

HEALTH MANAGEMENT ASSOCIATES  
**HMA Weekly Roundup**

Trends in State Health Policy

..... January 15, 2014 .....



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## IN FOCUS

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### IN FOCUS: OHIO'S MULTI-PAYER PAYMENT AND DELIVERY SYSTEM REDESIGN VISION REVIEWED

This week, our *In Focus* section reviews Ohio's State Health Care Innovation Plan, which was released at the end of October 2013 and targets payment and delivery system reforms built around patient centered medical homes (PCMHs) and a transition to episode-based payment models. The State Health Care Innovation Plan was prepared by Governor John Kasich's Office of Health Transformation (OHT) under the State Innovation Model (SIM) process that many states have undertaken. The vision for system redesign expands the state's existing Medicaid PCMH program over the coming years, both geographically and into the commercial insurance market, while encouraging participation and alignment from Medicare as well. Simultaneously, the state will begin to integrate episode-based payment models into the reimbursement structure, with a targeted goal of 50 percent of all care reimbursed under the episode-based model. Combined, the

state is targeting 80-90 percent of the population to be in some form of value-based health care payment model within five years. Below, we highlight the structure and timing for these two innovations as well as explore state estimates on near-term and long-term return on investment (ROI).

### **Patient Centered Medical Homes (PCMH)**

The PCMH model attributes or assigns an individual to a specified provider, known as the medical home. The medical home's goal to manage patient care, achieve better health outcomes, and reduce avoidable incidents and costs. Ohio already has undertaken significant efforts through pilots and other PCMH activities that lay the ground for successful implementation in the state. These include:

- The Center for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative
- A PCMH education pilot project
- The Ohio Patient-Centered Primary Care Collaborative
- Several community collaborations between public health and primary care

The PCMH model will be fostered through three distinct payment streams and incentives:

1. Payments and incentives to support provider business transformation, particularly for smaller medical practices. These payments will be targeted on short-term investments to transform provider practice into one that works effectively within the PCMH model.
2. Payments for services and other activities not currently reimbursed by Medicaid, including care coordination, non-traditional visits, and population health management.
3. Bonus payments, shared savings, or capitation models that reward to providers for favorably impacting risk-adjusted total costs of care over a period of time.

The state of Ohio will implement the PCMH model in three waves over the next five years. Wave 1 has already begun with the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care initiative in the Cincinnati and Dayton regions. Wave 2 is set to begin in mid-2014 and will expand the PCMH model in these two regions to include all willing provider, as well as expanding to an additional to-be-determined region and rural counties in these regions. Wave 3 would begin in mid-2015 and expand to all urban and rural markets in the state.

### **Episode-Based Payment Model**

Under an episode-based payment model, a single provider or provider entity will be held accountable for the full spectrum of care across all services and providers for a defined episode. The goal is to focus on coordination throughout an episode of care rather than focusing on specific visits or procedures. Ohio has estimated that between 50 and 70 percent of spending across commercial insurance, Medicare, and Medicaid may potentially be addressed through episode-based payments.

Under Ohio's design for the episode-based payment model, providers will continue to submit claims and receive fee-for-service (FFS) payments as they currently do. Providers will be evaluated over a performance period during which average cost will be calculated across all episodes of care. These average costs will be compared to established "abso-

lute threshold levels.” Providers who are above the acceptable level of spend will be subject to risk-sharing, while providers below the “commendable” level of spend will receive an incentive payment. The episode-based payment model will also include episode-specific quality measures, which may be tied to the overall payment structure.

Ohio’s long-term goal is to have 50 percent of health care spending tied to episode-based payments. The state will lead this effort where it can. Medicaid FFS providers will begin to receive performance information on a regular basis in 2014 and episodes will be included in Medicaid Managed care Organization (MCO) contracts. The state will encourage MCOs to pursue episode-based payment models in their other lines of business (i.e., commercial and Medicare). Ohio plans to design 20 episodes for the episode-based payment model over the next three years.

#### **Return on Investment**

Ohio is anticipating making significant near-term investments into the PCMH and episode-based payment models but anticipates significant return on investment (ROI) across all payers.

- The state anticipates potential savings of 1 to 2 percent in medical inflation and between 4 and 10 percent savings in reduced medical waste from the PCMH program over a 4 to 7 year timeframe.
- Episode-based payment models could potentially achieve 0.5 to 1.5 percent savings in medical inflation and 6 to 12 percent savings in reduced medical waste over a 2 to 4 year timeframe.
- Due to the state’s ability to impact the Medicaid program directly, Ohio anticipates the potential for \$400 million in net Medicaid savings in the first three years of implementation.
- Within the Medicaid population, Ohio has modeled an anticipated ROI of 5 to 10 times upfront costs and 7 to 15 times upfront costs across all payers.



## HMA MEDICAID ROUNDUP

### *California*

#### HMA Roundup – Alana Ketchel

**Court Confirms State Can Reduce Payment to Medi-Cal Providers.** A 10 percent cut in payment for Medi-Cal providers will remain as the Supreme Court denied hearing an appeal to a Ninth U.S. Circuit Court decision on January 13, 2014. State legislators approved the cut in June 2011 as an emergency budget reduction, but the cut did not take effect until January 2014 due to legal battles. The Governor, in his proposed 2014-2015 budget, exempted most doctors and hospitals from having to make retroactive payments to the state. However, according to an article by the *San Francisco Chronicle*, pharmacies will have to reimburse the state, and Medi-Cal payments for durable supplies will also be cut retroactively to the June 2011 date. [Read more.](#)

**Governor's Budget Shows Little Movement on Health Care.** On January 10, 2014, the Governor released his proposed budget for the 2014-2015 fiscal year. Due to the state's healthier financial outlook, some predicted that Brown would reverse the previous years' budget cuts such as the 10 percent Medi-Cal provider payment reduction. However, Brown did not restore payment to providers or replenish cut health care programs. The budget proposal does include funds for expansion of existing Medi-Cal benefits as well as support for California's In-Home Supportive Services. Chris Hoene of the California Budget Project predicts there may be room for negotiation before the budget is finalized. [Read more.](#)

**California Insurance Exchange Enrolls Close to 500,000.** On January 13, 2014, the US Department of Health and Human Services reported that nearly 500,000 people have so far selected health insurance through Covered California. The state's enrollees makes up 22 percent of the nation's 2.2 million enrollees. The report stated that 25 percent of Covered California's enrollees are young adults under the age of 34, which is lower than the administration's target of 40 percent. Larry Levitt of the Kaiser Family Foundation posited that the rate at which young adults are enrolling may still be sufficient to keep premiums low for the broader population. There are two months remaining in the open enrollment period. [Read more.](#)

**Lawmakers Address Assisted Living Home Missteps.** California legislators announced 12 bills aimed at improving care and patient safety in assisted living facilities on January 13, 2014. This was in response to September reports by UT-San Diego and the California HealthCare Foundation Center for Health Reporting that detailed abuse and neglect at the facilities and highlighted regulatory weaknesses that allowed abuses to persist. Some of the legislators' proposals would increase the fines

for offenses, require facilities to carry liability insurance, and increase transparency around facility violations. [Read more.](#)

**Proposed Bill to Provide Undocumented Immigrants Access to Insurance.** On January 10, 2014, State Senator Ricardo Lara (D-Bell Gardens) announced his intent to introduce a bill allowing undocumented immigrants access to health coverage. Lara's policy alternatives include creating a program that would offer state insurance subsidies, further expanding Medi-Cal, or implementing a temporary health insurance program, like one in Los Angeles, that is not supported with federal dollars. [Read more.](#)

## Colorado

### HMA Roundup – Joan Henneberry

**Connect for Health Colorado Reached Low-End Enrollment Target.** Over 50,000 individuals have purchased plans through December 2013, ranking Colorado fifth in the country for the number of people enrolled per capita. The breakout of enrollees includes 53 percent women and 47 percent men and, 22 percent of the enrollees are between the ages of 18 and 34 years. Connect for Health reports they will ramp up their efforts to increase the enrollment of the younger populations, although local advocacy groups have been highly criticized for some of their advertising to this population. Colorado has also enrolled 86,432 people into Medicaid during this open enrollment period.

## District of Columbia

**DC Issues MMIS Case Management RFI.** The District of Columbia Department of Health Care Finance is has issued a request for information (RFI) soliciting information for an implementation and training vendor that will provide a high-quality, beneficiary-centric, case management solution that is compliant with the framework, goals and objectives of Medicaid Information Technology Architecture (MITA), version 3.0. Questions are due to the state on January 22, 2014, with RFI responses due on February 5, 2014.

## Florida

### HMA Roundup – Elaine Peters and Gary Crayton

**Florida Sees December Surge in Marketplace Enrollment.** Enrollment reports indicate that roughly 140,000 Florida residents signed up for a qualified health plan through the federal Marketplace enrollment portal in December 2013, roughly eight times the total number of enrollees in the previous two months combined. Florida enrollment in Marketplace plans sits at an estimated 158,000. [Read more.](#)

**Florida Republicans Turn to Other Health Care Issues as Democrats Continue Work on Medicaid expansion.** As the 2014 legislative sessions begins, the *Tampa Bay Times* reports Florida republicans are looking to address health care issues such as providing more independence for highly trained nurses, increasing the number of medical students who go into primary care, and regulating virtual doctor visits. However, Florida democrats have pledged to continue to work on a solution to expand Medicaid in the state that could win enough republican votes. [Read more.](#)

**Florida Governor Appoints Lieutenant Governor.** On Tuesday, January 14, 2014, Florida Governor Rick Scott announced the appointment of Carlos Lopez-Cantera to the position of Lieutenant Governor, effective February 3, 2014. [Read more.](#)

## Georgia

### HMA Roundup – Mark Trail

**Governor’s State of the State Address Affirms State Independence on Medicaid.** Governor Nathan Deal made his State of the State address on January 15, 2014, asserting that the state will not be pressured into expanding Medicaid by the federal government, citing the current cost of Medicaid on taxpayers and the potential size of the expansion population.

**Legislative Committee on Medicaid Reform Releases Final Report.** The Joint Study Committee on Medicaid Reform issued its report last week, concluding that a premium assistance model for expanding Medicaid coverage, like those in Arkansas and Indiana, requires greater understanding as it pertains to the long-term impacts and costs for Georgia before it could be implemented. The report calls for actions to address physician shortages and workforce issues, but does not recommend specific actions.

**Demonstrators Push for Medicaid expansion, as Poll Shows Majority Support.** An estimated 200 people protested outside the Capitol on January 13, 2014, calling for the legislature to approve an expansion of the state’s Medicaid program. Meanwhile, a poll conducted by the Atlanta Journal-Constitution released on January 12 indicated that 57 percent of the state supports expanding Medicaid. [Read more.](#)

## Idaho

**Idaho Sues Home Meal Delivery Service for Nearly \$1 million in Medicaid Fraud.** Idaho announced a lawsuit against Homestyle Direct, a provider of home-delivered meals for the state’s Medicaid program, alleging nearly \$1 million in improper Medicaid billings. The state says bills were submitted for delivered meals that did not qualify for Medicaid reimbursement. [Read more.](#)

## Illinois

### HMA Roundup – Andrew Fairgrieve

**Illinois Announces Duals Demonstration MCO County Participation.** At the state’s Medicaid Advisory Committee meeting on Friday, January 10, 2014, the Department of Healthcare and Family Services (HFS) announced plan participation by county for the state’s capitated dual eligible financial alignment demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI). Highlights of the announcement are provided below:

- Aetna Better Health has dropped out of Lake County in the Greater Chicago region.
- HealthSpring and Meridian have dropped out of Kankakee County in the Greater Chicago region.
- Three plans have county participation approval on hold and have been given the ability to resubmit network documentation in May 2014:
  - Aetna Better Health in Kankakee (Greater Chicago)
  - Meridian in DuPage and Lake (Greater Chicago)

- Molina in McLean, Sangamon, Macon (Central Illinois)
- Several plans also will be monitored in certain counties where limited access to one provider type may exist.
- Humana and BCBS of Illinois were the only plans to fully pass all counties in the Greater Chicago region.

HFS also announced the start date for voluntary enrollments is March 1, 2014, with passive enrollment now pushed to June 1, 2014.

**Accountable Care Entity RFP Bidders Announced.** Illinois HFS has announced the list of bidders who have responded to the Accountable Care Entity (ACE) RFP by the January 3, 2014 due date. ACEs are newly envisioned provider-organized care coordination entities that will operate alongside traditional Medicaid MCOs beginning July 1 of this year. ACEs will initially receive a monthly care coordination fee but must transition to full-risk arrangements over a period of three years. ([Link to Bidders List](#)) The 11 bidders who submitted proposals are listed below:

- Access Community Health Network/HealthCura
- Accountable Care Chicago, LLC
- ACE Care Services
- Advocate Physician Partners ACE
- Alexian Brothers Health System/Population Health of Illinois, LLC
- Chicago Southside ACE
- Illinois Partnership for Health
- Loyola University Health System ACE
- NorthShore University HealthSystem/NorthShore Physician Associates
- St. Mary's Good Samaritan Hospital/Illinois Coordinated Care Network
- Trinity Community ACE

## Indiana

### HMA Roundup – Catherine Rudd

**Indiana Legislator to Introduce Medicaid Expansion Bills.** Indiana State Senator Karen Tallian (D-4<sup>th</sup> District) has announced she will introduce two bills to expand Medicaid in the state. Senator Tallian is urging republican legislators to “just say yes” to the Federal funds the expansion would bring in, arguing that Indiana tax dollars are funding expansions in neighboring states. [Read more.](#)

**Indiana Announces Healthy Indiana Plan will Enroll All Eligible Individuals on Waitlist.** Indiana's Family and Social Services Administration (FSSA) has announced that all eligible individuals currently on the waiting list for the Healthy Indiana Plan (HIP) will be enrolled this year. FSSA determined roughly 3,400 individuals on the waiting list are currently eligible and that the program has capacity for an additional 17,000 individuals this year. [Read more.](#)

## Kansas

**Kansas Hospital Association Working on Medicaid Expansion Plan.** The *Associated Press* is reporting this week that the Kansas Hospital Association is working on an alternative Medicaid expansion model for the state, although Governor Sam Brownback and fellow republicans are reportedly wary of such a move. The Hospital Association has hired Leavitt Partners, led by former Utah Governor Mike Leavitt, to design an alternative expansion model. Last year, the Kansas legislature voted to prohibit any expansion of Medicaid through June of 2015. [Read more.](#)

## *Louisiana*

**Former DHH Secretary Part of Coalition to Push Medicaid Expansion.** Former Louisiana Department of Health and Hospitals (DHH) Secretary David Hood is part of a coalition of Medicaid expansion supporters who will advocate for the passage of expansion legislation in 2014, according to the Associated Press. However, Hood has acknowledged that republican legislative opposition—and the threat of a veto by Governor Bobby Jindal of any bill that did pass—limit the hope for a Medicaid expansion in the state under the current legislature and administration. [Read more.](#)

## *Maine*

**Maine Democrats to Renew Push for Medicaid Expansion.** The Maine legislative session began January 8, 2014, with democrats announcing a renewed push for Medicaid expansion legislation. The democrat-controlled legislature expects continued opposition from Governor Paul LePage, who vetoed expansion legislation passed in last year's session. [Read more.](#)

**DHHS Announces It Will Not Extend Contract with NEMT Provider.** Maine's Department of Health and Human Services (DHHS) has announced it will not extend its contract with Connecticut-based Coordinated Transportation Solutions when it expires in June 2014. Coordinated Transportation Solutions provides Medicaid non-emergency medical transportation (NEMT) services under a \$28.3 million contract that began in August of last year. Medicaid beneficiaries have reported missed appointments, late rides, and poor call center performance since the contract began. [Read more.](#)

## *Maryland*

**Maryland's Hospital Spending Control Program Receives Federal Approval.** Maryland announced last week that it has received federal approval for a program that will cap total hospital spending across Medicaid, Medicare, and commercial insurance payers and set a limit that total spending amount can grow from year to year. Statewide hospital revenue for inpatient and outpatient services will grow by no more than 3.85 percent annually. Maryland has operated a hospital price-setting program for over 30 years, under which all hospitals are reimbursed at the same rate for services, regardless of payer. [Read more.](#)

## *Minnesota*

**State Marketplace Turns to United's Optum for Website Help.** Minnesota-based UnitedHealth's subsidiary Optum has been tapped by the state's health insurance Marketplace, known as MNsure, to help resolve issues with the enrollment system that is preventing some residents from enrolling in a qualified health plan. Optum is providing this work without cost and is not, at this time, under contract with MNsure. [Read more.](#)

## *New Hampshire*

**New Hampshire House Passes Medicaid Expansion Bill, Unlikely to Garner Senate Support.** Last week, New Hampshire's democrat-majority House passed a bill to expand Medicaid in the state. However, the bill is not expected to pass the republican-majority Senate. [Read more.](#)



## New Mexico

**New Mexico Primary Care Shortage Could Worsen in 2014.** New Mexico, already facing a shortage of primary care providers, could see a worsening situation in 2014 as new enrollees in Medicaid and Marketplace plans seek out providers. The *Albuquerque Journal* reported in the past week that all but one county in the state has been designated by the federal government as facing a shortage in primary care providers. *Modern Healthcare* reports that the Legislative Finance Committee has proposed diverting \$11.6 million to increasing medical residencies and loan repayment programs and medical education funding. [Read more.](#)

## New York

### HMA Roundup – Denise Soffel

**Fully Integrated Duals Advantage Update.** New York State shared some new details about its duals demonstration program, which will be establishing Fully Integrated Duals Advantage (FIDA) plans in eight downstate counties. Voluntary enrollment will begin in July 2014. If an individual does not select a plan or chooses to opt out of the demonstration, they will be passively enrolled in a FIDA plan beginning in September 2014. The state is working on a phasing plan for enrollment and expects implementation will take four to five months. MAXIMUS, the state's enrollment broker, will be responsible for helping individuals in plan selection. Plans will have no role in eligibility determination, plan selection, or the enrollment process. As of July, any new duals will be enrolled in a FIDA plan as their default option. They will have the option of opting out to join and MLTC of fee-for-service Medicare.

As a result of feedback from stakeholders, the state has introduced some changes to the Interdisciplinary Team (IDT) policy. These changes are designed to add more flexibility to the process, including allowing the nurse who performed the initial assessment being allowed to participate as a member of the IDT, identifying the FIDA plan care manager as the leader of the IDT, changing the timing of assessments for individuals currently enrolled in an MLTC to 60 days while maintaining the 30-day window for new enrollees, and delaying the universal credentialing requirement for all providers until the second year of the demonstration. New York will be using a Universal Assessment System that will incorporate social, functional, behavioral, wellness and prevention domains, caregiver status and capabilities, and member preferences and goals. Reassessments must be performed at least every six months. Decisions about the care plan cannot be modified by the FIDA plan, although decisions made by the IDT are appealable by the member or by any provider.

Twenty-three plans are in the Readiness Review process. Desk reviews are on-going; site reviews will begin this week. Networks are being reviewed for network adequacy, and plans will be provided the opportunity to correct any deficiencies identified. The state is working with CMS to finalize the enrollment process, and to develop an outreach and education campaign, including marketing materials and notices. The state is also finalizing the elements of the quality assurance plan as well as policies related to the consolidated appeals and grievances processes.

**New York Health Exchange Enrollment.** New York State of Health (NYSOH), the Official Health Plan Marketplace, released a [report on enrollment](#) representing information on individuals who enrolled through December 24, 2013, the cut-off for signing up for coverage as of January 1, 2014. As of December 24, 2013, 464,318 indi-

viduals had completed applications, and 230,624 people had enrolled in a health plan through the Exchange. Seventy-three percent enrolled in a Qualified Health Plan (QHP) while 27 percent enrolled in Medicaid. Among the Medicaid enrollments, 20 percent are newly eligible as a result of the ACA Medicaid expansion; 80 percent were already eligible under New York's previous Medicaid eligibility levels (150 percent federal poverty level [FPL] for parents, 100 percent FPL for childless adults). Note this only includes individuals who enrolled through the Exchange and does not include individuals who applied for Medicaid through their local district social services office. Among enrollments in QHPs, 44 percent were uninsured at the time of enrollment. The most recent enrollment numbers indicate that total enrollment through the Exchange has increased to 294,595 as of January 12, 2014.

The bulk of enrollment occurred outside New York City. The city accounted for 37 percent of all enrollments, with the rest coming from Long Island (21 percent), the Hudson region and the North Country (20 percent), the central region (15 percent), and the western part of the state (7 percent). This distribution does not track with the state's population, as over 42 percent of New Yorkers live in New York City, and fewer than 15 percent live on Long Island.

Sixteen plans are participating on the Exchange. Six of those generated 10 percent or more of total enrollment: Empire, Health Republic, Fidelis, Emblem, MetroPlus, and MVP. Excellus represented six percent of enrollment; the other nine plans each represented one to two percent of QHP enrollees.

NYSOH enrollees are choosing to enroll in higher-tier plans. Twenty-nine percent of total enrollment is in Platinum or Gold plans; eighteen percent is in Bronze plans, and only two percent in catastrophic plans. Thirty percent of enrollees are under the age of 35 years and 53 percent are female.

**New York Health Exchange Senate Hearing.** The New York State Senate Committees on Health and on Insurance held a hearing on "New York State of Health: A Discussion on Implementation" on January 13, 2014. Donna Frescatore, Executive Director of the Exchange, provided an update on Exchange operations. The republican committee chairs raised a number of questions and concerns, many of which had to do with small businesses whose policies had been cancelled as they were not compliant with ACA benefit requirement. Senators wanted to know how many policies had been cancelled and what alternatives these small businesses were finding through the Exchange. Ms. Frescatore noted that prior to the ACA, 15,000 different small business policies existed in New York, that she did not know how many individual policies had been cancelled, and that offerings through the Exchange were comparable to many of the small business policies outside the Exchange. She pointed out that any insurer participating in the Exchange had to offer a policy at each metal tier, providing a significant degree of choice. Other concerns were raised about the fact that virtually all plans offered through the Exchange do not include an out-of-network benefit (except in cases of medical necessity) making it difficult for consumers to select a plan that includes all their providers and potentially leaving consumers at risk of unexpected bills. A representative from the Medical Society of the State of New York noted that physicians remain confused about participation in Exchange plans and are concerned about payment rates in those plans. The hearing can be replayed through a link on the state senate [health committee web site](#).

## North Carolina

**North Carolina's Ongoing MMIS Issues Impact Medicaid Budgeting.** It was revealed this week at the legislature's Joint Legislative Oversight Committee on Health and Human Services that ongoing technical issues with NCTracks, the state's Medicaid payment management system, have impacted Medicaid budget forecasting. Issues with the NCTracks system have contributed to a lack of Medicaid cost and utilization data. [Read more.](#)

## Oregon

**Moda Health Plan Leading Enrollment in Cover Oregon.** According to Cover Oregon, the state's health insurance Marketplace, Moda Health Plan leads all qualified health plans with more than 9,600 out of nearly 13,700 completed enrollments as of January 4, 2014, nearly 70 percent of the market. Cover Oregon's enrollments were significantly delayed due to issues with the web-based enrollment portal when enrollment went live in October 2013. [Read more.](#)

## Pennsylvania

### HMA Roundup – Matt Roan

**Senate President Introduces Legislation Aimed at Welfare Fraud.** State Senator Joseph Scarnati (R-Jefferson) has introduced legislation proposing steeper penalties and more rigorous asset tests targeted at addressing welfare fraud. The proposed bill includes provisions that would increase the criminal penalties for receiving fraudulent benefits, impose higher fees for lost food stamp cards, and capping the value of vehicles that are excluded from asset tests at \$35,000. Opponents of the measure say that the new measures would add bureaucratic barriers to those in need who are seeking food stamps, cash assistance, and Medicaid. They also point out that the measures would place further administrative burdens on the Department of Public Welfare which has been struggling with slower application processing times with a staff already stretched thin. Senator Scarnati pointed out that he has received overwhelming feedback from constituents that people are receiving benefits undeservedly and that the measure is needed to protect the taxpayers who support these programs. [Read more.](#)

**Legal Disputes Over Tobacco Settlement Funds May Jeopardize State Funding Stream.** A recent court ruling could reduce funds paid to Pennsylvania through the tobacco settlement by as much as 75 percent. A panel of arbitrators found that Pennsylvania did a poor job enforcing terms of the settlement and, as a result, the tobacco companies are justified in reducing their payments. The arbitrators focused on enforcement activities in 2003 only, but the tobacco companies have said that they plan on returning to arbitration to see if they can reduce payments further for other years when state enforcement activities were insufficient. As a result of the ruling Pennsylvania stands to lose approximately \$242 million in tobacco settlement funds, which would be deducted from an expected payment in April. The implication of potential rulings related to years beyond 2003 could result in the state receiving hundreds of millions of dollars less than expected from the settlement between now and 2025. Programs supported with tobacco settlement funds in Pennsylvania that are likely to be impacted include home and community based services and Medicaid coverage for workers with disabilities. [Read more.](#)

**Robert Wood Johnson Foundation Grant to Support ACA Enrollment in Pennsylvania.** Amid lackluster enrollments through the Federal Health Insurance Marketplace and with only three months remaining in the initial open enrollment period, the Robert Wood Johnson Foundation has awarded a \$340,000 grant to several Pennsylvania organizations to hire and train certified application counselors. The organizations receiving funding operate under a consortium called InsurePA, which is led by the Philadelphia non-profit Public Health Management Corp. InsurePA plans to hire six counselors and recruit 50 volunteer counselors with a goal of providing enrollment assistance to at least 15,000 people in the state. Efforts will be focused in the Pittsburgh and Philadelphia metropolitan areas where nearly 40 percent of the state's uninsured residents reside. [Read more.](#)

### *Virginia*

**Governor Terry McAuliffe Sworn In, Makes Pitch for Medicaid Expansion.** Governor Terry McAuliffe took office this weekend and in his inaugural address made clear that Medicaid expansion would be one of his key legislative priorities this year. Medicaid expansion was a key election issue in the Governor's race last year. [Read more.](#)

### *National*

**Omnibus Spending Bill Targets ACA funding.** The \$1 trillion omnibus spending bill working through the House and Senate this week will cut roughly \$1 billion from the Prevention and Public Health fund as well as \$10 million in funding for the Independent Payment Advisory Board. [Read more.](#)

**HHS Announces Extension of High Risk Insurance Pool.** On January 14, 2014, the US Department of Health and Human Services (HHS) announced the extension of the Pre-existing Condition Insurance Plan through March 31, 2014. The plan was previously scheduled to end at the end of January. HHS extended the plan to allow those enrolled to complete enrollment in qualified health plans through the Marketplaces. [Read more.](#)



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## INDUSTRY NEWS

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**WellPoint CEO States Optimism on Marketplaces.** In statements made at a JP Morgan-hosted conference in San Francisco, California this week, WellPoint CEO Joseph Swedish was very optimistic regarding WellPoint's status in the 14 state Marketplaces in which the company is participating. Swedish did not state WellPoint's total Marketplace enrollment numbers. "Despite the near-term uncertainty, we believe exchanges will be growing as a big part of the market over time," Swedish said, as quoted by Kaiser Health News. [Read more.](#)

**WellCare Filing Reveals Kentucky to Adjust MCO Rates for Provider Fee Impact.** In an 8-K filing last week, WellCare indicates that it has received a contract amendment from the state of Kentucky, indicating it will make adjustments in the MCO rates for the ACA's Health Insurance Provider Fee. The contract amendment will "incorporate the impact of the fee not being allowable as a deduction for purposes of determining federal and state income taxes."

**Centene Appoints Massachusetts Plan CEO.** Centene's Massachusetts subsidiary, Celticare Health Plan, has officially named Jay Gonzalez to the position of plan CEO. Gonzalez, formerly the state's Secretary of Administration and Finance, had been serving as the plan's senior vice president and chief development officer for the past nine months. Celticare Health Plan serves individuals in the MassHealth and Health Connector programs. [Read more.](#)

**Blue Shield of California to Purchase GEMCare.** On January 7, 2014, the *San Francisco Business Times* reported that Blue Shield of CA agreed to purchase GEMCare, a 20,000-enrollee health plan based in Bakersfield, California. GEMCare, previously owned by Dignity Health, has 8,000 Medicare enrollees and 12,000 commercial or group health enrollees in Kern County and the Central Coast region. The acquisition still requires state and federal approval. [Read more.](#)

## RFP CALENDAR

| Date              | State                              | Event                     | Beneficiaries |
|-------------------|------------------------------------|---------------------------|---------------|
| January, 2014     | Delaware                           | RFP Release               | 200,000       |
| January 22, 2014  | Texas NorthSTAR (Behavioral)       | RFP Release               | 406,000       |
| February 1, 2014  | Florida LTC (Regions 5,6)          | Implementation            | 19,538        |
| February 27, 2014 | Georgia ABD                        | Proposals Due             | 320,000       |
| March 1, 2014     | Florida LTC (Regions 1,3,4)        | Implementation            | 18,971        |
| April 1, 2014     | California Duals                   | Passive enrollment begins | 456,000       |
| April 1, 2014     | Ohio Duals                         | Passive enrollment begins | 115,000       |
| April 17, 2014    | Texas NorthSTAR (Behavioral)       | Proposals due             | 406,000       |
| May 1, 2014       | Virginia Duals                     | Passive enrollment begins | 79,000        |
| May 1, 2014       | Florida acute care (Regions 2,3,4) | Implementation            | 681,100       |
| June 1, 2014      | Illinois Duals                     | Passive enrollment begins | 136,000       |
| June 1, 2014      | Florida acute care (Regions 5,6,8) | Implementation            | 811,370       |
| June 30, 2014     | Delaware                           | Contract awards           | 200,000       |
| 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 7, 2014      | Texas NorthSTAR (Behavioral)       | Contract Awards           | 406,000       |
| August 1, 2014    | Florida acute care (Regions 1,7,9) | Implementation            | 750,200       |
| September 1, 2014 | New York Duals                     | Passive enrollment begins | 178,000       |
| September 1, 2014 | Washington Duals                   | Passive enrollment begins | 48,500        |
| September 1, 2014 | Texas Rural STAR+PLUS              | Implementation            | 110,000       |
| November 3, 2014  | Georgia ABD                        | Implementation            | 320,000       |
| January 1, 2015   | Hawaii                             | Implementation            | 292,000       |
| January 1, 2015   | Tennessee                          | Implementation            | 1,200,000     |
| September 1, 2015 | Texas NorthSTAR (Behavioral)       | Implementation            | 406,000       |

## DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

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

| 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 |
| 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           | 7/1/2014                 | 9/1/2014                |   |
| North Carolina | MFFS                           | 222,151                            |              |  |                     |                     |                          | TBD                     |   |
| Ohio           | Capitated                      | 114,000                            | X            | 5/25/2012                              | 6/28/2012           | 12/11/2012          | 60 days prior to passive | 4/1/2014                | 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        | Capitated                      | 22,000                             | X            | TBD                                    | TBD                 |                     |                          | 1/1/2015                |   |
| Washington     | Capitated                      | 48,500                             | X            | 5/15/2013                              | 6/6/2013            | 11/25/2013          | 7/1/2014                 | 9/1/2014                | Regence BCBS/AmeriHealth; UnitedHealth  |
| Washington     | MFFS                           | 66,500                             | X            |  |                     | 10/24/2012          |                          | 7/1/2013;<br>10/1/2013  |   |
| Wisconsin      | Capitated                      | 5,500-6,000                        | X            | Not pursuing Financial Alignment Model |                     |                     |                          |                         |   |
| <b>Totals</b>  | <b>13 Capitated<br/>6 MFFS</b> | <b>1.5M Capitated<br/>485K FFS</b> | <b>11</b>    |  |                     |                     |                          | <b>8</b>                |   |

\* 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.

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## HMA NEWS

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### *HMA Teams to Assist New ACO Awardees*

In late December 2013, CMS announced approval for 123 new Accountable Care Organizations (ACOs) to participate in the Medicare Shared Savings Program, providing approximately 1.5 million more Medicare beneficiaries with access to high-quality coordinated care across the United States. ([Link to Announcement](#)).

In response to the CMS announcement, HMA has formed teams of professionals – including clinicians, former state and federal health care administrators, and experts in managed care, provider models, finance, and Health Information Technology – who have extensive experience working with Medicare ACOs and other provider organizations navigating changes from volume-based to value-based care. For more information on the services that HMA can provide, please visit HMA's Accountable Care Institute at [www.accountablecareinstitute.com](http://www.accountablecareinstitute.com).

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*Health Management Associates (HMA) is an independent health care research and consulting firm.*

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