HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 7, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

TEXAS SUBMITS UNCOMPENSATED CARE EVALUATION TO CMS

This week, our *In Focus* section reviews the independent evaluation of Texas' Uncompensated Care Pool submitted to the Centers for Medicare and Medicaid Services (CMS) by the Texas Health and Human Services Commission (HHSC). The evaluation, which was required under the Special Terms and Conditions (STCs) of the State's Section 1115 waiver, was completed by Health Management Associates colleagues Dianne Longley, Gaylee Morgan, Tom Marks, Steve Perlin and Mary Goddeeris.

Background

In December 2011, the HHSC received federal approval of the Texas Healthcare Transformation and Quality Improvement Program Waiver. The plan extended managed care, addressed concerns related to preservation of Texas' hospital safety net, and facilitated a critical transformation of the health care safety net from one driven by volume to one driven by value. A focal point within the waiver was funding for both a Delivery System Reform Incentive Payment (DSRIP) program and an Uncompensated Care program (UC Pool). Five-year funding authorized for the two statewide pools includes $17.6 billion allocated

for the UC Pool and $11.4 billion for DSRIP. The waiver expires in September 2016, but has been authorized for a 15-month extension.

Consistent with the approach it has taken in other states that operate uncompensated care pools, CMS required Texas to commission a detailed analysis of the state's uncompensated care costs, payments and the impact of environmental factors and potential policy changes. Pursuant to the waiver Special Terms and Conditions (STCs), the report includes the following:

1. A detailed description of the composition of current Medicaid hospital payments.
2. Analysis of Medicaid financing and how the non-federal match is funded.
3. Estimated cost incurred by hospitals to provide services to Medicaid beneficiaries compared to the cost to the corresponding payments received.
4. Estimated cost of uncompensated care provided by hospitals and the portion of uncompensated care attributed to charity care.
5. Analysis of the adequacy of Medicaid payments in relation to cost incurred by hospitals.
6. Analysis of Texas Medicaid payment adequacy relative to other states.[1]
7. Assessment of recent economic and environmental trends within Texas that may impact future reimbursement levels and the cost of caring for low-income populations.
8. Estimated financial impact of: 1) implementing a Medicaid expansion for low-income adults; 2) Medicaid DSH reductions required by the Affordable Care Act (ACA); 3) reestablishing supplemental upper payment limit (UPL) payments; and 4) fully funding Medicaid hospital costs through payment rates.

Key Findings

Texas hospitals face a large and growing uncompensated care burden. In FY 2015, the net costs of uninsured care for all hospitals participating in the UC Pool, prior to supplemental pool payments, were estimated at $5.2 billion. When Medicaid shortfall is included, unreimbursed costs grow to $8.7 billion in FY 2015. Before supplemental payments are considered, the payment to cost percentage across all hospitals is 48.4 percent. After the application of Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments as offsets to cost, the payment to cost percentage across the participating hospitals increases to 58.8.

Unreimbursed Hospital Costs, FY 2015

Amounts in billions	FY 2015
Total uninsured care	$5.20
Total Medicaid shortfall	$3.50
Total uncompensated care before supplemental payments	$8.70
Percentage of cost paid before supplemental payments	48.40%

[1] Note that this portion of the analysis and report were completed by Deloitte Consulting.

GME and DSH payments	$1.80
UC Pool payments	$2.90
Total unreimbursed Medicaid and uninsured after supplemental payments	$4.00
Percentage of cost paid after supplemental payments	76.30%

Applying UC Pool payments as an additional offset to costs increases the payment to cost percentage to 76.3 percent. While this represents a significant improvement in the coverage ratio relative to base payments only, it is important to note that even after applying UC Pool payments, Texas hospitals still face approximately $4 billion in remaining unreimbursed cost, including $1.8 billion in Medicaid shortfall and $2.2 billion in net uninsured cost.

Source of data. The analysis relied primarily on data collected from 356 hospitals participating in the Texas Medicaid DSH/UC Pool program using the State's audited reporting tool. The Medicare cost report S-10 worksheet was evaluated but ultimately discarded for the purpose of determining uninsured cost. While the S-10 has been the best publicly available source of hospital financial information for decades, it has shortcomings, gaps and variances that are described in detail in the report and that were noted in CMS' recent decision to delay the use of the S-10 for Medicare reimbursement policy.

Defining and estimating uncompensated care. Federal and state policies have consistently used all unreimbursed uninsured cost (including both uninsured charity care and uninsured bad debt) for quantifying uncompensated care. Using this definition, there was an estimated $5.2 billion of uninsured cost incurred in FY 2015 by Texas hospitals. The waiver STCs call for a more limited calculation of uncompensated care, however, focused on charity care and excluding bad debt. Due to significant variations in how hospitals classify charity care versus bad debt, many hospitals routinely under-report the portion of uninsured care that should be classified as charity care. Therefore, the report replicates a methodology utilized in California's recent uncompensated care analysis to impute the value of charity care based on the definition adopted by the Healthcare Financial Management Association (HFMA). After applying this "imputed charity care" factor to uninsured bad debt, an estimated $4.2 billion of the $5.2 billion of uninsured cost is attributed to charity care and the remainder is bad debt. Consistent with the principles applied across the Medicare and Medicaid programs, the entire estimate of uninsured cost less payments should be utilized for the purpose of defining uncompensated care.

Treatment of Medicaid shortfall. The STCs also specifically exclude all costs related to Medicaid shortfall from the calculation of uncompensated care cost. This provision stands in contrast to the original purpose of the UC Pool, as articulated in the STCs, to "defray the actual uncompensated costs of medical services that meet the definition of "medical assistance" contained in Section 1905(a) of the Act that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types …" The analysis includes calculations both with and without estimated Medicaid shortfall to be consistent with the original STCs as well as the reporting requirements articulated by CMS.

Medicaid Expansion and DSH Reduction impact. As of July 2016, Texas is one of 19 states that have opted not to expand their Medicaid program to low-income

adults, as allowed under the ACA. The impact of a Medicaid expansion would be an estimated $1.6 billion decrease in net uninsured cost and a $1.2 billion offsetting increase in the Medicaid shortfall. However, as of the writing of this report, Medicaid expansion in Texas does not appear to be likely in the near future.

Pursuant to the Affordable Care Act, DSH allotments are scheduled to undergo significant reductions beginning in FY 2018 based on the rationale that increased rates of coverage through Medicaid expansion and subsidized private insurance should significantly reduce the uncompensated care burden on providers. In FY 2015, DSH payments to Texas hospitals totaled $1.72 billion, which offset approximately 10 percent of uncompensated care in that year. Under the most favorable assumptions, the reductions will range from $134 million in FY 2018 to $537 million in FY 2025. Under the most unfavorable assumptions, the cuts will range from $386 million in FY 2018 to $1,543 million in FY 2025.

Importance of UC Funding. Under the current funding and reimbursement structure, Texas hospitals incur significant amounts of unreimbursed costs serving Medicaid and uninsured patients. Texas's uncompensated care burden is almost certain to grow, based on demographics, underlying market factors, and projected DSH cuts. While the implementation of a Medicaid expansion would blunt the impact to a certain degree, it would not come close to eliminating the uncompensated care burden in the state and it is unlikely to be implemented in the near future.

Summary of Hospital Unreimbursed Costs, FY 2017 Pro Forma

In Millions	Medicaid	Uninsured	Total
Unreimbursed cost, participating hospitals (1)	($3,804)	($5,517)	($9,321)
Non-participating hospitals (1)	($63)	($221)	($284)
Unreimbursed cost, before supplemental payments	***($3,867)***	***($5,737)***	***($9,605)***
GME pool (2)	$31	$0	$31
DSH pool (2)	$560	$1,162	$1,722
Unreimbursed cost, after supplemental payments	***($3,277)***	***($4,575)***	***($7,852)***
Pro forma effect, Medicaid expansion	($1,257)	$1,615	$358
Pro forma effect, DSH reductions (3)	$0	($749)	($749)
Unreimbursed cost, after pro forma adjustments (4)	***($4,534)***	***($3,709)***	***($8,243)***

(1) FY 2013 base payments and costs trended to FY 2017

(2) FY 2015 amounts, not expected to be materially different in FY 2017

(3) Represents FY 2021 estimate, assuming Texas' share of the ACA DSH reduction is the same as its current share of the federal DSH allotment

(4) Hospitals only

This pro forma analysis estimates that without payments from the 1115 waiver, Texas hospitals could incur $8.2 billion in unreimbursed Medicaid and uninsured care even after a Medicaid expansion. Including unreimbursed costs from the physician groups, ambulance providers and dental providers that currently receive a portion of the UC Pool payments adds $420 million to this amount, yielding a combined total in excess of $8.6 billion.

In the current environment, reimbursement from the 1115 waiver program helps ensure that adequate resources are available to millions of low-income Texas residents and the UC Pool provides an equitable, accountable and sustainable funding mechanism to help ensure access to care for the state's most vulnerable residents.

The report was submitted to CMS on August 31st. After reviewing, CMS will work directly with HHSC regarding any decisions or outcomes based on the report.

Link to Full Report and Executive Summary

HMA Medicaid Roundup

Alaska

Alaska Medicaid Expansion Exceeds Cost Estimates. *NewsMiner.com* reported on August 31, 2016, that Alaska's Medicaid expansion has exceeded first-year cost estimates by $30 million, raising concerns about the program's long-term impact on the state budget. The federal government will pay 100 percent of the cost of expansion through 2016; however, the state will be responsible for 5 percent in 2017 and 10 percent by 2020. Alaska expanded Medicaid on September 1, 2015, and expansion enrollment is at 20,400. Read More

Colorado

Colorado Expands Medicaid Coverage of Hepatitis C Treatment. *The Denver Post* reported on September 1, 2016, that Colorado's Medicaid program will expand coverage of high-cost hepatitis C treatment drugs for members in earlier stages of liver disease. The expansion also applies to all women trying to conceive within a year, regardless of liver disease status. Colorado has been paying for the 12-week drug treatment only for members with advanced-stage liver disease, but will begin covering it for stages two and three as well. The changes come following criticism from the American Civil Liberties Union Colorado and Denver Health medical center, as well as guidance from the state's drug review board. Approximately 14,400 Medicaid beneficiaries in Colorado have hepatitis C, 70 percent of which have stage two or higher liver disease. Read More

District of Columbia

HMA Roundup – Jessica Foster (Email Jessica)

District of Columbia on Schedule to Release Medicaid Managed Care RFP in October 2016. The District of Columbia Department of Health Care Finance (DHCF) said that it is on schedule to release a request for proposal for the re-procurement of its entire full-risk Medicaid managed care program in early October 2016. The existing contract with three Medicaid plans is entering its final year. DC is also considering whether to rebid the Child and Adolescent SSI Program as it begins its base year contract with Health Services for Children with Special Needs, the only bidder for the contract, on October 1, 2016. Separately, DHCF released its first-quarter 2016 Medicaid managed care performance report on August 24, 2016.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Approves 19 Percent Exchange Plan Rate Increase for 2017. *Politico* reported on September 2, 2016, that the Florida Office of Insurance Regulation approved an average rate increase of 19.1 percent for health insurers selling plans on and off the Exchange for 2017. The approved rates were higher than those requested by insurers in most instances. The average rate increase requested was 17.7 percent. Premiums for plans sold off the exchange received an average 14.6 percent increase. Read More

Kansas

Kansas Candidates Rethink Medicaid Expansion. *KMUW Wichita 89.1* reported on September 6, 2016, that some Kansas political candidates are pointing to the closure of Mercy Hospital in August 2015 as a reason why the state should expand Medicaid. "The refusal to expand Medicaid is part of the reason" the hospital closed, says Chuck Schmidt, a Democrat running for state Senate. Doug Blex, a Republican running for the state House, reversed his position on expansion following the closure. Meanwhile, other rural hospitals are at risk of closing as well. The Kansas Hospital Association estimates that the rejection of expansion has cost the state nearly $1.4 billion in additional federal funds. Read More

Maryland

Maryland Medicaid Drug Reimbursement to Separate Counseling, Methadone Treatment. *The Baltimore Sun* reported on September 6, 2016, that the Maryland Department of Health and Mental Hygiene will change the way it reimburses drug rehabilitation under Medicaid in an effort to incentivize providers to put more patients into counseling. Effective March, the state plans to separate outpatient counseling from methadone treatment, which are currently reimbursed under a single weekly fee. The Behavioral Health Administration recommended the change in December. The state has also proposed a reduction in methadone treatment reimbursement from $81.60 to $63 per week. The proposed regulations must be approved by the federal government prior to implementation. Read More

Massachusetts

Massachusetts Medicaid Personal Care Attendant Overtime Rule Takes Effect. Massachusetts announced on September 1, 2016, that a new rule has taken effect requiring MassHealth members to obtain approval for personal care attendants (PCA) who work overtime, defined as more than 40 hours per week. Under the new rule, members who live with their PCA must receive overtime approval annually. Read More

Nebraska

Nebraska Releases RFP for Dental Prepaid Ambulatory Health Plan. The Nebraska State Purchasing Bureau has issued a request for proposal (RFP) for a Medicaid dental Prepaid Ambulatory Health Plan (PAHP) to manage the state's Medicaid dental benefits program. The five-year, capitated contract would replace the state's existing Medicaid dental fee-for-service program for about 230,000 Medicaid enrollees. The contract would run from July 1, 2017, through December 31, 2022, with two, one-year optional extensions. A mandatory pre-proposal conference will be held on September 27, 2016, and questions regarding the RFP are due by October 3, 2016. Bidders can begin submitting proposals on October 25, 2016, with a tentative contract award date of January 3, 2017. Additional RFP attachments can be found by clicking here.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

CDC Awards Grant to Department of Health (DOH) and Substance Abuse and Mental Health Services Administration (SAMHSA) to Curb Opioid Crisis. On September 2, 2016, Governor Christie announced that DOH received a competitive grant of $727,688 to embark on a series of opioid crisis initiatives, and DHS will receive $6.9 million to target prescription and opioid misuse. DOH plans to focus on enhancements to data access and analysis, improvements in prevention planning, identifying and engagement of high risk communities, assessing the impact of state policies, and maximizing the New Jersey Prescription Monitoring Program's public health surveillance potential. DHS will receive a Strategic Prevention Framework for Prescription Drugs and launch prescription drug abuse prevention activities and education. Read More

New Jersey Zika Legislation for Medicaid Coverage is Under Review. On September 8, 2016, the New Jersey Senate Health, Human Services and Senior Citizens committee will meet and consider a bill (S-2476) by Senator Vitale to develop coverage terms for products and services that prevent and treat Zika. According to NJ Spotlight, Governor Christie vetoed a Democratic request for $5 million, although the state accepted $3 million in federal funding "to help mosquito control, testing programs, and local health efforts." Read More

GAO Report Cites New Jersey Medicaid for EHR-related Overpayments to Providers. On September 1, 2016, *NJBIZ* reported the federal Government Accountability Office (GAO) issued a report in August that found that New Jersey Medicaid incorrectly overpaid health care providers $2.3 million from February 2012 to September 2013 for their Medicaid electronic medical record initiatives. Providers qualified for incentive-based payments for implementing electronic health records. Ten out of 33 hospitals reviewed by the GAO were overpaid. About $118 million in total Medicaid EHR incentive payments were made by the Department of Human Services during this period. According to the GAO, the incorrect payment errors "occurred because the State agency's program integrity contractor failed to identify certain errors and inconsistently applied this new program's complex requirements." Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Office of Mental Health Announces Loan Repayment Program to Attract Psychiatrists to New York Psychiatric Centers. The New York State Office of Mental Health announced that applications are being accepted for the Doctors Across New York (DANY) Psychiatrist Loan Repayment Program. This incentive offers up to $150,000 in tax-free reimbursement for psychiatrists with active student loan debt who agree to serve at a New York State Office of Mental Health psychiatric center for at least five years. The DANY program is a state-funded initiative launched by the Department of Health, created in 2008 in response to the increasing physician shortage in New York State. The Office of Mental Health (OMH) has received approval for its own segment of the program dedicated to address OMH's psychiatrist recruitment and retention crisis. OMH will be providing a total of $1.5 million in funding for this program during the 2016-2017 fiscal year and will seek similar funding in future budgets. The OMH Psychiatrist Loan Repayment Program will support psychiatrist recruitment and retention at facilities where the OMH Commissioner determines there is a critical need. Read More

Medicaid Managed Care Advisory Review Panel (MMCARP) Meeting. The Medicaid Managed Care Advisory Review Panel (MMCARP) will meet in New York City on Thursday, September 29, 2016, 10:30 AM to 12:30 PM. The MMCARP, an oversight panel established by the New York State legislature, is charged with reviewing the capacity of the Medicaid managed care program to meet the needs of all Medicaid beneficiaries. An RSVP is required to attend the meeting. For more information, contact mcmeet@health.ny.gov.

Waiver Stakeholder Meeting. As part of its Care Management for All strategy, the New York Department of Health (DoH) is planning for the transition of individuals currently served by two waiver programs, the Nursing Home Transition and Diversion (NHTD) waiver program and the Traumatic Brain Injury (TBI) waiver program, into Medicaid managed care plans as of January 2018. The transition plan can be viewed here.

In order to assure a smooth transition, DoH has established a stakeholder workgroup to oversee the NHTD & TBI waiver transition planning process. DoH will be holding a workgroup meeting for stakeholders on Wednesday, September 14, 2016, from 1:00 p.m. to 3:00 p.m. The meeting is open to the public and can be attended in person or via webinar. The meeting will be at One Commerce Plaza, room 1613 in Albany. Registration is required for the webinar.

Balancing Incentive Program Funding Opportunity. The New York Office for the Aging released a Request for Applications for Partnerships to Expand and Enhance NY Connects. Authorized by the Patient Protection and Affordable Care Act (ACA), New York State's Balancing Incentive Program (BIP) has expanded the State's Aging and Disability Resource Centers (NY Connects) to broaden the populations for which it provides information, assistance and linkage to Long Term Services and Supports (LTSS). Up to six Independent Living Centers (ILCs) and/or community-based organizations will be chosen in six regions across the State. NY Connects is an essential component of the State's efforts to rebalance the LTSS system so that people can live independently and remain in their home and community. The core functions of the NY Connects program include the provision of Information and Assistance

(I&A) and Options Counseling/Person-Centered Counseling (OC/PCC) on LTSS for older adults and individuals of all ages with disabilities, as well as their caregivers; implementing an active Long Term Care Council (LTCC); and operation of an ongoing public education campaign to promote the visibility of the program. As a result of the federal Balancing Incentive Program (BIP), NY Connects has expanded its geographic reach and enhanced its functionality to broaden the populations it serves and add new partners to fully assume the required No Wrong Door (NWD) structural reform. New York State Office For the Aging (NYSOFA) will select through this RFA process up to six (6) Independent Living Centers (ILCs) and/or not-for-profit Community Based Organizations (CBOs) to perform NY Connects functions in a specified region. Further, the selected contractors will work in collaboration with the NY Connects NWD partners, including the Office for Persons with Developmental Disability's (OPWDD) Developmental Disability Regional Offices (DDROs) and the Office of Mental Health's (OMH) Local Government Units (LGUs). Applications are due September 30, 2016. Read More

Fully Integrated Duals Advantage (FIDA) Program. The New York Department of Health Division of Long Term Care will provide an update on the advertising campaign, outreach strategies, and success stories of the Fully Integrated Duals Advantage (FIDA) program, via webinar on Friday, September 16, 2016 from 2-3 pm. Registration is required.

North Carolina

North Carolina Medicaid Case Management Not-for-Profit CCNC Reports Savings. *The News & Observer* reported on September 2, 2016, that not-for-profit Medicaid case management company Community Care of North Carolina (CCNC) is touting savings from its effort to coordinate care for 1.6 million Medicaid members in the state. CCNC, which has provided case management services in North Carolina for 18 years, would lose its contract if the state moves ahead with plans to transition to full-risk Medicaid managed care. Data published by CCNC in the N.C. Medical Journal suggests that costs for North Carolina's Medicaid program were five percent below an established benchmark in 2015. A transition to Medicaid managed care would require approval by the Centers for Medicare and Medicaid Services, and a decision isn't expected until after the November elections. Either way, CCNC is expected to compete for a contract. Read More

Ohio

Ohio Home Health Agency Overpaid $4.9 Million. *The Canton Repository* reports Ohio Auditor David Yost announced an audit of Great Nursing Care, Inc. of Reynoldsburg, Oh, in which he found Medicaid overpayments totaling $4.9 million. Yost stated this is the largest Medicaid overpayment found since the auditor took office in 2011. The audit covered the time period from July 1, 2011 through June 30, 2014. Findings included a lack of, or lapses in, required first-aid certification for home health-care aides; providing services prior to physician authorization; and failure to fulfill the requirements of the initial competency evaluation. After receipt of the draft report, the provider informed the Auditor that they have ceased operations. Read More

Ohio Awarded $2 Million for Opioid Misuse and Overdose Programs. *WMFD-TV (Mansfield)* reports Ohio has been awarded nearly $2 Million in grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) to combat the opioid epidemic. The funding is designed to support ongoing work focused on reduction of high overdose death rates, and to improve toxicology and drug screening. Read More

Former Ohio Department of Aging Director Forms Advocacy Coalition. *The Columbus Dispatch* reports Barbara Riley, former Director of the Ohio Department of Aging is forming a coalition of seniors and their families to identify critical issues facing older citizens and develop solutions to address growing financial and healthcare needs, and help inform policy makers about their needs and the growing impact on the state's budget. Ohio currently spends 36 percent of its Medicaid budget on services for seniors. The coalition includes AARP Ohio, the Alzheimer's Association's Northwest Ohio Chapter, Meals On Wheels, the Ohio Assisted Living Association, the Ohio Association of Area Agencies on Aging, the Ohio Association of Gerontology and Education, the Ohio Association of Senior Centers, the Ohio Council for Home Care and Hospice, the Ohio Coalition for Adult Protective Services, LeadingAge Ohio and Pro Seniors. Read More

Study Finds Ohio Leads Nation in Institution-to-Community Transitions. *Gongwer*-Ohio reports the Ohio Office of Health Transformation has cited a Mathmatica Policy Research report that Ohio moved more than 1,600 people from institutional settings to homes in the community in 2015, more than any other state. The HOME Choice program, Ohio's version of the federal *Money Follows the Person* program, "ranks first nationally in transitioning individuals with mental illness into home-based settings and second in overall transitions completed" over its eight years, OHT said in a news update. Read More

Oklahoma

Oklahoma ABD Care Coordination Model to be Called SoonerHealth+. The Oklahoma Health Care Authority reported on August 31, 2016, that the fully capitated, statewide care coordination model for Medicaid-enrolled individuals who are aged, blind, and disabled will be called SoonerHealth+. The agency plans to release a request for proposals for the program in late 2016 following approval by the Centers for Medicare & Medicaid Services. The next stakeholder meeting to collect public comments on the program will be held on September 13, 2016.

Oregon

Oregon to Impose Minimum MLR on Medicaid CCOs. *The Register-Guard* reported on September 5, 2016, that Oregon will impose an 80 percent MLR on Coordinated Care Organizations (CCOs) serving the state's Medicaid program. The minimum MLR will rise to 85 percent by 2018, the same ratio required for Medicare plans. If a CCO fails to meet the minimum, it will have to reimburse the state the difference. The Oregon Health Authority will monitor CCO MLRs in quarterly financial reports and annual worksheets. CCOs manage publicly funded health services for low-income and disabled individuals through the Oregon Health Plan. Read More

Oregon Seeks Ability to Extend Renewal Application Deadline for Patient-Centered Primary Care Homes. The Oregon Health Authority announced on September 1, 2016, that it is seeking the flexibility in certain cases to extend the grace period to 90 days from 30 for renewal applications due January 1, 2017 for the state's Patient-Centered Primary Care Homes (PCPCH) program. During the grace period, PCPCHs would not have a lapse in their recognition status.

Tennessee

Tennessee 1115 Waiver Renewal Held Up By Uncompensated Care Discussions. *Modern Healthcare* reported on August 31, 2016, that discussions between the Centers for Medicare & Medicaid Services (CMS) and Tennessee over an extension of the state's uncompensated care funds are holding up renewal of the state's 1115 waiver. The funding mechanism, known as the Unreimbursed Hospital Cost pool, was originally authorized in 2010 as part of the state's broader 1115 waiver and equates to $500 million in annual payments to hospitals. A March 2016 report by Public Consulting Group showed that there would be $229 million in uncompensated care even if the state expanded Medicaid. The original 1115 waiver authorized Tennessee's Medicaid managed care program in 2002 and is set to expire on September 30, 2016, after two extensions have been approved by CMS. Read More

Texas

Texas Fears Budget Cuts as Medicaid Costs Rise. *The Dallas Morning News* reported on September 2, 2016, that Texas is potentially facing a $1.3 billion to $1.6 billion Medicaid budget shortfall. Texas lawmakers are expected to pass a supplemental appropriations bill along with the state's next two-year budget to provide emergency funds for Medicaid. Overall, the state is bracing for potential cuts as the state economy slows and Medicaid spending is running above expectations. While the state expects to end its current two-year budget cycle with a $4.1 billion surplus, lawmakers are concerned about the Medicaid shortfall and increased spending requests from other state agencies. Read More

National

U.S. Encourages 'Simple Choice Plan' Options for 2017 Exchanges. *Kaiser Health News* reported on September 2, 2016, that the federal government is encouraging insurers participating on the Affordable Care Act Exchanges to offer six new standardized "simple choice plan" options in 2017 to make it easier for consumers to compare plans. The six options include a Bronze, Silver, and Gold option, plus three more Silver options for individuals qualifying for cost-sharing reductions based on income. The plans have standardized deductibles and annual out-of-pocket maximums. Read More

CMS to Launch Pre-Enrollment Verification System Pilot in 2017. *The Hill* reported on September 6, 2016, that the Centers for Medicare & Medicaid Services (CMS) will launch a pilot program in 2017 to test a new "pre-enrollment verification system," which would check to ensure enrollees are eligible for health coverage on the Exchanges during Special Enrollment Periods (SEPs). SEPs allow individuals to sign up outside of open enrollment under specific circumstances, such as changing residences. The pilot comes amid insurer exits

from the Exchanges and complaints that SEPs increase costs for plans when sick enrollees use the special periods to enroll. Read More

National Health Interview Survey Finds Insurance Gains Slowing. *U.S. News* reported on September 7, 2016, that growth in the number of Americans with health insurance slowed significantly this year, according to the National Health Interview Survey from the Centers for Disease Control and Prevention. The number of uninsured declined 1.3 million during the first three months of this year, compared to a 9 million decline in 2014. Still, the current uninsured rate is at a record low of 8.6 percent. The survey also reported continued growth in penetration of high-deductible plans. Read More

Lyft, Uber Patient Transportation Pilot Programs Reduce Wait Times, Increase Access. *Fierce Healthcare* reported on September 6, 2016, that Medicaid and Medicare non-emergency transportation pilot programs that use ride-coordination software platforms like Lyft and Uber have resulted in lower costs, reduced waiting times, and increased access to care. Transportation requests made through the Uber platform are directed to a newly formed transportation company Circulation. Requests made through Lyft are directed to National MedTrans. In New York and California, Lyft was able to cut average per-ride costs by 32.4 percent and wait times by 30 percent. Read More

INDUSTRY NEWS

Mylan Medicaid Rebates for EpiPens Are Under Scrutiny. *The New York Times* reported on September 2, 2016, that two Congressional Representatives are questioning whether Mylan overcharged the Medicaid program for its EpiPen allergy treatment device. Two key Congressional representatives wrote the Secretary of the U.S. Department of Health and Human Services seeking to clarify whether EpiPen should be classified as a generic or brand name drug. Current law requires a Medicaid rebate of 23.1 percent of the average manufacturer price for brand name drugs and 13 percent for generic drugs. Mylan argues that it has complied with state and federal Medicaid laws. The letter comes amid scrutiny of Mylan for increasing the price of EpiPens from $100 to $600 since 2007. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
September 12, 2016	Rhode Island	Proposals Due	231,000
September 22, 2016	Nevada	Contract Awards	420,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Washington, DC	RFP Release	200,000
October, 2016	Massachusetts	RFP Release	860,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	119,814	34.2%	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; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	48,218	35.5%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,480	4.4%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,419	10.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**362,006**	**28.9%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

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