HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 5, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

- IN FOCUS: THE 340B DRUG DISCOUNT PROGRAM: RECENT AND POTENTIAL REGULATORY CHANGES
- ALABAMA DELAYS RCO IMPLEMENTATION
- ALASKA, MINNESOTA CONSIDER EXCHANGE MARKET REINSURANCE PROGRAMS
- ARKANSAS RENEWS MEDICAID EXPANSION
- MEDICAID FUNDING CUTS IN COLORADO, TEXAS BUDGET PROPOSALS
- INDIANA RELEASES NEMT RFP
- WELLMARK TO EXIT IOWA INDIVIDUAL INSURANCE MARKET IN 2018
- KANSAS GOVERNOR VETOES MEDICAID EXPANSION, OVERRIDE FAILS
- NEW YORK EXPANDS FIDA DEMONSTRATION
- SOUTH CAROLINA MEDICAID DIRECTOR SOURA RESIGNS
- SOCIETY OF ACTUARIES RELEASES REPORT ON MEDICAID MCO PROFIT MARGINS
- ANTHEM LIKELY TO EXIT "HIGH PERCENTAGE" OF EXCHANGES IN 2018
- SVC IS NOW HMA MEDICAID MARKET SOLUTIONS

IN FOCUS

THE 340B DRUG DISCOUNT PROGRAM: RECENT AND POTENTIAL REGULATORY CHANGES

This week, our *In Focus* section comes to us from HMA's Donna Strugar-Fritsch, Anne Winter, and Julia Elitzer, and addresses recent regulatory changes in the federal 340B drug discount program. Section 340B of the Public Health Service Act authorized the program in 1992. The program is designed to offer deep pharmaceutical pricing discounts to safety net providers to stretch federal funding. Providers eligible to purchase drugs under the 340B

program are called "covered entities". Covered entities may either dispense prescription medications in house or contract with community pharmacies to dispense drugs on their behalf. Since 1992, the program has grown significantly, which has triggered recent regulatory action, as described below.

Recent Activities

340B Mega-Guidance. The Office of Pharmacy Affairs (OPA), the HRSA entity that administers the program, has been crafting its "340B Mega-Guidance" for several years. The guidance addressed many aspects of the 340B program including the definition of eligible patients, contract pharmacy compliance requirements, hospital eligibility criteria, eligibility of off-site outpatient locations, and other factors that would have significantly curtailed drugs eligible for 340B discounts. OPA received an overwhelming response during the public comment process for the guidance. After lengthy delay, the Mega-Guidance was sent to the Office of Management and Budget on September 1, 2016. President Donald Trump's administration withdrew the Mega Guidance from OMB review on January 30, 2017. Currently, there is no public timetable or review process in place to continue work on the guidance. The impact of the January, 2017 federal regulatory freeze put in place by the White House may negate or necessitate major re-writing of the guidance. Moreover, the guidance is likely to be affected by the executive order requiring that for every one new regulation, two must be revoked.

340B Ceiling Price Calculation. Unrelated to the guidance described above, on January 5, 2017, HRSA issued its final rule on manufacturer calculation of 340B Drug Ceiling Prices and its authority to assess civil monetary penalties on manufacturers who knowingly overcharge a 340B covered entity. This rule, under development for several years, will for the first time enable 340B covered entities to calculate the accuracy of prices they are charged for 340B discounted drugs. HRSA will establish a ceiling price calculation tool and make it available to covered entities. The 340B ceiling price the average manufacturer price less the amount of the drug's eligible federal Medicaid rebate.

This rule was to be effective on March 6, 2017 and HRSA stated its intent to begin applying the rule on transactions starting April 1, 2017, in keeping with the calendar quarter. However, in the Federal Register notice HRSA proposes delaying the effective date of the rule to October 1, 2017. HRSA is currently accepting public comment on this additional delay; comments will be accepted through April 19, 2017.

Medicaid and Actual Acquisition Cost. The Medicaid Covered Outpatient Drug Rule was issued in February 2016 and is unaffected by the recent Executive Orders curtailing new regulation. Under the rule, states had until April 1, 2017 to submit a new State Plan Amendment (SPA) that complies with the requirement that Medicaid reimbursement for drugs be based on the Actual Acquisition Cost (AAC) of the drug. As a note, the AAC methodology does not apply to Medicaid managed care programs. This has major implications for 340B covered entities, because it passes the entire discount from the covered entity to Medicaid. CMS has advised state Medicaid directors that for drugs purchased through the 340B program, reimbursement should not exceed the 340B ceiling price.

The AAC requirement is specific to ingredient cost and does not address dispensing costs. Many states offer an "enhanced" dispensing fee for covered entities to help defray administrative costs.

Covered Entity Audits and Continued Program Integrity Challenges. HRSA continues to conduct audits of 340B covered entities to determine program compliance. In FY 2016, HRSA conducted nearly 200 audits and found that more than 60 percent of the DSH hospitals audited had incidents of diverting drugs purchased at 340B discounts to ineligible patients, and nearly a quarter of the DSH hospitals audited had incidents of duplicate discounts in which both a 340B discount and a Medicaid rebate were provided for the same drug. In addition, covered entity arrangements with contract pharmacies were especially prone to audit findings. These findings underscore the critical importance of covered entities conducting self-audits and of auditing their contract pharmacies.

Impact to the 340B Program if the Affordable Care Act is Repealed

A full repeal of the Affordable Care Act (ACA) would eliminate several provisions impacting the 340B program. The following provisions would be completely eliminated under a repeal or possibly changed under a replacement deal.

- Inclusion of qualifying children's hospitals, critical access hospitals, free standing cancer hospitals, sole community hospitals, and rural referral centers as eligible 340B covered entities.
- Exemption of orphan drugs from the 340B definition of a "covered outpatient drug" and thus ineligible for 340B drug discounts. ACA repeal could make orphan drugs used on an outpatient basis potentially eligible for 340B pricing.
- Ability to invoice and collect rebates for drugs dispensed by Medicaid Managed Care Organizations, thereby eliminating potential for duplicate discounts.

Both Congress and the Trump Administration have interest in developing strategies to stem the cost of pharmaceuticals. Because of the deep discounts the 340B program offers, the program could serve as a lever in drug pricing solutions.

For More Information

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HMA Medicaid Roundup

Alabama

State Receives Federal Approval to Delay Medicaid RCO Implementation. *Modern Healthcare* reported on April 3, 2017, that Alabama received approval from the Centers for Medicare & Medicaid Services (CMS) to delay the implementation of Medicaid regional care organizations (RCOs), the state's regional managed care program. The state will begin enrolling beneficiaries in the new RCOs by October 1, 2017. However, CMS first must conduct an onsite review to ensure that the state is ready for the transition. Alabama originally passed legislation to establish the RCO program in 2013. Read More

Alaska

State Seeking 1332 Waiver Funding for Reinsurance Program to Help Stabilize Exchange Market. *Kaiser Health News* reported on April 5, 2017, that Alaska is seeking a Section 1332 waiver to fund reinsurance to stabilize the state's Exchange market. The waiver, which was submitted to the Centers for Medicare & Medicaid Services (CMS) in December, requests the authority to redirect $51.6 million in federal funding for premium subsidies toward the state's reinsurance program. Alaska's reinsurance program was established in 2016 through a 2.7 percent tax on all insurers, funding a $55 million reinsurance fund to cover medical bills for patients with high costs. The program is credited with keeping premium rate increases for 2017 lower than anticipated, as well as offsetting some of the significant losses Premera's Alaska health plans have seen in the individual market in recent years. The 1332 waiver would add federal funding to the reinsurance program for the next five years, with an option to renew beyond that period. Lori Wing-Heier, director of the Alaska Division of Insurance, says she expects approval of the waiver to come quickly. Read More

Arkansas

House Approves Hybrid Medicaid Expansion Extension. *ABC News* reported on March 30, 2017, that the Arkansas Ho use approved a Medicaid budget that would continue to fund the state's Arkansas Works hybrid Medicaid expansion program for an additional year. A day earlier the measure had failed to pass. Arkansas Works currently covers around 300,000 members; although Governor Asa Hutchinson asked earlier this month to move 60,000 off the program and onto the Exchange. The budget now heads to Hutchinson for final approval. Read More

California

HMA Roundup – Julia Elitzer (Email Julia)

Kaiser San Diego Set to Open First New Hospital in Four Decades. *The San Diego Union-Tribune* reported on April 3, 2017, that Kaiser Permanente will unveil its first new medical center in San Diego since 1975. The seven-story facility worth $850M will be finished ahead of schedule and open to admit patients April 25, 2017. The hospital, located in the Kearny Mesa neighborhood, will hold a capacity of 321 beds, but will open with 253. Read More

California Healthcare Performance Information System (CHPI) Launches New Web-based Quality Tool. *The California Healthcare Performance Information System (CHPI)* on March 22, 2017, announced the launch of a new website providing a free resource for consumers to search ratings on more than 10,000 physicians across California. Data on more than 10 million patients was analyzed to create the ratings, measuring how well physicians and practice sites provide recommended medical tests and procedures for patients with healthcare conditions. Each physician received a star rating of one to four stars on measures in their area of specialty. Read More

Colorado

Senate Passes Budget with $500 Million in Cuts to Hospitals for Uncompensated Care. *The Denver Post* reported on March 30, 2017, that the Colorado Senate has approved a $26.8 billion state budget bill that cuts $500 million in payments to reimburse hospitals for uncompensated care. The budget could put rural state hospitals at risk of closure. Republican Senate leaders said the cuts to hospitals are unavoidable, with some blaming Medicaid expansion. Democratic legislators were able to add some amendments to the budget, including $5.1 million in federal funds for the state's health care exchange. Read More

Medicaid Reimbursement System Continues to See Problems. *The Denver Post* reported on March 29, 2017, that Colorado providers continue to experience problems with the state's new Medicaid reimbursement system. Many providers are reporting claims rejections and long wait times in attempting, often unsuccessfully, to address problems by phone. The Colorado Medicaid department stated that the problems are mostly related to lack of familiarity among providers with the new technology. In the first month, the reimbursement system paid less than half of the nearly 4 million claims submitted. Most providers affected are small; although large hospitals have reportedly also struggled with the system. Read More

District of Columbia

DHCF Imposes Income Limit on Medicaid Home Care. *The Washington City Paper* reported on March 30, 2017, that the District of Columbia Department of Health Care Finance (DHCF) recently finalized an income cap rule for Medicaid-funded home care that disqualifies more than 100 individuals who are over 65 or who have a disability. Under the rule, the program is now limited to individuals with incomes lower than $2,200 a month. While the

income cap was supposed to take effect when the program began in 2008, DHCF did not finalize the rule until 2016. Since 2008, DHCF found that 106 program participants were over that income limit. Terminations from the program began in the second half of 2016 and will be spread out over the first half of 2017 as well. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Legislative Session Ends with Several Health Care Bills Passed. *Georgia Health News* reported on March 31, 2017, that the Georgia legislative session closed on March 30, 2017, after the approval of some last-minute health care bills. Legislation that passed included bills to raise the tax credit for individuals and companies who provide donations to Georgia's rural hospitals, to allow dental hygienists to practice in certain settings without a dentist present, and to allow optometrists to administer drug injections. Legislation that failed included a bill to end surprise medical bills from out-of-network providers delivered at in-network settings. Read More

Officials Worry Anthem May Exit Exchange Market. *Georgia Health News* reported on April 4, 2017, that Anthem may be considering exiting a majority of its Exchange markets in 2018. Anthem's Blue Cross and Blue Shield of Georgia is the only plan option in 96 of Georgia's 159 counties, leading state officials to worry that the plan's exit would have a profound effect on the market. The state hopes that the Trump administration's promise to maintain subsidies and enforce tax penalties means Blue Cross would be less likely to pull out of the market. Last year, Blue Cross told *Georgia Health News* that the company had no plans to exit the Georgia Exchange market. State officials are asking insurers that want to offer Exchange coverage for 2018 to submit their proposed rates by May 16, 2017, ahead of the June 21 federal deadline. Read More

Indiana

HMA Roundup – Pat Casanova (Email Pat)

Indiana Procuring NEMT Broker for the Fee-For-Service Medicaid Population. In 2015, the Indiana Family and Social Services Administration (FSSA) paid approximately 760,000 claims for non-emergency medical transportation (NEMT) services to an estimated 69,000 Fee-For-Service (FFS) Medicaid members. These claims were paid directly by the FSSA on a FFS basis. By contrast, the State's managed care entities (MCEs) procure NEMT services for their enrollees through a capitated arrangement. The FSSA has released a RFP to create a similar capitated transportation benefit, led by a Broker, for the FFS population. FSSA has spent significant resources following-up on allegations of fraud, waste, and abuse related to the delivery of NEMT services in the FFS population. FSSA sees this RFP and the resulting Contract as an opportunity to improve ride documentation, vehicle fleet records, billing accuracy, eligibility monitoring, and program quality control. Link to RFP

Report Puts Annual Cost for Medicaid Enrollees Who Smoke at $540 Million. *Indy Star* reported on April 5, 2017, that Medicaid beneficiaries who are smokers cost the state $540 million a year, according to a report from the

Richard M. Fairbanks Foundation. The state's Medicaid program spends $904.61 per member per month for smokers, compared to $597.58 for non-smokers. The Fairbanks Foundation and the state legislature have been exploring ways to reduce smoking rates in the state, including an increase in the cigarette tax. The report was prepared by SVC, Inc., a consulting firm founded by Seema Verma, which was recently acquired by Health Management Associates. Read More

Iowa

Federal Risk Corridor Payments to Medicaid MCOs Could Reach $225 Million. *The Des Moines Register* reported on March 29, 2017, that federal risk corridor payments to Iowa Medicaid managed care plans for expansion members could be up to $225 million in fiscal 2019, according to a projection from the state Department of Human Services. The Centers for Medicare & Medicaid Services must ultimately sign off on the payments. The state recently agreed to tap the risk corridor program to help Medicaid plans make up for an estimated $450 million in losses. Read More

Wellmark to Exit Iowa Individual Insurance Market in 2018. *The Des Moines Register* reported on April 3, 2017, that Wellmark Blue Cross & Blue Shield of Iowa plans to exit the Iowa individual health insurance market in 2018, following $90 million in losses over three years. The move impacts more than 21,400 enrollees, including 18,900 with coverage purchased off-Exchange, and 2,500 with coverage purchased on the Exchange. Individual and family policies will remain in effect until the end of calendar 2017. Aetna and Medica remain on the Iowa Exchange, but have not yet confirmed their participation for 2018. Approximately 77,000 Wellmark individual plan members who bought policies that took effect before January 1, 2014, will not be affected. Wellmark exited the South Dakota Exchange market last year. Read More

Kansas

House Vote Falls Short on Override of Governor's Medicaid Expansion Veto. *KCUR* reported on April 3, 2017, that the Kansas House fell short by three votes in an attempt to override Governor Sam Brownback's veto of Medicaid expansion legislation, which came at the end of last week. The House voted 81-44 in favor of overriding the Governor's veto, falling short of the 84 votes needed. Read More

Minnesota

Reinsurance Law to Take Effect for Individual Health Plans. *Twin Cities* reported on April 3, 2017, that a new reinsurance law will take effect in Minnesota, providing individual health plans with up to $542 million to cover medical claims for high-cost members over the next two years. The state Department of Commerce estimates that the program will reduce health insurance premiums by 20 percent for 2018. The program will be paid for out of the state's general fund, as well as a special fund that helps provide health care to individuals at lower income levels. Read More

Minnesota Health Plan Losses Driven by Medicaid in 2016. *MPR News* reported on April 3, 2017, that Medicaid business accounted for about half of the $687 million in total operating losses reported by health plans in Minnesota in 2016. Individual plan losses also made up a large percentage. The plans drew down $560 million in reserves to cover the shortfalls, including $374 million for state-sponsored programs. Minnesota has relied on competitive bidding among Medicaid plans over the last several years in order to help drive down costs. Read More

Mississippi

Senate Approves Audits of Medicaid Beneficiaries. *U.S. News & World Report* reported on March 29, 2017, that the Mississippi Senate has passed a bill that would allow the state to hire a contractor to audit recipients of Medicaid, welfare, and food stamps for potential fraud. The contractor would check residency, identity, and income of the recipients. Additionally, the measure would impose work requirements on certain individuals as well as track where their benefit money is spent. The bill has already passed the House and now heads to Governor Phil Bryant. Republican supporters claim the bill can save $4 million to $5 million annually. However, that claim has been contested by the bill's opponents. Read More

Missouri

House Republicans Block Medicaid Expansion. *Springfield News-Leader* reported on March 29, 2017, that Missouri's Republican-led House voted 102-41 against a proposal to expand Medicaid in the state. The measure had been attached by state Representative Kip Kendrick (D-Columbia) to a Republican-sponsored bill to explore Medicaid waivers. Missouri's Republican Governor Eric Greitans also opposes expansion. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

CMS approves Community Care Waiver renewal. On March 31, 2017, the New Jersey Department of Human Services (DHS) announced that CMS approved the Division of Developmental Disabilities' (DDD) Community Care Waiver (CCW) renewal, which will allow DDD to fully transition to a fee-for-service model. DHS has been working towards renewal since 2013 operating under temporary three-month extensions during the waiver renewal process. The renewed waiver will provide community-based services to adults that are 21 and older with intellectual or developmental disabilities who have been determined to need a high level of care. It will provide 11,000 state residents with intellectual and developmental disabilities with a broader array of services, which include day habilitation, individual supports, respite, individual employment supports, support coordination, assistive technology, community transition services, environmental modifications, personal emergency response system, transportation, and vehicle modifications. The waiver will be effective through June 30, 2021. Additional information will be issued by DDD this week regarding timing and rollout.

New Jersey launches pilot of an electronic end-of-life registry. On April 3, 2017 NJ Spotlight reported that the Department of Health and New Jersey Hospital Association (NJHA) have unveiled a new electronic registry initiative, Practitioner Orders for Life-Sustaining Treatment (POLST). POLST will make end-of-life care information more accessible to emergency medical technicians, physicians, hospital and nursing home staff and others across the state. Administered by the NJHA's Institute for Quality & Patient Safety, the pilot will begin with hospitals and long term care facilities in four healthcare systems. Read more

New Jersey's state budget faces revenue shortage. On April 4, 2017 the Observer NJ reported that New Jersey's state budget is facing a $436 million revenue gap over two years, according to an analysis by the Office of Legislative Services (OLS). Weak revenue collections also contributed to a downgrade of New Jersey's state bond rating at the end of March. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Fully Integrated Duals Advantage (FIDA) Demonstration Expands. The New York State Department of Health announced the expansion of the Fully Integrated Duals Advantage (FIDA) Demonstration to Suffolk and Westchester Counties. The FIDA demonstration was originally approved to run January 1, 2015 through December 31, 2017. In November of last year, it was extended through December 2019. FIDA fully integrates Medicare and Medicaid benefits in a way not previously available in New York State. The state notes that although the demonstration is completing its second year, it is still early on in terms of understanding the impact of FIDA. The first round of preliminary data from the independent evaluation is at least six months away; the two-year extension allows more time to assess the impact of FIDA on quality and cost of care.

New York Fails to Pass Budget. New York's fiscal year has begun without the state having enacted a budget. The legislature passed emergency spending measures known as extender bills that will continue to finance state government operations for an additional two months, through May 31. This is the first time since Governor Andrew Cuomo was elected that the state has failed to pass an on-time budget. The reason for the delay is that NY has increasingly used the budget as the vehicle for passing a wide variety of policy issues, many of which have little to do with the actual budget. Health-related issues are not among the outstanding issues still being resolved. Read More

Department of Health Report Looks at Health Workforce Shortages. The New York Department of Health has released a new report titled "Performing Provider Systems (PPS) Job Title Vacancy Rate Snapshots, Demonstration Year 1 (DY1)" to give a high-level overview of health sector job vacancy rates. As part of the Delivery System Reform Incentive Payment Program the state conducts a PPS Compensation and Benefits Survey, which examines 22 job titles considered to be most involved in health care transformation. The intent of the report is to inform DSRIP workforce trends, regional patterns and shortages by job title and/or region. The top job titles, where PPSs had vacancies above 8 percent, included primary care physicians, primary care

nurse practitioners, psychiatrists, and psychiatric nurse practitioners. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Governor Kasich Puts New Limits on Narcotic Pain Killer Prescriptions. *The Columbus Dispatch* reported on March 30, 2017 that the Kasich Administration has proposed new rules limiting prescriptions for pain killers. The new rules will limit prescriptions to seven days for adults and five days for children. Prescriptions now can be written for 30 to 90 days of painkillers. In addition to the limits, the new rules will require doctors to provide a specific diagnosis or procedure code on every prescription written for a controlled substance. Read More

Access Ohio Acquires Assets of Central Ohio Mental Health Center. *The Columbus Dispatch* reported on April 4, 2017, that the assets of Central Ohio Mental Health Center, a provider of mental health services in Ohio's Delaware and Morrow counties, have been acquired by Access Ohio, a for-profit behavioral health organization based in Columbus, Ohio. Central Ohio Mental Health Center has faced financial issues. Both companies provide similar county-based mental health services. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Senate Hearings on Proposed Department Consolidations. On March 29, 2017, *Pennsylvania Legislative Services* reported on a joint public hearing held by the Senate Aging and Youth Committee, Senate Health and Human Services Committee, Senate Intergovernmental Operations Committee, and Senate Appropriations Health and Human Services Subcommittee to discuss Governor Tom Wolf's proposal to create a unified Department of Health and Human Services (DHHS), comprised of four departments: Aging, Human Services, Drug and Alcohol Programs (DDAP), and Health. The hearing is a first of a series to examine the proposed departmental consolidation and its potential savings.

DDAP Acting Secretary Jennifer Smith testified on behalf of the four affected departmental secretaries. Smith said that the new organization design will maintain the current deputate structures of the Office of Developmental Programs; Office of Children, Youth, and Families; and Office of Child Development and Early Learning, while creating or modifying structures within seven deputates:

- Office of Eligibility and Self Sufficiency
- Office of Medical Assistance Programs
- Office of Behavioral Health and Substance Use Disorder Services
- Office of Aging and Adult Community Living
- Office of Health Care Quality and Licensure
- Office of Public Health
- Office of Administration

In terms of a timeline, internal workgroups and bureau/division reviews are ongoing and staff mapping, gathering of stakeholder feedback, and transition planning will take place soon to successfully implement the merger by July 1, 2017. Acting Secretary Smith stated that enabling legislation for the plan will be released "as soon as possible", but had no specific timeline. She also said that the governor's decision and announcement for the Secretary of DHHS would not come until they have statutory authority for the merger.

South Carolina

Medicaid Director Christian Soura Resigns. *The Post and Courier* reported on March 30, 2017, that Christian Soura, director of the South Carolina Department of Health and Human Services (DHHS), has announced his resignation effective April 7, 2017. Soura has held the position since 2015 and is also currently president of the National Association of Medicaid Directors. DHHS Deputy Director of Health Programs Deirda Singleton will serve as interim director. Read More

Texas

House Committee Proposes $1 Billion in Cuts to Health and Human Services. *The Texas Tribune* reported on March 29, 2017, that the Texas House Appropriations Committee has proposed $1 billion in state funding cuts to Texas Health and Human Services, the department that manages the state's Medicaid program. If implemented, the state would also forfeit another $1.4 billion in federal funding. The cuts were part of an attempt to bring the budget proposal down from $221 billion to $218 billion. The budget is expected to move to the state House floor for a vote next week. Read More

Senate Passes Bill Allowing Telemedicine, Ending Years-Long Debate. *The Houston Chronicle* reported on March 29, 2017, that the Texas Senate unanimously approved legislation that would allow telemedicine services in the state, ending a long dispute over telemedicine regulations for doctors, providers, and insurance companies. The legislation, which is expected to help residents of rural counties in Texas, requires that a doctor-patient relationship be established prior to a diagnosis, treatment, or prescription via telemedicine. As of 2015, 80 of the state's 254 counties had five or fewer physicians. Read More

Virginia

Medicaid Adds Addiction, Recovery Treatment Services Benefit. *Richmond Times-Dispatch* reported on March 31, 2017, that under Virginia's new Medicaid Addiction and Recovery Treatment Services (ARTS) benefit, the state will increase provider rates for substance use intensive outpatient, partial hospitalization, day treatment, case management, and medication assisted treatment for opioid addiction. ARTS was proposed by the Governor's Task Force on Prescription Drug and Heroin Abuse in 2015. Approximately 1.1 million individuals covered by Medicaid and Family Access to Medical Insurance Security (FAMIS) will have access to the new benefit package. The Medicaid rates for substance use treatment services have not increased since

2007, and as a result, many providers opted not to participate in Medicaid. Read More

Hospital Supplemental Payment Proposal Faces Opposition. *Richmond Times-Dispatch* reported on April 2, 2017, that a proposal to provide supplemental payments through Virginia's Medicaid program to 25 private hospitals has run into opposition from Governor Terry McAuliffe and General Assembly budget leaders. The proposal would allow private hospital systems to pay for services the state currently provides in order to free up federal matching funds to pay for uncompensated medical care. However, recent Centers for Medicare & Medicaid Services (CMS) decisions to disallow certain supplemental payments in Texas and Louisiana have raised concerns about the future of Virginia's proposed program, despite the fact that it was approved by CMS in 2016. Governor McAuliffe is pushing to remove the plan from the state budget, and General Assembly budget leaders are reportedly sharing the Governor's concerns. Read More

Washington

Health Care Authority Faces Lawsuit from Retail Pharmacies Over Medicaid Dispensing Fees. *Drug Store News* reported on March 30, 2017, that retail pharmacies have joined forces in a lawsuit against the Washington State Health Care Authority, claiming the state is failing to pay adequate fees for dispensing prescription drugs to Medicaid recipients. The National Association of Chain Drug Stores, Washington State Pharmacy Association and National Community Pharmacists Association argue that fees paid by Washington under a new rule are below the cost incurred by pharmacies to dispense Medicaid prescriptions and are well below rates paid in other states. The lawsuit, filed in state Superior Court of Washington, seeks "Medicaid reimbursement rates that cover the actual costs that pharmacies incur when they serve Medicaid patients, as required by law." Read More

Wisconsin

Governor Walker to Release Proposal on Medicaid Work Requirements, Premiums, Drug Screening. *The Washington Post* reported on April 2, 2017, that Wisconsin Governor Scott Walker plans to release a proposal in mid-April to implement Medicaid work requirements, premium payments, and drug screening. If approved, Wisconsin would be the first state to require mandatory drug screening as part of determining Medicaid eligibility. The approach is one of several ideas from Republican Governors who are hoping to tighten Medicaid eligibility rules. Read More

National

CMS Finalizes Rule to Change Uncompensated Care Reimbursement for Hospitals. *Modern Healthcare* reported on March 31, 2017, that the Centers for Medicare & Medicaid Services (CMS) released a final rule on March 30, 2017, that changes the way hospitals are reimbursed for uncompensated care. Under current rule, uncompensated care payments are based on the difference between Medicaid costs (inpatient and outpatient) and Medicaid payments received. The new rule also subtracts Medicare or private pay payments, in

addition to Medicaid payments. The rule takes effect 60 days from April 3, 2017. Read More

CMS Sends Rule to Stabilize Individual Health Insurance Market to OMB. *Modern Healthcare* reported on April 3, 2017, that the Centers for Medicaid & Medicare Services (CMS) has sent a proposed rule to help stabilize the individual health insurance market to the Office of Management and Budget (OMB) for final review. The new rule makes it harder to enroll in health plans outside of the open enrollment period by requiring applicants to "demonstrate they had coverage for one or more days during the 60 days preceding the date of the qualifying event that would make them eligible for special enrollment." Health plans have argued that allowing consumers to sign up for coverage when they need expensive care, sometimes dropping coverage soon afterward, can put upward pressure on premiums by skewing the risk pool. OMB will have 90 days to review the rule. Read More

Exchange Cost-Sharing Reduction Payments to Continue, Says House Speaker Ryan. *The Hill* reported on March 30, 2017, that cost-sharing reduction payments to insurers will continue until a lawsuit challenging the payments is resolved, according to House Speaker Paul Ryan. House Republicans filed the lawsuit against the Obama administration, arguing that payments to insurers for providing discounted deductibles to low-income Exchange enrollees were being made without the necessary Congressional appropriation. Insurers say if the payments are discontinued, plans would be forced to raise rates and even potentially exit the Exchanges. Read More

Senate Bill Would Allow Individuals to Use Subsidies Outside of Exchanges. *FierceHealthcare* reported on March 30, 2017, that two U.S. Republican Senators have proposed a bill intended to help individuals in markets with limited Exchange plan options. The bill would allow individuals to use subsidies to purchase health insurance outside of the Exchange, as long as the insurance is approved by the state for sale in the individual market. In 2017, 32 percent of counties in the United States had only one insurer offering plans on the Exchange. The bill also waives the individual mandate penalties for these individuals. Read More

White House Proposes Changes to Republican Health Care Bill. *CNBC* reported on April 4, 2017, that Vice President Mike Pence and two White House officials have proposed several changes to the American Health Care Act, which was pulled ahead of a vote last month, in an attempt to attract the votes of hardline conservatives. Among the changes, states could seek waivers allowing insurance companies to deny coverage for certain pre-existing conditions. The House Freedom Caucus wants to review the new offer's language in writing before making any decisions. Read More

Industry Research

Society of Actuaries Releases Report on Medicaid MCO Profit Margins. The Society of Actuaries published a report in April 2017 titled, *Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting*. The report, which was published with the assistance of HMA Information Services, "describes the components of margin for calculating capitation rates in a Medicaid context along with a description of practical issues that may be encountered by MCOs." Read More

Expanded Coverage Under ACA Results in 240,000 More Health Services Jobs, Study Says. *The Incidental Exconomist* reported on April 4, 2017, that according to a study funded by the Altarum Institute and the Robert Wood Johnson Foundation, expanded health insurance coverage under the Affordable Care Act resulted in an additional 240,000 health care jobs between 2014 and 2016. Authors Charles Roehrig, Ani Turner, and Katherine Hempstead note that when coverage expands, so does utilization of health care services, resulting in increased hiring. Read More

INDUSTRY NEWS

Anthem Likely to Exit "High Percentage" of Exchanges in 2018, Per Analyst. *Reuters* reported on March 30, 2017, that Anthem is likely to exit a high percentage of its individual Exchange markets in 2018, according to analysts from investment bank Jefferies Group. Other large insurers, including Humana, Aetna, and United, already reduced their Exchange presence. Anthem currently sells Exchange plans in 144 rating regions. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
April 7, 2017	MississippiCAN	Proposals Due	500,000
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
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
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
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	Georgia	Implementation	1,300,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
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 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
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

SVC is Now HMA Medicaid Market Solutions

SVC, founded by CMS Administrator Seema Verma, is now part of Health Management Associates (HMA). The acquisition, announced March 13, 2017, by HMA founder Jay Rosen, was finalized late Friday, March 31. SVC now becomes HMA Medicaid Market Solutions (HMA MMS), a subsidiary of HMA.

Working closely with state officials and others, our newest colleagues at HMA MMS have established innovative Medicaid solutions that advance alternatives to traditional Medicaid. Together, our team of experts at HMA and HMA MMS offer unmatched experience and expertise to help organizations navigate what is expected to be an era of expanded state flexibility.

Learn about HMA MMS and meet our newest colleagues at: https://www.hmamedicaidmarketsolutions.com/

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.

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