HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 26, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CMS STATE MEDICAID DIRECTORS LETTER PROVIDES ESTATE RECOVERY GUIDANCE

This week, our *In Focus* section reviews the February 21, 2014, letter from The Centers for Medicare and Medicaid Services (CMS) to State Medicaid Directors, providing guidance on existing estate recovery rules under Modified Adjusted Gross Income (MAGI) eligibility rules. Under MAGI rules, there is no consideration for assets in determining eligibility. The guidance provided in the letter is in response to many state inquiries to CMS regarding the handling of Medicaid long term supports and service (LTSS) rules regarding estate recovery and whether these rules will apply to the MAGI eligibility population. CMS clearly states that the impact of LTSS estate recovery rules on the MAGI population should be very limited for two reasons:

1. Most Medicaid users of LTSS are deemed eligible under non-MAGI categories of eligibility, such as age or disability; and
2. States are not required to include LTSS benefits in the Alternative Benefit Plans (ABPs) offered to MAGI eligible individuals.

Despite the limited potential, the CMS letter clearly indicates that some individuals may be receiving LTSS services while falling under specific MAGI ABP exemptions and, as such, states will be required to provide all state plan services to these individuals, including LTSS. In these instances, estate recovery and other rules would apply, as detailed below.

Estate Recovery, Medicaid Liens, and Transfers of Assets

CMS states that in most instances, the rules of Section 1917 of the Social Security Act, which outlines under what circumstances states are required to pursue estate recovery, as well as policies on Medicaid liens and transfers of assets, will apply to MAGI individuals receiving Medicaid LTSS.

- Under estate recovery rules, MAGI individuals under the age of 55 will not be subject to estate recovery.
- Individuals over the age of 55 when they received medical assistance, however, will not be exempt from estate recovery rules. Under Section 1917, states must seek recovery from the estates of these MAGI individuals age 55 and older for "amounts at least equal to medical assistance….for nursing facility services, home and community based services (HCBS), and related hospital and prescription drug services."

  However, it is important to note that the CMS letter clearly views estate recovery as a potential barrier to Medicaid enrollment and intends to "explore options and use any available authorities" to eliminate estate recovery for anything other than LTSS for this MAGI group.
- Under Section 1917, states are permitted to place liens on real property owned by Medicaid beneficiaries who are residents of nursing facilities, intermediate care facilities, or other medical institutions. However, CMS has determined that the conditions of Medicaid liens are dependent on the rules for "post-eligibility treatment of income" or PETI rules. At this time, PETI rules do not apply to MAGI individuals and, as such, any MAGI individual receiving LTSS may not have liens placed on their property.
- Section 1917 also addresses the transfer of assets from individuals receiving Medicaid LTSS, including rules such as a "look-back" period on assets transfers. CMS has concluded that asset transfer rules should apply to MAGI eligible individuals receiving LTSS who meet the definition of "institutionalized," as well as those defined as "non-institutionalized" in states that have opted to apply asset transfer rules to the non-institutionalized LTSS population.

Future CMS Review of PETI Rules

As mentioned above, the current post-eligibility treatment of income (PETI) rules do not currently encapsulate the MAGI population, and as such, liens do not apply to the MAGI population and MAGI individuals under 55 are exempt from estate recovery rules. PETI is the process that determines an individual's available income, after deductions for personal needs, to contribute to the cost of institutional or community-based LTSS. While the CMS letter states that the current statutes do not capture MAGI

individuals, the authority exists to expand PETI rules to the MAGI population. The CMS letter indicates that because of "equity reasons," the administration is considering rulemaking to adjust PETI for MAGI individuals receiving LTSS.

While this would likely expand the scope of estate recovery and Medicaid liens in the MAGI population, the overall impact would still only apply to those limited MAGI populations receiving LTSS due to eligibility or a state ABP providing LTSS.

Link to CMS State Medicaid Directors Letter (February 21, 2014)

HMA Medicaid Roundup

Arkansas

Community Health Centers Face Financial Pressure from the State's Private Option. On February 21, 2014, Kaiser Health News reported on the financial pressures facing Arkansas community health centers due to the implementation of a Medicaid "private option" in the state. While nearly 200,000 Arkansans will be eligible for Medicaid under the new health care law, private plans pay significantly lower rates to community health centers than does traditional fee-for-service Medicaid. Federal approval of the state's waiver included a request that Arkansas negotiate a new payment system for its 12 health centers, although no such agreement has yet been forged. While Arkansas Medicaid Director Andy Allison argues that health centers will see fewer uninsured patients under the new health care law, health center officials believe that they will treat among the sickest and poorest patients, requiring higher reimbursements to do so. The future of the private-option Medicaid expansion plan remains uncertain in the state's legislature. Read more.

California

HMA Roundup—Alana Ketchel

California reinstates dental coverage for all adults on Medicaid. On February 20, 2014, Kaiser Health News reported on the restoration of adult dental benefits under Medi-Cal. In June 2013, Governor Jerry Brown signed into law a measure that restores adult dental benefits to Medi-Cal recipients, includes some preventive and restorative procedures, with limits on extractions and root canals, and no coverage for partial dentures and implants, which had been covered until five years ago. Approximately 1.6 million adults currently on Medi-Cal and 1.3 million more new Medi-Cal recipients will qualify for Denti-Cal, bringing the total number of people covered by the program to 10 million by June 2015 and raising the cost of the program from $682 million to $942 million. Dentists, however, continue to face among the lowest Medicaid reimbursement rates in the country, compounded by a 10 percent Medi-Cal provider cut in rates. Read more.

Covered CA Exceeds Enrollment Goals. On February 19, 2014, KQED's "State of Health" reported that 828,638 people have signed up for private insurance through the exchange as of February 15. The state's original goal had been 500,000 to 700,000 by the end of March. The rate of Latino enrollment showed modest improvement with 7 percent of enrollees indicating Spanish as their primary language through January 31. However, Spanish speakers make up close to 30 percent of the state's population. Covered California recently launched a new marketing campaign targeting the Latino population. Read more

Assembly Bill to Extend Medicare/Medicaid Rate Parity Introduced. On February 24, 2014, Assembly member Richard Pan introduced a bill (AB 1759) to continue the Affordable Care Act's parity provision indefinitely. The provision guarantees that Medicare and Medi-Cal pay the same rates for primary care services. The bill makes the provision permanent only if "federal financial participation is available". The American Academy of Family Physicians supports the measure. Read more

Covered CA Enrollment Portal Reopens. Covered California reopened its online enrollment portal on Monday, February 24th after taking it down Wednesday due to technical glitches. The provider directory remains offline. Read more

Duals Demonstration Schedule Proceeding as Planned. Despite advocates' request for delay, enrollment in Cal MediConnect will proceed as planned. This week, notices are scheduled to go out to roughly 92,000 individuals eligible for both Medi-Cal and Medicare in Riverside, San Bernadino and San Diego counties for May 1 enrollment. These notices will include a "choice form" in which recipients can elect to opt out of the demonstration program and remain in fee-for-service Medi-Cal or be passively enrolled into a managed care plan. San Mateo has an April 1 passive enrollment date while the other four participating counties are delayed until at least July. Read more

NSCLC Report Asserts California is Behind in Assisted Living Regulations. Last week, the National Senior Citizens Law Center distributed a report highlighting the need for California to update its assisted living regulations to keep pace with a changing industry. NSCLC asserts that the state's assisted living law, enacted in 1985, has only been intermittently amended, resulting in the state falling behind other states in terms of standards of care, resident rights, and accountability. Read more.

Provider Shortage Could Impact Exchange Plan Pricing. On February 23, 2014, the San Jose Mercury News reported that certain groups of providers are demanding higher rates to participate in exchange plan networks. The state requires that insurers allow customers access to primary care physicians within 15 miles or 30 minutes of their homes and that insurers maintain certain physician-to-patient ratios. Therefore, in rural areas of the state where there is a physician shortage, providers have increased leverage in plan negotiations. While some plans have already restored payment rates for these rural providers, it is unclear what impact this may have on plan pricing. A spokesman for Anthem Blue Cross stated that if medical costs continue to rise, premiums for exchange plans are also likely to rise in the future. Read more

Colorado

HMA Roundup—Joan Henneberry

Health Care Cost Study Group tackles cost drivers. On February 19, 2014, Health News Colorado reported that state Insurance Commissioner Marguerite Salazar convened the Health Care Cost Study Group, which includes industry representatives, health policy cost experts and consumers. The Colorado resort region, which includes Aspen, Vail and Garfield and Summit counties, feature the country's highest health premiums. Earlier this year, Salazar decided not to change Colorado's geographic rating system, but has asked the study group to offer a proposal by May 2014 to lower health costs and premiums. Read more.

Connecticut

Connecticut offers its model insurance exchange marketplace to struggling states. On February 24, 2014, the New York Times reports that Connecticut will begin selling its online insurance marketplace services to states that have struggled with their own exchanges this year. Kevin Counihan, chief executive of the Connecticut exchange, said that the exchange's technology will be licensed and sold as an "exchange in a box" to other states. Several states have expressed interest in starting or revamping their own marketplaces using Connecticut as a model. The Obama administration supports Connecticut's efforts to share its technology and hopes this might help more states run independent exchanges by 2015 or 2016. Read more.

Delaware

Delaware MCO RFP Bidder's Conference Attendees List Published. Delaware held a pre-bidder's conference on Friday, February 14, 2014, for parties interested in bidding on the joint Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) RFP. DSHP is the state's traditional Medicaid managed care program, while DSHP Plus provides managed care to Medicaid aged, blind, and disabled individuals, dual eligibles, and long term care users. Combined, the two programs serve around 180,000 beneficiaries. The parties in attendance at the pre-bidder's conference included representatives from:

- Magellan
- Gateway
- AmeriHealth Caritas
- Christiana Care Health System
- Delaware Physicians Care, Inc. (Aetna)
- Riverside Health
- Highmark BCBS
- UnitedHealthcare
- Hewlett Packard

RFP responses are due to the state on April 4, 2014, with contracts going live on January 1, 2015. The HMA Weekly Roundup reviewed the Delaware RFP on February 5, 2014, available here.

District of Columbia

False DC Medicaid claims for home care result in at least $75 million in fraudulent payments. On February 20, 2014, federal prosecutors charged 25 people for fraudulent Medicaid claims charged to the District of Columbia. These home-care firm owners, nurse staffing agencies, home-care aides, and patient recruiters were accused of convincing patients to fake illnesses so that the healthcare providers could bill for home-care services that were never provided. The authorities say that some patients were given kickbacks for their roles. U.S. Attorney Ronald Machen states that Medicaid billings for home care septupled in seven years to $280 million in 2013 and that Medicaid fraud in the District had reached "epidemic levels." Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Senate President could kill new house bill for advanced practice nurses. On February 24, 2014, Health News Florida discusses Florida Senate President Don Gaetz's opposition to a new house bill that would give advanced-practice nurses more authority over patient care. The bill would allow advanced practice nurses to see patients without direct physician supervision and to prescribe controlled drugs. The bill has the potential to address the shortage of primary care physicians in the state and to promote collaboration between doctors and nurses. Gaetz claims he will vote against the bill if it gets to the Senate floor, which would effectively kill the legislation. He argues that primary-care shortages can be alleviated by increasing the number of seats in medical residency programs, a suggestion supported by the Florida Medical Association. The bill's chief author, physician and House representative Cary Pigman, says the government should not play favorites "when there are no demonstrated nor compelling public safety concerns" regarding the legislation. He cites that 23 states have allowed nurses to independently practice with no major complications. The potential rejection of this bill echoes the Medicaid expansion proposal put forth by the Senate last year, which was killed by House Speaker Will Weatherford. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia governor promotes state proposal that requires legislative approval for Medicaid expansion. On February 24, 2014, thinkprogress.org reported that Georgia Governor Nathan Deal is promoting GOP-sponsored state bill, HB 990, which would require lawmakers to give legislative approval for any Medicaid expansion plan. The Deal administration explains that since legislators are responsible for passing the state budget, they should have a say regarding Medicaid expansion. But critics say that federal dollars will supply 100 percent of funds for Medicaid expansion for the first three years, meaning the state Medicaid budget will be unaffected by taking on Medicaid expansion. In a state with Republican majorities in both legislative houses, Georgia will likely not see Medicaid expansion if HB 990 is passed. Read more.

Senate panel passes bill mandating autism coverage. On February 21, 2014, Georgia Health News reports that the Senate Insurance and Labor Committee has recently passed three health-related bills, one of which mandates private insurance coverage for treatment of children with autism. Committee Chairman Tim Golden was the lead sponsor of SB 397, which dictates that treatment costs would be covered up to $35,000 per year for each child. Children are eligible for this coverage until age 6. Golden states that the Department of Public Health is also working on a pilot program aimed at early diagnosis of autism and intervention. Autism prevalence in Georgia is higher than the national average, and the state is one of just 16 states that does not have a mandate for autism therapy. The bill will now be sent to the Senate Rules Committee before heading to the Senate floor for consideration. Read more.

Illinois

HMA Roundup – Andrew Fairgrieve and Erika Wicks

Passages Hospice Closes in Wake of Federal Investigation. Passages Hospice LLC announced this week that it would cease business operations due to CMS halting all Medicaid and Medicare reimbursements following an investigation into one of Passages' co-owners for inappropriate billing for hospice services. Passages, based in Lisle, Illinois, was serving approximately 550 hospice patients, who have since been transferred to other facilities. Crain's Business Chicago is reporting that some of these transferred patients have been deemed ineligible for hospice care. Read more.

Medicaid Advisory Committee Meeting Set for March 7, 2014. The next meeting of the Illinois Medicaid Advisory Committee (MAC) will be held on March 7, 2014, at 10 am Central. MAC meetings are held in both Springfield and Chicago. Link to Agenda.

Maine

Maine considering providing emergency dental care to adult Medicaid recipients. On February 24, 2014, the Anchorage Daily News reports that low-income adults in Maine could gain dental coverage for the first time through Medicaid. Currently, only pediatric dental care is covered by Medicaid. The proposal, which is now being considered by Maine lawmakers, is meant to "reduce uncompensated emergency room treatment for dental pain" and other problems caused by poor oral health. Read more.

Maryland

Maryland terminates contract with Noridian due to problematic healthcare marketplace site. On February 24, 2014, The Washington Post announced the termination of the contractor that built Maryland's $193 million online health insurance marketplace. The Maryland Health Benefit Exchange ended its contract with Noridian Healthcare Solutions and has now contracted Optum/QSSI to repair the system's issues. Read more.

FY 2015 Budget: HMA reviewed Maryland's FY 2015 operating budget for Medical Care Programs. Key highlights include:

- A proposed 12.2 percent increase ($886 million) in the operating budget over FY 2014, which consists of a 15.6 percent increase in federal funds (attributable to the ACA Medicaid expansion) and a 6.1 percent increase in State general funds.
- The Budget includes the following proposed rate changes:
    - Managed care organizations: The FY 2014 rate setting process resulted in a recommended rate increase of 6.8 percent of which 2.0 percent is to cover the costs of a new annual tax included as part of the ACA. The proposed budget would reduce the rate increase by 1.0 percent for the six month period beginning July 1, 2014.
    - Inpatient/outpatient: +1.65 percent
    - Nursing homes: +1.725 percent
    - Waiver services: +2.5 percent (effective January 1, 2015)

  - Personal care services: +2.5 percent (effective January 1, 2015). The funding supports an increase in rates from $10.22 to $11.75 an hour.

- A proposed six-month temporary extension in eligibility redeterminations due to issues with the new Health Insurance Exchange ($5.2 million). The budget document acknowledges that the Maryland health Insurance exchange (HIX) is unable to convert income data from the existing Medicaid enrollment system (the Client Automated Resource and Eligibility System (CARES)) into the MAGI calculation needed to do redeterminations because of a variety of system architectural flaws. CARES cannot do these redeterminations because it does not have the new MAGI rules. Medicaid has proposed a six-month delay in eligibility redeterminations. Thus, an individual that would have been redetermined in January 2014 will now be redetermined in July 2014.
- Other notable items:
  - In calendar 2011, Maryland's managed care organizations (MCO) outperformed their peers on 75 percent of the nationally recognized measures used by the department to measure MCO performance.
  - There is a lengthy discussion of the Medicaid Enterprise Restructuring Project (MERP) which is designed to replace the legacy MMIS system. The replacement project began in 2008 and is estimated to cost over $185 million. The current estimated go-live date is September 2015 thought based on the certain issues with the fiscal agent subcontractor, CSC, this date is considered unrealistic. Like many MMIS projects, the MERP has faced many complex challenges which have resulted in a fractured relationship between the state and CSC. In fact, CSC has filed a $62 million claim against the state while the state is holding CSC to meeting certain requirements or it will consider the contract in default. If the requirements aren't met, the state is considering an alternative solution involving CNSI which is currently a subcontractor to CSC on this project.

Massachusetts

HMA Roundup—Rob Buchanan

MassHealth restores dental coverage to low-income adults. On February 20, 2014, The Berkshire Eagle reports that Massachusetts' "MassHealth" Medicaid system will restore adult dental coverage on March 1. The coverage applies to over 800,000 low-income adults around the state, who lost most dental services after Medicaid budget cuts in 2010. Read more.

Minnesota

Legislative Auditor report calls for better coordination of prisoner health services. On February 20, 2014, Minnesota Public Radio discussed a Minnesota Legislative Auditor report which concludes that health services in state prisons must be better coordinated. The report, presented by Joel Alter and Legislative Auditor Jim Nobles, investigates the Department of Corrections' handling of inmate medical, dental, and mental health needs. While Minnesota's prison population has one of the lowest mortality rates in the nation, the report shows that the state still has not developed a way to manage prisoners with chronic conditions. The Legislative Auditor's office also

notes that low mortality might not be a strong metric for quality of care, and that some prison deaths are the result of "service delivery problems." The Legislative Auditor has suggested making prison mortality data more publicly available or creating a state corrections ombudsman, but Corrections Commissioner Tom Roy says he already provides prisoners with a "significant voice" to address their concerns. Read more.

Missouri

Chamber of Commerce Offers Medicaid Expansion Proposal. On February 20, 2014, St. Louis Public Radio discussed a new proposal presented to the Missouri Chamber of Commerce to expand Medicaid. The proposal, filed by Representative Noel Torpey, would tap into federal subsidies the Republican-controlled General Assembly had previously declined to accept for fiscal and philosophical reasons. The legislation would expand Medicaid coverage to working adults who earn less than the federal poverty level. The state currently provides Medicaid coverage only to adults making no more than 19 percent of the poverty level. The proposal will expand coverage to hundreds of thousands of Missourians and will help keep many rural and urban healthcare centers open. Read more.

Nebraska

Nebraska HHS Committee passes Medicaid expansion bill to full legislature. On February 24, 2014, The Grand Island Independent announced that Nebraska's Health and Human Services Committee has voted to send a Medicaid expansion bill to the full legislature for debate. The new proposal builds on last year's Medicaid bill, which stalled in the Legislature, by making use of private insurance, cost-sharing and wellness incentives. Governor Dave Heineman says that he and other conservative state senators still oppose Medicaid expansion. Read more.

Nevada

Nevada insurance exchange director resigning. On February 21, 2014, The Wall Street Journal reports on the resignation of Nevada insurance exchange director Jon Hager. Hager has recently sited technical problems with the state's exchange process and is the fifth exchange director "in the 14 states that opted to run their own exchanges" to be leaving his position. Nevada has one of the highest proportions of uninsured residents in the country. Read more.

New Jersey

HMA Roundup—Karen Brodsky

Governor Christie Budget Highlights for FY 2015. On February 25, 2014, Governor Chris Christie gave his SFY15 budget (2015 Budget Proposal) address, entitled "Attitude of Choice," to the New Jersey Legislature. The FY14 annual budget stands at $33 billion and the Office of Legislative Affairs in the Treasury Department reports that mid-way through the fiscal year, revenues collected have lagged the Administration's projections by $331 million. The proposed FY15 budget is $34.5 billion, an increase of about 4.2 percent from the previous year. Ninety-four percent of the increase was attributed to pensions, health benefits, and debt service. Key budget hearing items include:

- A $2.25 billion pension payment
- $9 billion in direct aid to schools
- An additional $4.5 million in funding to expand New Jersey's mandatory drug court program and funding for an innovative substance abuse treatment program that integrates employment services
- **An increase in Medicaid spending, from $3.95 billion to $4.16 billion**
- Acknowledged existing reforms to advance Medicaid and its managed NJFamilyCare program including:
    - Pursuing a three year accountable care organization pilot program;
    - Continued expansion of Medicaid to give more residents at or near the poverty line access to critical health services, while saving New Jersey taxpayers approximately $181 million in fiscal year 2015 and covering nearly 300,000 residents;
    - Funding for children in NJFamilyCare will increase by $21 million to over $143 million, and will support coverage for over 194,000 children;
    - The Medicaid 1115 waiver, which allows New Jersey to pursuing managed long term services and supports, includes a $125 million increase to deliver high quality care under a new Managed Long Term Supports and Services (MLTSS) system, allowing seniors to stay in their homes and communities rather than nursing homes. Keeping individuals from entering an institutional setting will offset the cost of these new services, providing appropriate care in the least restrictive environment possible;
    - Called upon Rutgers Biomedical and Health Sciences, University Hospital, and Rutgers Camden, to join with New Jersey's Medicaid managed care organizations to help innovate and improve health care delivery under Medicaid and NJFamilyCare beyond studying how to improve care for "super-utilizers" for the federal government to a focus on New Jersey; and
    - Advancing prevention, by protecting increased funding for cancer screening and increasing funds for newborn screening under Emma's Law.
- $2.3 billion for higher education, an increase of $159 million, or almost 8 percent above last year
- $985.1 million in state hospital funding, which is unchanged from SFY14, although it shifts $25 million from Charity Care to University Hospital
- Continued transition to a new formula for the distribution of Charity Care that focuses on predictability, equitability, transparency and accountability. Hospitals will receive $650 million in Charity Care payments in fiscal year 2015.
- No direct plans to reduce or increase taxes, although tax changes are included such as the extension of the state's 7 percent sales tax to Internet sales by out-of-state retailers
- The budget is based on a 5.8 percent increase in estimated revenue.

Read more Here and Here.

Exchange Grant May Be At Risk. In February 2012, New Jersey received a grant from Centers for Medicare and Medicaid Services (CMS) to help build an insurance exchange. However it failed to submit an acceptable plan to DHSS by the February 19, 2014 deadline for how it would use the funds. The state received the grant two years ago for use in building a state insurance exchange. After Governor Chris Christie announced a year later that the state would opt for a federal marketplace, rather than a state-run, state and federal officials began discussions about how the money could be spent. State Department of Banking and Insurance (DOBI) Commissioner Kenneth E. Kobylowski wrote to U.S. Secretary of Health and Human Services Kathleen Sebelius, "In short, we find ourselves with preliminary approval to use a small portion of this grant in ways that are unnecessary while we are unable to use the bulk of this funding to meet needs that are urgent and growing ever greater as we approach the end of the initial enrollment period". The state wanted to use the grant to cover the additional costs incurred by its NJ FamilyCare call center to respond to the increase in questions about Medicaid Expansion. The state Office of Consumer Protection handles marketplace questions for New Jersey residents and has not experienced a high call volume. Read more

New York

HMA Roundup—Denise Soffel

New York Enrollments Top 500,000. According to the New York State of Health, as of February 25, 2014, more than 800,000 New Yorkers had completed applications for health insurance, with 501,205 enrolled in coverage. Since October, 276,681 New Yorkers were enrolled in private plans on the exchange, while 224,524 were enrolled in Medicaid. About 70 percent of the private plan enrollees have qualified for subsidies to cover plan premiums. Read more

State and Federal Authorities Settle with Radiology Group for $15.5 Million in Fraudulent Claims. On February 25, 2014, the Associated Press published an article that features a $15.5 million settlement by a Long Island radiology practice with federal and New York state officials. Doshi Diagnostic Imaging Services and Diagnostic Imaging Group will pay $2.9 million to New York State's Medicaid program, $190,000 to New Jersey's Medicaid program, and $12.4 million to the Medicare program to resolve claims that the practice submitted false claims for diagnostic claims that were unnecessary, not ordered, or not performed from 1999 to 2010. Read more

Ohio

Ohio planning to process 160,000 frozen Medicaid applications. On February 22, 2014, the Columbus Dispatch reported that 160,000 Ohio Medicaid applications that were frozen during the enrollment process will be processed. The applications were originally submitted on the HealthCare.gov website, but computer problems prevented them from being transferred to the state for processing. While many applicants might have refiled with the state after having problems with online enrollment, state and county officials recognize that they must follow up on all frozen applications to ensure all applicants receive coverage. The applications will first be sorted by state officials before being sent to county Job and Family Services departments for processing. Read more.

Pennsylvania

HMA Roundup – Matt Roan

For-Profit Nursing Homes Request Additional Funding, Cite Decreasing Profit Margins. According to a study by Washington DC based Avalere Health released last week by the Pennsylvania Health Care Association (PHCA), profit margins for freestanding skilled nursing facilities have decreased 63 percent between 2007 and 2012 falling from 3.2 percent to 1.2 percent. PHCA, which represents for-profit nursing homes contends that the shrinking of already thin margins leaves many facilities on the brink of bankruptcy. One major factor contributing to the lower profit margins, according to PHCA, are low Medicaid reimbursement levels that fail to cover the cost of rendering care. They report that the average facility loses $25.92 per day on residents covered by Medicaid. Facilities that have more than 75 percent of residents on Medicaid have average profit margins of only 0.3 percent. PHCA has requested that the Legislature add $16 million in state funding to support Medicaid nursing home payments. Read more

South Dakota

South Dakota House rejects Medicaid expansion. On February 24, 2014, the Argus Leader announced that South Dakota's House of Representatives has rejected Medicaid expansion in a 50-19 defeat. Democrats that put forth the bill reasoned that in addition to providing thousands of uninsured with healthcare coverage, the influx of federal funds would boost the state's economy and lead to millions of dollars in tax revenue. The majority of Republicans opposed the bill, some because of objections to increasing the nation's deficit and others because the proposal does not allow South Dakota to design its own expansion plan independent from the federal government. The House also rejected the original bill, which proposed a state-funded healthcare plan for low-income workers with full-time employment. Read more.

Utah

Proposal for a Medicaid expansion alternative debuts for full House consideration. On February 24, 2014, the Salt Lake Tribune reported on the Republican-backed proposal for an alternative to Medicaid expansion, which was debuted this week for debate by the full House as part of a larger bill that proposes additional regulatory changes. Democrats and Utah's Republican Governor Gary Herbert object to the "Access Utah" plan, as it "costs more and would offer leaner coverage to fewer people than options put forward earlier by a legislative task force that studied the matter for over a year." Access Utah forgoes the $500 to $600 million in federal funding the state would have received for federal Medicaid expansion and instead plans on spending state funds to subsidize commercial insurance for some Utahans in the Medicaid coverage gap. The sickest adults and parents with dependents would receive the first subsidies, and any leftover funds would provide subsidies to others in the coverage gap. Lawmakers will determine how much money will be allocated to the plan, which will therefore determine how many people in the gap receive subsidies. Read more.

Wyoming

Wyoming Medicaid expansion bill fails in Senate. On February 21, 2014, a major attempt to get a compromise Medicaid expansion bill through the Wyoming state Legislature failed in the Senate. The bill's sponsor, Senator Chris Rothfuss, claimed the bill would save the state $80 million over four years while bringing in $400 million and providing health care to 17,600 uninsured residents. Read more.

National

Exchange Enrollments Reach 4 Million. On February 25, 2014, the Los Angeles Times reported that health exchange enrollments, nationwide, have reached four million, implying about 700,000 sign-ups in February. However, the Obama Administration has not yet disclosed how many of those who selected coverage have paid the premiums, or the likelihood of reaching the Administration's target of 7 million in 2014. Officials plan to maintain aggressive outreach efforts to encourage enrollment during the open enrollment period, which ends at the end of March. Read more.

Few Americans Opting for Bronze Level Plans. On February 20, 2014, Bloomberg News reported that few Americans have selected "bronze" level plans, generally the cheapest coverage option available on health exchanges. The majority of consumers have selected the mid-level "silver" plans, which benefits from cost-sharing subsidies that keep both premiums and deductibles low. While every tier of insurance plans receives a federal subsidy for premiums, only the silver plans receive a subsidy to reduce deductibles and co-payments. Only 19 percent of enrollees chose bronze plans, compared to 62 percent who chose silver. Read more.

Innovative Medicaid Delivery Alternatives Analyzed. On February 24, 2014, the Pew Charitable Trusts profiled the various ways states are pursuing enhanced federal Medicaid matching funds through state-specific program designs. New Hampshire and Pennsylvania have taken steps to emulate the successful efforts of Arkansas, Michigan, and Iowa in crafting programs with cost-sharing elements, premium assistance for private plans, and other benefit tweaks. In addition, Tennessee and Indiana continue dialogues with HHS to guide and approve of their own versions of the "private option." Utah, Virginia, Missouri, and Montana are profiled in the article. Read more

Governors Agree "Obamacare" is Here to Stay. On February 24, 2014, the Washington Post highlighted the common interests among governors of both parties, despite lingering ideological differences over Medicaid expansion and the Affordable Care Act. There is general bipartisan agreement that the ACA is here to stay, and that it would be "complicated, if not impossible," to repeal the law. With millions of beneficiaries qualifying for new health plans nationally under the law and enhanced federal matching funds that are being left on the table, Iowa Governor Terry Branstad characterized his efforts as "trying to make the best of a bad situation". Read more.

Financial Impact of New Healthcare Laws Vary Across Industries. On February 24, 2014, the Wall Street Journal profiled the expected effect of the ACA on different industry segments based on earnings transcripts from 80 public firms. Overall, media and advertising companies and staffing and outsourcing firms are enjoying more spending from healthcare clients. Many large employers are spending more on insurance benefits for full-time employees and training for part-time employees. Meanwhile, insurance companies are anticipating financial hits due to new covered populations skewing older and more expensive. Read more.

INDUSTRY NEWS

WellPoint General Counsel and Executive Vice President John Cannon Dismissed. According to an SEC 8K filing, WellPoint Inc. terminated General Counsel John Cannon on February 19, 2014, "without cause". Cannon will remain with the company until March 3, 2014. Cannon had served as the company's executive vice president and general counsel since December 2007, as well as interim CEO for seven months from 2012 to 2013. Read more

WellCare Chief Financial Officer Tom Tran to Step Down. On February 21, 2014, WellCare Health Plans announced that CFO and Senior Vice President Tom Tran would be stepping down from his position when a successor has been named, or by November 30, 2014. Tran agreed to assist in the transition to a new CFO. Read more.

Brookdale Senior Living and Emeritus Senior Living Sign Definitive Merger Agreement. On February 20, 2014, Emeritus Senior Living and Brookdale Senior Living announced a merger agreement to create "the only nationwide network of senior living communities with fully integrated ancillary services across the continuum of care." The consolidated company will boast nearly 113,000 units in 1,161 communities, spanning 46 states. Read more.

Tenet Healthcare Reports Fourth Quarter Results; Expects 15 Percent Reduction in Uninsured Volumes. On February 25, 2014, Tenet Healthcare reported fourth quarter and year-end 2014 financial results. With the Vanguard Health Systems operations included, Tenet reported quarterly revenues of $3.89 billion, up 67 percent from the prior year, and a net loss of $24 million, or ($0.24) per share. However, adjusted for acquisition costs and one-time charges, Tenet posted net income of $43 million, or $0.43 per share, down from the prior year's fourth quarter EPS of $0.60. CFO Daniel Cancelmi said that the company expects a 15 percent drop in its uninsured volumes, with 10 percent of those patients gaining Medicaid coverage and five percent gaining private coverage on the exchanges. Read more

HCPEA Names New President. On February 25, 2014, the Healthcare Private Equity Association announced the election of Michael Dal Bello as its next President. Dal Bello, who currently works with Pritzker Group Private Capital, will succeed current HCPEA President Joseph Ibrahim of The Riverside Company on July 1, 2014. HCPEA is a trade organization that promotes healthcare private equity investing as a means to strengthen the healthcare economy. Read more.

RFP CALENDAR

Date	State	Event	Beneficiaries
February 21, 2014	Texas NorthSTAR (Behavioral)	RFP Release	840,000
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
March 7, 2014	Georgia ABD	Proposals Due	320,000
March 21, 2014	Puerto Rico	Proposals Due	1,600,000
April 1, 2014	Maryland (Behavioral)	Proposals Due	250,000
April 1, 2014	California Duals	Passive enrollment begins	456,000
April 4, 2014	Delaware	Proposals Due	200,000
April 8, 2014	Texas STAR Health (Foster Care)	RFP Release	32,000
April 11, 2014	Puerto Rico	Contract Awards	1,600,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
May 1, 2014	Texas NorthSTAR (Behavioral)	Proposals Due	840,000
June 1, 2014	Illinois Duals	Passive enrollment begins	136,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 6, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June 12, 2014	Delaware	Contract awards	200,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
July 1, 2014	Michigan Duals	Implementation	70,000
July 1, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
Late October 2014	Texas STAR Kids	Proposals Due	200,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Ohio Duals	Passive enrollment begins	115,000
January 1, 2015	Washington Duals	Passive enrollment begins	48,500
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982						7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	3/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho	Capitated	22,548	X	TBD	August 2013			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
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	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013			TBD	
South Carolina	Capitated	68,000	X			10/25/2013	2/1/2014	7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**12 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Contributes to HHS Congressional Express Lane Eligibility Report

HMA Contributors:

Jennifer Edwards – Managing Principal
Eileen Ellis – Managing Principal
Rebecca Kellenberg - Subcontractor
Diana Rodin – Senior Consultant
Sharon Silow-Carroll – Managing Principal

The U.S. Department of Health and Human Services recently submitted a final independent evaluation of the Express Lane Eligibility (ELE) policy to Congress. Health Management Associates and The Urban Institute worked with Mathematica Policy Research to conduct this multi-year review. The final report to Congress examines how different states implemented ELE, estimates the impact of ELE adoption on total enrollment, takes a look at enrollment and renewal trends along with administrative costs and/or savings, and reviews service utilization. **Link to Congressional Report.**

As part of the evaluation process, HMA's Jennifer Edwards and Diana Rodin also produced a Case Study of Massachusetts' Express Lane Eligibility Processes. **Link to Massachusetts Case Study.**

HMA Upcoming Appearances

"Transforming Medicaid: What it Means for States and Your Audience"
Association of Health Care Journalists – Health Journalism 2014
Joan Henneberry – Presenter
March 29, 2014
Denver, Colorado

"HIT: Creating Connectivity Between Jails and Communities"
Health Reform and Criminal Justice: Building Connectivity Conference
Capri Dye – Panelist
April 4, 2014
Wilmington, Delaware