaction measures, a news release said. The ACO will cover 2,200 Hunterdon HealthCare employees and 5,700 Aetna enrollees, said Jeffrey Weinstein, executive director and CEO of Hunterdon HealthCare. (Modern Healthcare)

RFP CALENDAR

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

Date	State	Event	Beneficiaries
July 6, 2012	Florida CHIP	Contract awards	225,000
July 24, 2012	Kentucky - Region 3	Proposals Due	170,000
July 30, 2012	Massachusetts Duals	Proposals Due	115,000
July 31, 2012	Illinois Duals	Contract awards	136,000
August 13, 2012	Ohio Duals	Contract awards finalized	122,000
August 31, 2012	Massachusetts Duals	Contract awards	115,000
September 20, 2012	Ohio Duals	Contracts finalized	122,000
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
Late 2012	New Hampshire	Implementation (delayed)	130,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	136,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
October 1, 2013	Florida LTC	Implementation	90,000
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
October 1, 2014	Florida acute care	Implementation	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

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

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

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

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

HMA Recently Published Research

Financing County Medi-Cal Eligibility and Enrollment in California

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

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

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

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

Comprehensive Hospital EHRs Improve Quality and Efficiency

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

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

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

Mike Nardone, Principal

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

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

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

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

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