HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MEDICAID AND EXCHANGE ENROLLMENT UPDATE – DECEMBER 2016/JANUARY 2017

This week, our *In Focus* section reviews updated reports issued by the Department of Health & Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) on Medicaid expansion enrollment from the "*December 2016 Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report,*" published on February 28, 2017. Additionally, we review 2017 Exchange enrollment data from the "*Health Insurance Marketplaces 2017 Open Enrollment Period: Final State-Level Public Use File,*" published by CMS on March 15, 2017. Combined, these reports present a picture of Medicaid and Exchange enrollment at the beginning of 2017, representing more than 74

million Medicaid and CHIP enrollees and more than 12 million Exchange enrollees.

Key Takeaways from Medicaid Enrollment Report

- Across all 50 states and DC, Medicaid and CHIP enrolled more than 74.1 million individuals as of December 2016.
- Medicaid and CHIP enrollment is up nearly 2.4 million members since December 2015, a 3.3 percent increase in enrollment.
- From December 2015 to December 2016, six states saw double-digit percentage growth in Medicaid and CHIP – Montana (33.6 percent); Alaska (32.0 percent); Louisiana (31.4 percent); Florida (21.3 percent); Arkansas (13.0 percent); and Maryland (11.1 percent).
- During 2016, six states (Alabama, District of Columbia, Illinois, Michigan, New Hampshire, and Utah) saw enrollment growth between 0 percent and 1 percent. Meanwhile, 12 states (Delaware, Georgia, Maine, Massachusetts, Minnesota, Mississippi, New York, North Dakota, Oregon, Vermont, Wisconsin, Wyoming) saw enrollment decline across Medicaid and CHIP.
- Medicaid and CHIP enrollment is up nearly 16.3 million (more than 28 percent) from the "Pre-Open Enrollment" period, defined as July 2013 through September 2013.
- The top five states in percentage growth of Medicaid and CHIP enrollment since the Pre-Open Enrollment period are Kentucky (102.8 percent), Nevada (87.5 percent), Colorado (75.5 percent), Arkansas (70.3 percent), and New Mexico (69.3 percent).
- The top five states in percentage growth of Medicaid and CHIP among states that did not expand Medicaid are Tennessee (31.1 percent), North Carolina (26.9 percent), Idaho (25.6 percent), Florida (17.4 percent), and Missouri (15.4 percent).
- The top five states in total enrollment growth of Medicaid and CHIP are California (4.15 million), New York (712,000), Washington (693,000), Florida (642,000), and Ohio (630,000).

Table 1 – Overall U.S. Medicaid/CHIP Enrollment Growth – Pre-Open Enrollment Monthly Average through December 2016

	Number of States	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Dec. 2016)	Dec. 2016 % Change	Dec. 2016 # Change
Expanded Medicaid	32	37,867,811	51,628,843	*36.3%*	*13,761,032*
Have Not Expanded	19	20,000,576	22,537,011	*12.7%*	*2,536,435*
Total - All States		**57,868,387**	**74,165,854**	***28.2%***	***16,297,467***

Key Takeaways from 2017 Exchange Enrollment Report

- Final Exchange enrollments for the 2017 plan year, published in March 2017, showed Qualified Health Plan (QHP) plan selections of more than 12.2 million across all 50 states and DC.
- 2017 QHP selections are down nearly 466,000 from 2016 QHP selections, a decline of 3.7 percent across all 50 states and DC.

- From 2016 to 2017, six states saw double-digit percentage growth in QHP selections. Three were State-Based Marketplace (SBM) states: Minnesota (31.7 percent); Massachusetts (24.7 percent); and Washington (12.4 percent). The other three were Federally Facilitated Marketplace (FFM) states: Hawai'i (30.0 percent); South Dakota (13.9 percent); and Utah (12.3 percent).
- A total of 15 states saw declines in QHP selections between 0 percent and negative 5 percent. Another nine states saw declines of negative 5 percent to negative 10 percent. A total of 11 states saw double-digit percentage declines in QHP selections from 2016 to 2017.
- Overall, the 12 states with SBMs saw growth of nearly 2 percent from 2016 to 2017, while all other Exchange/Marketplace administration models saw declines in enrollment.

Table 2 – Overall U.S. Exchange QHP Selection Growth – February 2016 through January 2017

Marketplace Administration Model (as of 2017)	Number of States	Selected QHP (Feb. 2016)	Selected QHP (Jan. 2017)	QHP % Change	QHP # Change
State-Based Marketplace (SBM)	12	2,962,226	3,014,198	*1.8%*	*51,972*
State-Based Marketplace - Federal Platform (SBM-FP)	5	457,433	450,703	*-1.5%*	*(6,730)*
Federally Facilitated Marketplace (FFM)	28	8,352,411	7,907,022	*-5.3%*	*(445,389)*
Partnership Marketplace	6	909,804	844,080	*-7.2%*	*(65,724)*
Total - All States		**12,681,874**	**12,216,003**	***-3.7%***	***(465,871)***

The table on the following page (Table 3) provides state-level data on Medicaid and Exchange enrollment.

Medicaid and Exchange Enrollment Data Sources

Link to CMS Medicaid Expansion Enrollment Report:

"December 2016 Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report" (February 28, 2017)

Link to CMS Marketplace Open Enrollment Period Public Use Files:

"2017 Marketplace Open Enrollment Period Public Use Files" (March, 2017)

Table 3 – Medicaid/CHIP Enrollment Growth Across All States (December 2016) and Final 2017 Exchange Enrollment (January 2017)

State	Expanded Medicaid	Exchange Model	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Dec. 2016)	Dec. 2016 % Change	Dec. 2016 # Change	Selected Exchange QHP (Feb. 2016)	Selected Exchange QHP (Jan. 2017)	QHP % Change	QHP # Change
US Total			**57,868,387**	**74,165,854**	***28.2%***	***16,297,467***	**12,681,874**	**12,216,003**	***-3.7%***	***(465,871)***
Alabama	No	FFM	799,176	883,070	*10.5%*	*83,894*	195,055	178,414	*-8.5%*	*(16,641)*
Alaska	Yes	FFM	122,334	173,321	*41.7%*	*50,987*	23,029	19,145	*-16.9%*	*(3,884)*
Arizona	Yes	FFM	1,201,770	1,739,041	*44.7%*	*537,271*	203,066	196,291	*-3.3%*	*(6,775)*
Arkansas	Yes	SBM-FP	556,851	948,181	*70.3%*	*391,330*	73,648	70,404	*-4.4%*	*(3,244)*
California	Yes	SBM	7,755,381	11,901,083	*53.5%*	*4,145,702*	1,575,340	1,556,676	*-1.2%*	*(18,664)*
Colorado	Yes	SBM	783,420	1,375,041	*75.5%*	*591,621*	150,769	161,568	*7.2%*	*10,799*
Connecticut	Yes	SBM	618,700	761,310	*23.0%*	*142,610*	116,019	111,542	*-3.9%*	*(4,477)*
Delaware	Yes	Partnership	223,324	241,664	*8.2%*	*18,340*	28,256	27,584	*-2.4%*	*(672)*
District of Columbia	Yes	SBM	235,786	264,849	*12.3%*	*29,063*	22,693	21,248	*-6.4%*	*(1,445)*
Florida	No	FFM	3,695,306	4,337,514	*17.4%*	*642,208*	1,742,819	1,760,025	*1.0%*	*17,206*
Georgia	No	FFM	1,535,090	1,723,548	*12.3%*	*188,458*	587,845	493,880	*-16.0%*	*(93,965)*
Hawaii	Yes	FFM	288,357	345,724	*19.9%*	*57,367*	14,564	18,938	*30.0%*	*4,374*
Idaho	No	SBM	238,150	299,005	*25.6%*	*60,855*	101,073	100,082	*-1.0%*	*(991)*
Illinois	Yes	Partnership	2,626,943	3,099,444	*18.0%*	*472,501*	388,179	356,403	*-8.2%*	*(31,776)*
Indiana	Yes	FFM	1,120,674	1,498,978	*33.8%*	*378,304*	196,242	174,611	*-11.0%*	*(21,631)*
Iowa	Yes	Partnership	493,515	622,071	*26.0%*	*128,556*	55,089	51,573	*-6.4%*	*(3,516)*
Kansas	No	FFM	378,160	408,885	*8.1%*	*30,725*	101,555	98,780	*-2.7%*	*(2,775)*
Kentucky	Yes	SBM-FP	606,805	1,230,475	*102.8%*	*623,670*	93,666	81,155	*-13.4%*	*(12,511)*
Louisiana	Yes	FFM	1,019,787	1,415,385	*38.8%*	*395,598*	214,148	143,577	*-33.0%*	*(70,571)*
Maine	No	FFM	266,900	267,657	*0.3%*	*757*	84,059	79,407	*-5.5%*	*(4,652)*
Maryland	Yes	SBM	856,297	1,265,867	*47.8%*	*409,570*	162,177	157,832	*-2.7%*	*(4,345)*
Massachusetts	Yes	SBM	1,296,359	1,661,951	*28.2%*	*365,592*	213,883	266,664	*24.7%*	*52,781*
Michigan	Yes	Partnership	1,912,009	2,297,344	*20.2%*	*385,335*	345,813	321,451	*-7.0%*	*(24,362)*
Minnesota	Yes	SBM	873,040	1,026,547	*17.6%*	*153,507*	83,507	109,974	*31.7%*	*26,467*
Mississippi	No	FFM	637,229	675,657	*6.0%*	*38,428*	108,672	88,483	*-18.6%*	*(20,189)*
Missouri	No	FFM	846,084	976,256	*15.4%*	*130,172*	290,201	244,382	*-15.8%*	*(45,819)*
Montana	Yes	FFM	148,974	243,320	*63.3%*	*94,346*	58,114	52,473	*-9.7%*	*(5,641)*
Nebraska	No	FFM	244,600	237,567	*-2.9%*	*(7,033)*	87,835	84,371	*-3.9%*	*(3,464)*
Nevada	Yes	SBM-FP	332,560	623,574	*87.5%*	*291,014*	88,145	89,061	*1.0%*	*916*
New Hampshire	Yes	Partnership	127,082	187,129	*47.3%*	*60,047*	55,183	53,024	*-3.9%*	*(2,159)*
New Jersey	Yes	FFM	1,283,851	1,761,395	*37.2%*	*477,544*	288,573	295,067	*2.3%*	*6,494*
New Mexico	Yes	SBM-FP	457,678	775,020	*69.3%*	*317,342*	54,865	54,653	*-0.4%*	*(212)*
New York	Yes	SBM	5,678,417	6,390,438	*12.5%*	*712,021*	271,964	242,880	*-10.7%*	*(29,084)*
North Carolina	No	FFM	1,595,952	2,025,016	*26.9%*	*429,064*	613,487	549,158	*-10.5%*	*(64,329)*
North Dakota	Yes	FFM	69,980	84,587	*20.9%*	*14,607*	21,604	21,982	*1.7%*	*378*
Ohio	Yes	FFM	2,341,481	2,971,319	*26.9%*	*629,838*	243,715	238,843	*-2.0%*	*(4,872)*
Oklahoma	No	FFM	790,051	804,355	*1.8%*	*14,304*	145,329	146,286	*0.7%*	*957*
Oregon	Yes	SBM-FP	626,356	966,178	*54.3%*	*339,822*	147,109	155,430	*5.7%*	*8,321*
Pennsylvania	Yes	FFM	2,386,046	2,918,260	*22.3%*	*532,214*	439,238	426,059	*-3.0%*	*(13,179)*
Rhode Island	Yes	SBM	190,833	294,264	*54.2%*	*103,431*	34,670	29,456	*-15.0%*	*(5,214)*
South Carolina	No	FFM	889,744	996,551	*12.0%*	*106,807*	231,849	230,211	*-0.7%*	*(1,638)*
South Dakota	No	FFM	115,501	119,956	*3.9%*	*4,455*	25,999	29,622	*13.9%*	*3,623*
Tennessee	No	FFM	1,244,516	1,631,305	*31.1%*	*386,789*	268,867	234,125	*-12.9%*	*(34,742)*
Texas	No	FFM	4,441,605	4,768,961	*7.4%*	*327,356*	1,306,208	1,227,290	*-6.0%*	*(78,918)*
Utah	No	FFM	294,029	304,468	*3.6%*	*10,439*	175,637	197,187	*12.3%*	*21,550*
Vermont	Yes	SBM	161,081	167,130	*3.8%*	*6,049*	29,440	30,682	*4.2%*	*1,242*
Virginia	No	FFM	935,434	977,452	*4.5%*	*42,018*	421,897	410,726	*-2.6%*	*(11,171)*
Washington	Yes	SBM	1,117,576	1,810,889	*62.0%*	*693,313*	200,691	225,594	*12.4%*	*24,903*
West Virginia	Yes	Partnership	354,544	567,064	*59.9%*	*212,520*	37,284	34,045	*-8.7%*	*(3,239)*
Wisconsin	No	FFM	985,531	1,037,863	*5.3%*	*52,332*	239,034	242,863	*1.6%*	*3,829*
Wyoming	No	FFM	67,518	61,925	*-8.3%*	*(5,593)*	23,770	24,826	*4.4%*	*1,056*

Sources: CMS Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report (December 2016); CMS 2017 Marketplace Open Enrollment Period Public Use Files (January 2017). Kaiser Family Foundation State Health Insurance Marketplace Types, 2017.

Notes: "SBM" = State-Based Marketplace; "SBM-FP" = State-Based Marketplace - Federal Platform; "FFM" = Federally Facilitated Marketplace.
Connecticut and Maine did not report Pre-Open Enrollment Period enrollment data to CMS for the report. HMA has substituted the December 2013 Medicaid enrollment total from the Kaiser Family Foundation, compiled by Health Management Associates (HMA) from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured (KCMU).

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

California Drug Price Transparency Bill Introduced in Senate. *Healthfax* reported on March 20, 2017, that California State Senator Ed Hernandez introduced a bill, SB 17, that would require health plans to provide more information to the state Department of Managed Health Care and the Department of Insurance with annual reports on drug pricing. Health plans would provide information on the 25 most commonly prescribed drugs, the 25 most expensive drugs, and the 25 drugs with the highest year-over-year increases in price. The bill would also require health plans to report on the percentage of premiums that are spent on prescription drugs. Read More

DHCS Estimates Cost-Shift Impact of AHCA Medicaid Provisions. The California Department of Health Care Services (DHCS) reported on March 21, 2017, that the Medicaid provisions of the proposed American Health Care Act (AHCA) would result in a significant shift in Medicaid costs to the state of California, amounting to $6 billion in 2020 and $24.3 billion by 2027. The General Fund share is estimated to be $4.3 billion in 2020, increasing to $18.6 billion in 2027. The AHCA would impose a new per capita Medicaid funding methodology for nearly all enrollees and expenditures in Medi-Cal. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Proposes Changes to 1115 Waiver, Seeks Medicaid Flexibility. *News Service of Florida* reported on March 17, 2017, that the Florida Agency for Health Care Administration (AHCA) submitted a four-page letter to U.S. Health and Human Services Secretary Tom Price asking for more flexibility in the state's Medicaid program. The letter proposes the following changes to Florida's section 1115 demonstration waiver for the Managed Medical Assistance (MMA) program:

- "A block grant of federal funds as a replacement for various supplemental payment programs
- Flexibility to set eligibility criteria and eliminate retroactive eligibility"
- A strengthened relationship between Medicaid beneficiaries and primary care providers
- Elimination of federal requirements that lead to duplicative work at the state level and federal level for certified Medicaid managed care rates

- Removal of federal administrative burdens placed on the state by the "Access Rule"

The state estimates these changes will save $830 million in taxpayer dollars. Read More

AHCA to Release Medicaid Managed Care Reprocurement Data Book on March 30. The Florida Agency for Health Care Administration (AHCA) announced on March 15, 2017, that it will release the data book for the Statewide Medicaid Managed Care (SMMC) Reprocurement on March 30, 2017. The state is currently developing the Invitation to Negotiate (ITN). A public meeting will be held on Wednesday, April 12, 2017, 8:30am – 11:30am ET, in Tallahassee to discuss the data book.

Nursing Facility Carve Out Would Cost $200 Million More in Annual Medicaid Expenditures. *Florida Politics* reported on March 21, 2017, that carving nursing homes out of Florida's Statewide Medicaid Managed Care (SMMC) program would add about $200 million in ongoing annual costs, according to the Agency for Health Care Administration (AHCA). AHCA's analysis of legislation proposing the carve out (SB 682) found that Florida health plans are more successful at transferring members into lower-cost home and community-based care settings than prior programs, which relied on nursing homes. Medicaid managed care was also found to provide expanded benefits not available under fee-for-service. Read More

Legislators Work to Repeal Hospital Certificate of Need Law. *Naples Daily News* reported on March 17, 2017, that Florida lawmakers are focusing on repealing the certificate of need (CON) law for hospitals, but will likely exclude nursing homes and hospice. Conservative Florida legislators blame hospitals for making health care more expensive and inefficient and have called for a break-up of the "hospital industrial complex." However, bills introduced earlier this year in the state House and Senate to repeal the CON process have yet to be passed. Those bills included repeal of the CON process not just for hospitals, but for nursing homes and hospice as well. Read More

Senate Committee Votes to Allow 24-Hour Stays in Ambulatory Surgical Centers. *The Herald Tribune* reported on March 14, 2017, that a Florida Senate committee approved legislation (Senate Bill 222) that would allow patients to stay at ambulatory surgical centers for up to 24 hours. However, the Senate blocked a proposal establishing recovery care centers that would allow patient stays of up to 72 hours. Over the past few years, Florida House leaders have pushed to end regulations that prevent ambulatory surgical centers from keeping patients in their facilities overnight. Read More

Judge Stays Order Requiring SNFs to Return $357 Million in False Medicaid, Medicare Claims. *Modern Healthcare* reported on March 16, 2017, that U.S. District Judge Steven Merryday has stayed an order requiring four Florida-based operators of multiple skilled-nursing facility to pay back $347 million in funds from false Medicaid and Medicare claims. Judge Merryday said that forcing repayment could cause the companies to default on loans, triggering "the collapse of scores of skilled-nursing facilities in 17 states." That's because the four companies – CMC II, Salus Rehabilitation, 207 Marshall Drive Operations, and 803 Oak Street Operations – have a joint-loan of $168 million with more than 100 other skilled-nursing facilities. MidCap Financial has the authority to stop lending to all the facilities participating in the joint loan if even one defaults. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

House Insurance Committee Passes Surprise Billing Legislation. *Georgia Health News* reported on March 20, 2017, that the Georgia House Insurance Committee advanced legislation to reduce surprise billing, which occurs when patients utilize hospitals in their network, but receive unexpected bills from out-of-network providers. While health plans praised the legislation, physician groups are opposing the House bill, which differs from a previously passed Senate version that would reimburse providers 80 percent of local benchmark charges for procedures. Read More

Illinois

HFS Posts Medicaid Managed Care RFP Mandatory Offeror Conference Attendees List, Presentation. On March 21, 2017, the Illinois Department of Healthcare and Family Services (HFS) posted the attendance list and presentation slides from the March 10, 2017, mandatory offeror conference for the statewide Medicaid managed care request for proposals (RFP). The RFP, issued on February 27, 2017, will rebid the majority of the state's existing Medicaid managed care contracts, and expand the program statewide in 2018, covering roughly 2.7 million Medicaid beneficiaries in total. The attendee list follows:

- Addus HomeCare
- Aetna Better Health of Illinois
- Agilon Health
- AltaStaff, LLC
- Anthem, Inc.
- Beacon Health Options
- BlueCross BlueShield of Illinois
- Canary Telehealth
- Cigna HealthSpring
- Community Care Alliance of Illinois
- CountyCare/CCHHS
- Engaging Solutions, LLC
- Family Health Network
- Fineline Printing Group
- FoCoS Innovations
- Harmony/WellCare
- Humana
- IlliniCare Health
- MCNA Insurance Co
- Molina Healthcare
- Meridian Health Plan
- NextLevel Health Partners Inc.
- Trusted Health Plan
- United Healthcare Community & State/Optum
- Valence Health/Evolent Health

The Offeror Conference presentation slides are available here. RFP responses are due on May 15, 2017.

Indiana

Indiana University Health Sells Three Hospitals. *Modern Healthcare* reported on March 15, 2017, that Indiana University Health (IU Health) sold three hospitals in preparation for a $1 billion plan to replace its 331-bed Indiana University Hospital and 625-bed Methodist Hospital by 2020. IU Health divested Goshen Health as well as an 80 percent interest in LaPorte Hospital and Starke Hospital. Effective June 1, IU Health will also lease 25-bed Frankfort Hospital. Read More

Iowa

Report Finds Medicaid MCOs are Spending Less, Still Losing Money. *The Des Moines Register* reported on March 15, 2017, that Iowa Medicaid managed care organizations (MCOs) have been successful in reducing per member per month medical expenditures, but continue to lose millions of dollars, according to a report from the Iowa Department of Human Services. PMPM healthcare expenditures on adults, for example, declined by double-digit rates; however, the three MCOs serving the state's Medicaid population still expect to lose a total of $450 million in the first year of the program. Read More

Kansas

Lawmakers Pass Bill to Reverse $47 Million in Medicaid Cuts. *KCUR.org* reported on March 16, 2017, that the Kansas Senate passed a bill on March 16, 2017, that would reverse $47 million in Medicaid reimbursement reductions to hospitals, safety net clinics, nursing homes, and community mental health centers. Kansas legislators are working to reverse a total of $56 million in cuts ordered by Governor Sam Brownback last summer. While the implementation date is set for July 1, 2017, the state will not have the funds to reverse the cuts until January 1, 2018. Read More

Legislature Continues Work on Medicaid Expansion Legislation as ACA Repeal Progresses. *NPR.org* reported on March 20, 2017, that Kansas lawmakers are revisiting the idea of expanding Medicaid as Congress and the Trump administration move closer to a repeal and replacement of the Affordable Care Act. Governor Sam Brownback and legislators have blocked expansion for the past few years. However, during the 2016 elections, several conservative incumbents were replaced by more moderate Republicans and Democrats who promised to reignite the push for Medicaid expansion. The state House recently passed expansion legislation, and a Senate committee is expected to vote on the measure on March 23. Read More

Michigan

Medicaid Behavioral Health System Saves Money, Study Says. *Crain's Detroit Business* reported on March 21, 2017, that Michigan's Medicaid behavioral health system, served by prepaid behavioral health plans, has saved the state $5.3 billion over the past 18 years, according to a report by the Michigan Association of Community Mental Health Boards. The report also says the state would save an additional $7.4 billion from 2015 to 2024 under the current system than under Medicaid managed care. Governor Rick Snyder has proposed carving behavioral health into fully capitated Medicaid managed care, in contrast to the current system in which 10 prepaid inpatient health plans run by the public mental health system contract with providers. Dominick Pallone, executive director of the Michigan Association of Health Plans, disagreed with the study, which based its projections on national Medicaid rate increases instead of Michigan Medicaid rate increases. The Michigan Department of Health and Human Services issued a report to the Legislature in early March that recommended pilot projects to test integration of physical and behavioral health. Read More

Medicaid MCOs Submit Pilot Proposals for Integrated Physical, Behavioral Health. *Crain's Detroit Business* reported on March 19, 2017, that many of Michigan's Medicaid managed care organizations (MCOs) have submitted a series of pilot proposals for the integration of managed physical and behavioral health. Currently, Medicaid MCOs in the state manage physical health, while 10 public mental health authorities, or prepaid inpatient health plans (PIHPs), manage behavioral health. The Michigan Department of Health and Human Services conducted a study on the integration of managed physical and behavioral health last year; however, the final workgroup report to the legislature recommended that the state maintain separate behavioral and physical health systems. The current mental health system will stay the same in 2018 unless the legislature authorizes regional pilot studies. Meridian Health Plan, Priority Health, UnitedHealthcare, and Blue Cross Complete were four of the eight MCOs to submit proposals. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Legislative Budget Proposals. Both the Assembly and the Senate passed one-house budget proposals for FY 2018. These will form the basis of negotiations with Governor Andrew Cuomo, whose Executive Budget proposal was introduced in January. By law the budget must be passed before the new fiscal year, which starts April 1, 2017. Some areas of disagreement between the legislative proposals and the executive budget are highlighted below.

Global Cap - The Executive proposes extending the state Medicaid Global Cap through FY 2019. The Global Cap limits Department of Health (DOH) Medicaid spending growth to the 10-year average of the medical component of the Consumer Price Index (CPI), which is currently estimated at 3.2 percent. The budget also includes language that would allow the governor to suspend the global cap in the case of changes to the availability of federal financial participation in Medicaid expenditures or changes in federal Medicaid eligibility. Both houses of the legislature would extend the Global Cap only through the current fiscal year. They also both rejected the executive proposal to unilaterally reduce spending should federal revenues be lower than anticipated.

Minimum Wage Increases - The FY 2017 Enacted Budget included funding for the minimum wage totaling $44 million. The FY 2018 Executive Budget includes $255 million to support costs of the minimum wage. These funds are allocated to implement new minimum wage requirements and will be used to support direct salary costs and fringe benefits for health care workers reimbursed by the Medicaid program. Both houses of the legislature support the executive proposal.

Pharmacy Initiatives – The budget proposes price ceilings for high-cost prescription drugs. It would impose a 100 percent supplemental rebate for any amount that exceeds a benchmark price recommended by the Drug Utilization Review Board. The budget also proposes the elimination of "prescriber prevails" for all drugs except atypical

antipsychotics and antidepressants. Finally, the budget proposes a licensure requirement for pharmacy benefits managers, including requiring that they report any potential conflicts of interest. The Assembly budget proposal rejects these changes.

Capital Spending – The budget extends this year's capital program for health care facilities. The language is identical to last year's health care facility transformation program and includes $500 million in spending, of which at least $30 million is earmarked for community-based health care providers. The Assembly adds an additional $200 million to the capital program and increases the allocation for community-based providers to $125 million. The Senate includes $300 million above the Executive Budget's proposal, for a total of $800 million for the Health Care Facility Transformation Program. The funding is included subject to additional details to ensure appropriate regional disbursement and appropriate disbursement among community-based providers and all facilities.

Health Care Regulation – The budget proposal establishes a health care regulation modernization team, which is meant to review a whole host of regulations governing licensure and oversight of health care facilities. The Assembly makes no provision for a regulation modernization process; the Senate narrows both the membership of the modernization team and narrows the scope of the team's work.

Consolidation and Cuts to Public Health Programs – The budget proposes consolidating 39 different public health awareness and prevention programs, including disease prevention, maternal and child health, workforce support, and programs that serve health care needs of individuals, into four pools, and proposes reducing funding by 20 percent. The Assembly and Senate budget proposals do not include any provision for consolidation of public health programs or reductions in funding. Link to Budget Summary. Read More

NYC Health + Hospitals Reports Losses. *Crain's HealthPulse* reports that New York City Health + Hospitals reported a $776 million operating loss for the first half of fiscal year 2017. Health + Hospitals, the public hospital system in New York City, operates 11 acute care hospitals, six Diagnostic and Treatment Centers, four long-term care facilities, a certified home health care agency, and more than 80 community health clinics. H + H has a mission to provide services for everyone who needs care, regardless of their ability to pay. H + H has an annual budget of roughly $7 billion; the contribution from New York City is expected to top $2 billion until at least 2020, as state and federal funding has declined. The public health system's operating loss widened by 84.5% over 2015, when the system lost $420.4 million. After investment losses and interest expenses, the system lost $842.6 million. The system's current financial plan relies on increasing enrollment in MetroPlus, the managed care plan operated by H + H, to stabilize the system. While MetroPlus has seen increases in enrollment, it is not sufficient to offset declining utilization in the system's hospitals and health centers. Since H + H President Dr. Ramanathan Raju resigned in November 2017, the system has been overseen on an interim basis by Stanley Brezenoff, a former president (1981-84) and board chair (1984 – 85) of the system. Read More

Medicaid Costs are Political Lever in Attempt to Win AHCA Votes. *The New York Times* reported on March 20, 2017, that U.S. House Republicans are proposing to shift Medicaid costs from certain New York counties to the state in an effort to win support for the American Health Care Act (AHCA). Upstate New York Republicans pushed for the special provision, which could save counties outside of New York City $2.3 billion a year, but could also impact the amount of federal matching funds the state receives. New York Governor Andrew Cuomo opposes the AHCA, as well as the special provision, which would only affect New York. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Joint Medicaid Oversight Committee Hears Changes to Ohio Behavioral Health Redesign. The Ohio Departments of Medicaid and Mental Health and Addiction Services announced changes to the ongoing Behavioral Health Redesign in the Joint Medicaid Oversight Committee. These changes are due, in part, to input from providers and advocates. There are two major policies that are being modified. First, Qualified Mental Health Specialists (QMHSs) with a minimum of three years of experience in a relevant field may now provide the MH Day Treatment service. The new policy also removes the limit of 24 hours (96 units) for Mental Health or SUD Nursing services per patient, per calendar year. There will no longer be limits to medically necessary nursing services. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Patient Safety Authority Finds HIT Linked to Nearly 900 Medication Errors. The Pennsylvania Patient Safety Authority released an in-depth analysis of health information technology (HIT)-related medication errors. Between January 1 and June 30, 2016, Pennsylvania health care facilities reported 889 medication-error events that indicated health information technology as a contributing factor. In this in-depth analysis of HIT-related medication errors, the Authority identified contributing factors of a recent report sample. Use of HIT, such as computerized prescriber order entry systems and pharmacy information systems, can help prevent patient safety problems; however, if designed or implemented poorly, HIT can have significant adverse consequences for patient safety. The most frequently reported errors included dose omission, wrong dose or over-dosage, and extra dose; the most commonly reported systems involved were the computerized prescriber order entry and the pharmacy systems. Read More

Texas

HHSC Opens Investigation into Medicaid Transportation Privatization. *Houston Chronicle* reported on March 20, 2017, that the Texas Health and Human Services Commission (HHSC) is investigating the privatization of the state's Medicaid transportation program in response to rising costs and complaints. According to a report by the Legislative Budget Board, Medicaid transportation costs are $316 million higher than if the state was still

administering the program. The investigation will address why contracts went to organizations that did not provide cost information and scored poorly on the state's rating system. Read More

Medicaid Payment Policy Decreased Elective Premature Births, Study Shows. *Kaiser Health News* reported on March 17, 2017, that the Texas Medicaid program has seen a decline in elective premature births since 2011, when it began withholding payment to providers who induce early labor or provide non-medically necessary cesarean deliveries before 39 weeks, according to a Medica Research Institute study published in *Health Affairs*. The study shows that the percentage of early elective deliveries for Texas Medicaid beneficiaries has decreased from 10.63 to 2.03 since 2011. The length of the pregnancies also increased by almost a week, with babies weighing almost half a pound more at birth. Read More

National

Republican Lawmakers Tweak American Health Care Act in Attempt to Win Broader Support. *Modern Healthcare* reported on March 20, 2017, that House Republicans announced changes to the American Health Care Act (AHCA) in hopes of winning over Republicans who oppose the legislation. The changes include prohibiting additional states from expanding Medicaid, establishing Medicaid work requirements, giving states the option to receive block grants or per capita funding, and repealing the Affordable Care Act taxes by the end of 2017, among other changes. Read More

AHCA Would Increase Medicaid Costs for States, Moody's Says. *The New York Times* reported on March 17, 2017, that the House Republican-proposed American Health Care Act (AHCA) would increase the financial burden of Medicaid costs on state and could cause a negative shift in state credit ratings, says Moody's Investors Service. The AHCA would shift federal Medicaid funding from a state-match to a per capita cap, as well as phase out funding for Medicaid expansion by 2020. The Congressional Budget Office estimates that these changes would reduce federal Medicaid spending by $880 billion between 2017 and 2026. Moody's concludes that states will likely be forced to decide whether or not to maintain their Medicaid expansion programs once they bear more of the financial responsibility. Read More

Medicaid Cuts in AHCA Could Threaten HCBS, Advocates Say. *McClatchy* reported on March 20, 2017, that Medicaid cuts proposed in the American Health Care Act (AHCA) could force states to roll back funding for home and community-based services (HCBS), potentially shifting more older adults and individuals with disabilities to nursing homes. Spending on HCBS services has increased in recent years, accounting for 53 percent of total Medicaid spending on long-term services and supports in 2014. Advocacy groups are concerned that Medicaid funding limitations could threaten the ability of these individuals to continue living independently in HCBS settings. Read More

President Trump Voices Support for AHCA as Opposition Remains. *The New York Times* reported on March 17, 2017, that President Trump voiced support for Medicaid work requirements for able-bodied beneficiaries and per capita funding caps for states, as proposed by the American Health Care Act. While many Republican Governors have expressed support for the changes, which

would allow greater control over spending and flexibility to define eligibility and benefits, many members of Congress remain opposed to the plan. Critics say that the changes would limit access to Medicaid in states that have conservative Governors and legislatures. President Trump's support for the AHCA has encouraged House Republicans that the legislation will pass. However, some say the changes are not enough to convince the strongly conservative House Freedom Caucus and Republican Governors in expansion states, both of whom remain opposed to the bill. Read More

BCBS of Alabama, Tennessee File Separate Risk-Corridor Payment Lawsuits. *Modern Healthcare* reported on March 16, 2017, that Blue Cross Blue Shield of Alabama (BCBS-AL) and Blue Cross Blue Shield of Tennessee (BCBS-TN) are the latest health plans to file lawsuits against the federal government demanding payment of funds under the Affordable Care Act (ACA) risk-corridor program. The two separate lawsuits allege that the federal government is in breach of its contract by not providing the promised risk-corridor payments to plans that lost money on the ACA Exchanges. BCBS-AL says it should have received more than $90 million from 2014 and 2015, while BCBS-TN said it should have received $161 million. Both insurers say they have received only 12.6 percent of the total owed. Read More

Medicaid Innovation Accelerator Program National Webinar scheduled for March 27. As part of CMS's Medicaid Innovation Accelerator Program (IAP), the Center for Medicaid and CHIP Services is seeking to improve the care and health for Medicaid beneficiaries and reduce costs by supporting states' ongoing payment and delivery system reforms through targeted technical support. On March 27th, IAP's *Medicaid Beneficiaries with Complex Needs and High Costs* program area will host a webinar for states that highlights several considerations states can take into account as they pursue value-based payment arrangements, including how payment strategies can support improved care coordination for their target populations. In addition, participants will also learn about states that are using various types of alternative payment strategies to drive better outcomes for their Medicaid beneficiaries with complex care needs. This webinar, ***Applying Alternative Payment Strategies to Activities Focused on Medicaid Beneficiaries with Complex Care Needs and High Costs***, is open to states and all interested state Medicaid agencies and stakeholders. HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Beneficiaries with Complex Needs and High Costs (BCN) track through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates. Registration Link

Industry News

PSA Healthcare, Epic Health Services Merge to Form Aveanna Healthcare. *PR Newswire* reported on March 16, 2017, that PSA Healthcare and Epic Health Services announced that the two companies successfully merged to form Aveanna Healthcare, the largest pediatric home health care company in the nation. Aveanna is owned by Bain Capital and J.H. Whitney Capital Partners as a partnership with the previous PSA management team. The company was formed after Bain Capital acquired Epic Health Services in December 2016. The company, headquartered in Atlanta, GA, will provide services in 23 states. Read More

RCCH HealthCare Partners Receives Approval to Acquire Ascension Hospital in Idaho. *Modern Healthcare* reported on March 21, 2017, that Idaho Attorney General Lawrence Wasden has approved RCCH HealthCare Partners' acquisition of Ascension's St. Joseph Regional Medical Center. The sale required the State Attorney General's approval because the facility will be converted from not-for-profit to for-profit. Tennessee-based RCCH HealthCare, formed last year by the merger of RegionalCare Hospital Partners and Capella Healthcare, has also agreed to acquire Ascension's Lourdes Health in Pasco, WA. The news follows Ascension's announcement in January to sell Catholic Health System and Ministry St. Joseph Hospital to Marshfield Clinic. Read More

Aetna CFO Says Medicaid Business Expected to Grow. *Hartford Courant* reported on March 16, 2017, that Aetna Inc. expects its Medicaid business to grow in the coming years, despite recent contract bid losses in Pennsylvania, Missouri, and Nebraska, according to Shawn Guertin, chief financial officer. Aetna serves Medicaid in 16 states, generating 13 percent of its total revenues from Medicaid. Read More

Anthem CEO Meets with President Trump, HHS Secretary Price to Discuss Medicaid Funding, AHCA. *Modern Healthcare* reported on March 15, 2017, that Anthem CEO Joseph Swedish met with President Trump and Secretary of Health and Human Services Tom Price to discuss Medicaid and the proposed American Health Care Act (AHCA). During the meeting, Swedish urged Trump to adequately fund Medicaid and continue health care cost sharing subsidies. He also stressed the need for ending Affordable Care Act taxes and fees on insurers. Anthem has been supportive of the House GOP repeal legislation, saying it benefits insurers. Read More

Company Announcements

- **"Crotched Mountain Community Care's Implementation of MCG Earns 2016 Doyle Award"** Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
March, 2017	Washington, DC	Contract Awards	190,000
April 7, 2017	MississippiCAN	Proposals Due	500,000
April 10, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
April 13, 2017	Massachusetts	Proposals Due	850,000
April 14, 2017	Washington (FIMC - North Central RSA)	Proposals Due	66,000
April 27, 2017	Alaska Coordinated Care Demonstration	Proposals Due	TBD
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 30, 2017	Illinois	Contract Awards	2,700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
Summer 2017	Florida	RFP Release	3,100,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of state dual eligible financial alignment demonstration status.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	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	45,469	33.4%	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	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	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	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**386,647**	**30.8%**	

** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

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

HMA NEWS

Early Bird Registration Now Open for HMA's 2017 Conference: *"The Future of Medicaid is Here: Implications for Payers, Providers and States"*

Health Management Associates is happy to announce that Early Bird Registration is now open for our second conference on *Trends in Publicly Sponsored Healthcare*, **September 11-12, 2017**, in **Chicago, Illinois,** at the Renaissance Chicago Downtown Hotel. The theme of this year's event is ***The Future of Medicaid is Here: Implications for Payers, Providers and States.***

Featured speakers already include some of the nation's most innovative healthcare leaders. Visit the conference website to receive the Early Bird rate and to stay up-to-date on the latest conference news:

https://2017futureofmedicaid.healthmanagement.com

Confirmed Speakers to Date (in alphabetical order; others to be announced):

- Laurie Brubaker, SVP, Aetna Medicaid
- David Cotton, CEO, Meridian Health Plans
- Susan Fleischman, MD, VP, Medicaid, CHIP, and Charitable Care, Kaiser Permanente
- Patrick Gordon, Associate VP, Rocky Mountain Health Plan, a UnitedHealthcare plan
- Tamara Hamlish, Executive Director, ECHO-Chicago, Project Manager, HepCCATT
- Jesse Hunter, EVP, Products, Centene Corp.
- Gary Jessee, Deputy Executive Commissioner, Medical and Social Services, Texas HHS
- Nathan Johnson, Chief Policy Officer, Washington Health Authority
- Allison McGuire, MPH, Executive Director, Montefiore Hudson Valley Collaborative
- J. Mario Molina, MD, President, CEO, Molina Healthcare
- Michael Monson, Corporate VP, Long Term Care & Dual Eligibles, Centene Corp.
- Pamela Morris, President, CEO, CareSource
- Joe Moser, Director of Medicaid, Indiana Family and Social Services Administration
- Fran Soistman, EVP, Government Services, Aetna, Inc.
- Paul Tufano, Chairman, CEO, AmeriHealth Caritas

For information on group rates and sponsorship opportunities contact Carl Mercurio at cmercurio@healthmanagement.com or 646-590-5929.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.