Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

May 31, 2017

RFP Calendar

Dual Eligibles Calendar

HMA News

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In Focus

HMA's Vern K. Smith, PhD, Discusses Medicaid Per Capita Caps in *Health Affairs* Blog Post

This week, our *In Focus* section highlights a recent Health Affairs blog post authored by HMA Senior Advisor Vern K. Smith, PhD, titled *"Can States Survive The Per Capita Medicaid Caps In The AHCA?"* The blog post, originally posted by Health Affairs on May 17, 2017, provides a discussion of the impact

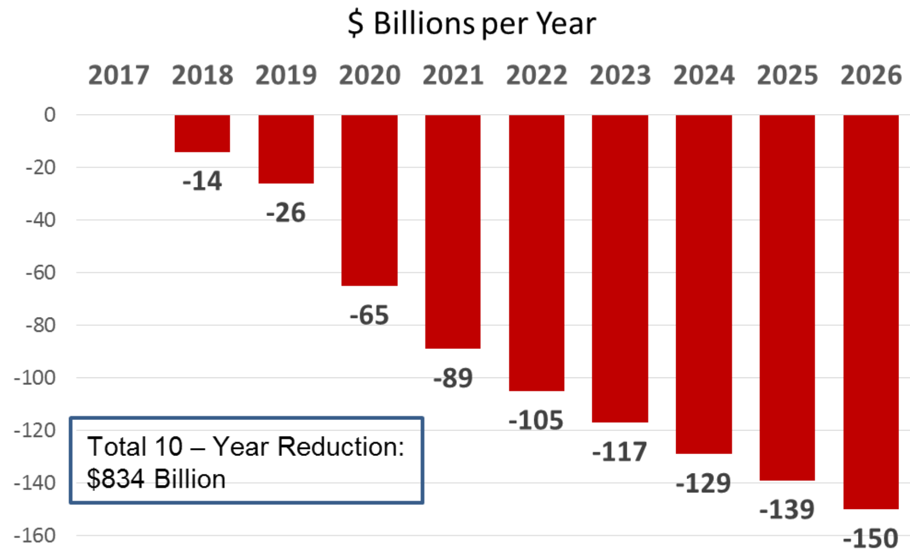
of per capita caps on federal Medicaid funding to states as proposed in the American Health Care Act (AHCA), as well as a May 25 update based on the revised Congressional Budget Office (CBO) score released on May 24. Vern's blog post is reprinted in its entirety with permission from *Health Affairs*.

"Can States Survive the Per Capita Medicaid Caps in the AHCA?"

The American Health Care Act of 2017 (AHCA), H.R. 1628, as adopted by the House of Representatives on May 4, would significantly change Medicaid financing, by changing both how Medicaid is financed and the amount of future federal support of the program. The changes are historic in scope, with seismic implications for states and the budget-driven decisions states will have to make for their Medicaid programs.

According to CBO scoring of the AHCA on May 24, the Medicaid provisions would reduce federal support to states for Medicaid by $834 billion over the ten year period from 2017 to 2026. These savings would be achieved by ending the financing formula by which the federal government has supported Medicaid since its beginning in 1965, consisting of federal matching rates that range from 50 percent to 73 percent, with higher rates going to states with lower average personal income.

The new federal financing formula would institute state options for a per capita cap or block grant, with formulas intentionally set to ensure federal savings. The per capita cap would be adjusted annually by the Medical CPI for all eligibility groups, plus an additional 1 percent only for the aged and disabled eligibility groups for 2020 and subsequent years. The per capita cap is to be a limit on federal funds, so a state is at full financial risk for any spending above that cap, but a state does not keep any portion of savings if it keeps spending under the per capita limit. The per capita cap allows federal Medicaid support to states to change as Medicaid enrollment changes, such as the large increases that have occurred during times of economic downturn. A block grant option is available to states only for the eligibility groups that are not disabled or aged, and a block grant would be adjusted annually by the regular CPI only. The ACA Medicaid expansion is effectively ended as the preferred matching rate is replaced by the per capita cap or block grant beginning in 2020.



Source: HMA, based on CBO Scoring of H.R. 1638, The American Health Care Act of 2017, May 24, 2017.

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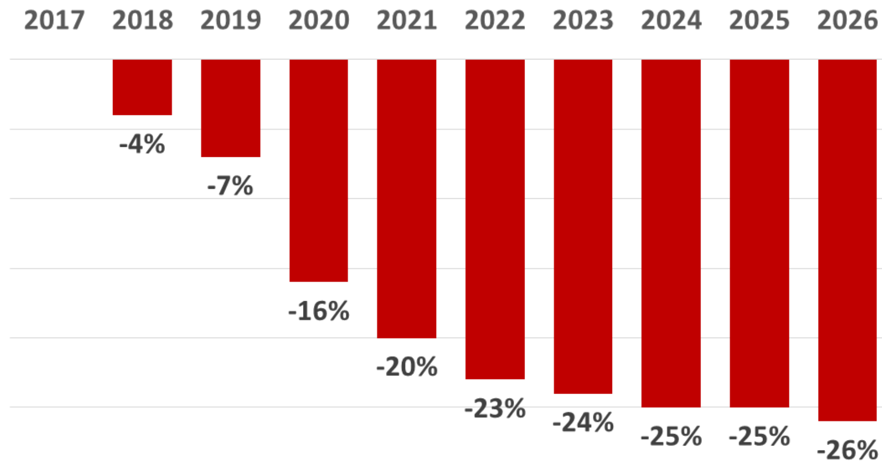
Quantifying the Federal Funding Cuts

The proposed per capita caps are designed to dramatically reduce federal payments that support state Medicaid programs, with $14 billion less federal support to states in 2018, with larger annual reductions in federal Medicaid support to states each year, reaching $150 billion in 2026. [Figure 1]

According to the CBO 2017 Medicaid baseline, in the absence of the AHCA, federal payments to states for Medicaid benefits in 2026 would have been $576 billion. In other words, the $150 billion reduction in 2026 represents a 26 percent reduction in federal funds that states would have used to support their Medicaid programs. [Figure 2]



Source: HMA, based on CBO Scoring of H.R. 1638, The American Health Care Act of 2017, May 24, 2017.
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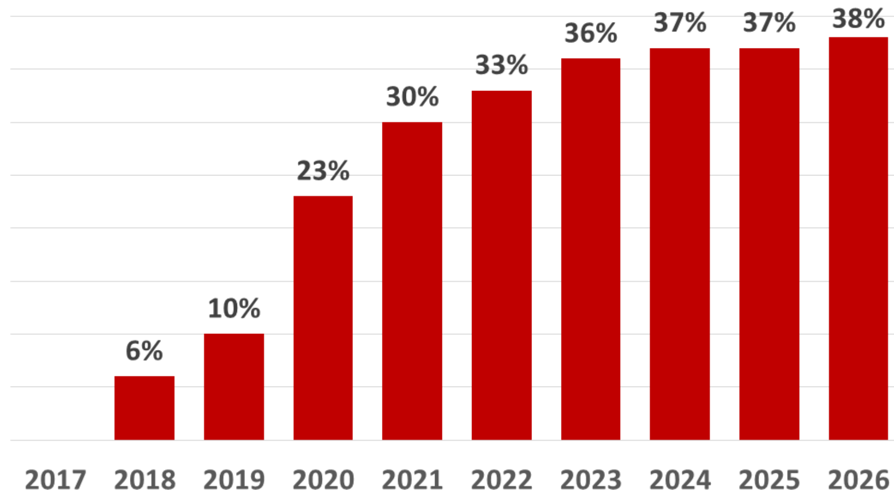
The impact of these cuts in federal support for Medicaid will vary from state to state. Some states could be advantaged, though certainly almost all will suffer financially. The 31 states that implemented the Medicaid expansion will experience the steepest cliff in cuts to federal funds as the preferential matching rate for newly eligible adults ends in 2020. How individual states will be affected will depend on many factors, including how previous cost containment actions impact base year expenditures, actual cost growth for specific eligibility categories, cost trends for specific services disproportionately needed by Medicaid populations, opportunities for new Medicaid reforms or cost cuts in the future.

From a state perspective, the challenge of responding to the proposed reductions in the federal Medicaid federal funds may be daunting. Indeed, from a state perspective, Medicaid is a very lean program, especially since the extreme fiscal pressures of the two major economic downturns since 2000 forced states to take every action possible to control growth in Medicaid spending. Taking advantage of flexibilities within current Medicaid law, these actions included redesign of delivery and payment systems, coordination of care for high cost populations, special initiatives to address use of emergency rooms, greater use of managed care, as well as restrictions on provider payments, eligibility and benefits.

For states, a threshold question is, how much would the state have to add to its current budget in state funds to make up for the loss in federal funding? What would be the necessary percentage increase in state support to maintain the current program? The relative increase and actual dollar amounts will vary across states, but on average, the necessary increases in state funds would be over 20 percent by 2020, and over one-third and increasing every year after 2022. [Figure 3]



Source: HMA, based on CMS projections 2017, and CBO Scoring of H.R. 1638, The American Health Care Act of 2017, May 24, 2017.

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Impact on State Budgets

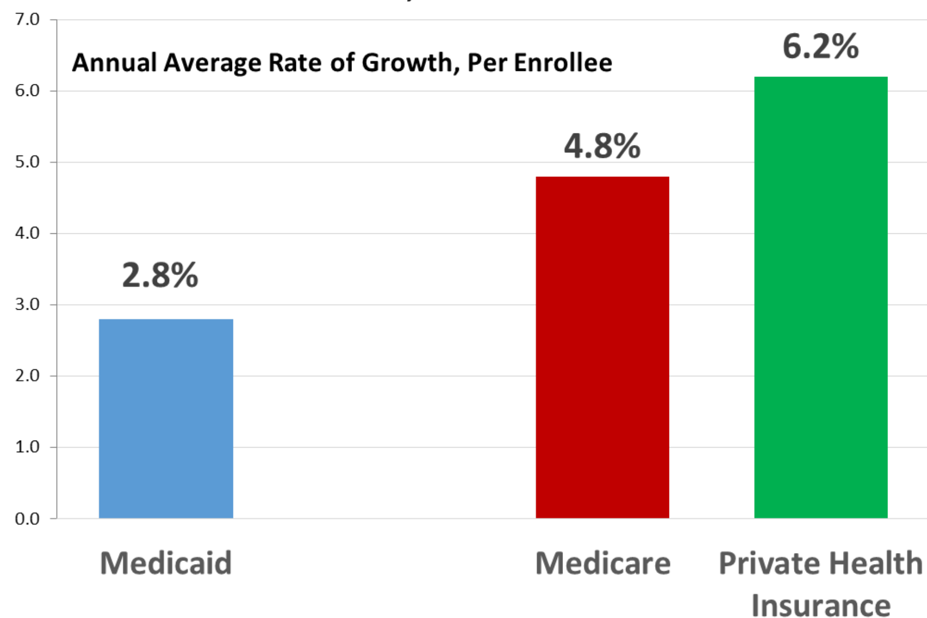
From a state budget perspective, the increase in state general fund dollars necessary to maintain the current Medicaid program would be massive. Even the additional 6 percent in state funds needed immediately in 2018, on top of growth in state budgets already adopted for 2018, would require states to move quickly, likely by restricting provider payment rates or benefits. Cutting provider payment rates is usually the first option states use to achieve short term Medicaid savings, even though Medicaid rates are already low relative to other payers and further cuts could impact provider participation and access. Once provider rates and benefits are restricted, states would have to create further savings from delivery system initiatives, perhaps taking advantage of new federal flexibility in Medicaid design, as few options for further savings would remain.

Within 3 or 4 years, states would need to increase state support by a third or more above already anticipated program growth. Given that Medicaid is the largest program in state budgets in terms of total Medicaid spending, and one-sixth of state budgets in terms of state general fund spending, future annual increases of these proportions would be impossible to accomplish without new state revenues or program restrictions. Inevitably, states would be forced to consider significant tax increases, or major cuts to Medicaid or other state programs on a scale never seen in previous periods of economic stress and state budget shortfalls.

States receive scant credit for the success they have achieved in ensuring Medicaid is a lean program. Primarily due to the requirement that states must balance their budgets annually, states have long been compelled to constrain spending growth for Medicaid as best they could within the fiscal resources of the state. Looking at the 13 pre-ACA years since 2000, Medicaid per enrollee

spending increased by just 2.8 percent, compared to 4.8 percent for Medicare, and 6.2 percent for private health insurance, based on CMS data on per enrollee spending by insurer. (Medicaid and Medicare growth rates were adjusted to account for the 2006 implementation of Medicare Part D. Calculation not shown.) [Figure 4]

Figure 4: Per Enrollee Annual Cost Growth for Medicaid, Medicare and Private Insurers, 2000 to 2013



Source: Vernon Smith, "Can States Survive the Per Capita Medicaid Caps in the AHCA?" Health Affairs Blog, May 17, 2017. http://healthaffairs.org/blog/2017/05/17/can-states-survive-the-per-capita-medicaid-caps-in-the-ahca/

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Given that Medicaid is already lean, as a result of a perennial state focus on Medicaid cost controls, it is impossible to imagine how states could respond to the challenge of massive reductions in federal Medicaid support to states proposed in the AHCA without harming current beneficiaries. The proposed shift in fiscal responsibility from the federal government to the states is so large, no amount of new flexibility could allow a response that wouldn't include large state tax increases or severe reductions in coverage that would affect the medical services needed by the children, pregnant women, persons with disabilities, the elderly and other adults now served by Medicaid.

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http://healthaffairs.org/blog/2017/05/17/can-states-survive-the-per-capita-medicaid-caps-in-the-ahca/

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

Senate, Assembly Seek to Raise Medicaid Provider Payments Using Tobacco Tax Funds. *Los Angeles Times* reported on May 26, 2017, that the California Senate and Assembly want to use funds from the state's tobacco tax to increase payment rates to Medicaid providers. The move by the legislature differs from Governor Jerry Brown's proposal to use the tobacco tax revenues for overall Medi-Cal spending. The Senate proposal starts with $150 million in physician rate increases in 2018 for those working in both high-need areas and specialties, increasing over time, while the Assembly is proposing approximately $857 million in incentive payments. Both plans also call for higher reimbursement rates for family planning service providers and expanded Medi-Cal eligibility for immigrants without legal status up to age 26. Read More

Assembly, Senate Budget Committees Approve Covering 80,000 Undocumented Young Adults Under Medicaid. *California Healthline* reported on May 26, 2017, that the California Assembly and Senate budget committees approved the use of some tobacco tax funding to cover 80,000 undocumented young adults up to age 26 under Medi-Cal. The Assembly approved $54 million, while the Senate approved $86 million. The committees must agree on a single amount before beginning budget negotiations with Governor Jerry Brown. There is still disagreement among lawmakers and the Governor over other spending priorities for the tobacco tax money. Governor Brown hopes to use the tax revenue to boost overall Medi-Cal spending, while some lawmakers hope to raise provider and dentist rates. Last May, California expanded Medi-Cal coverage for children under 19 regardless of legal residency status. Read More

District of Columbia

DC Announces Intent to Award Medicaid Managed Care Contracts. The District of Columbia Department of Health Care Finance announced on May 25, 2017, its intent to award managed care contracts for the Medicaid and Alliance programs to AmeriHealth Caritas, Trusted Health Plan, and new entrant Amerigroup. Incumbent plans were AmeriHealth Caritas, Trusted, and MedStar Family Choice. Contracts are for one year beginning in October 2017 with four option years. There are more than 181,400 Medicaid members and approximately 15,500 Alliance beneficiaries who will be served under the contracts. The proposed contracts must be approved by the D.C. Council.

Florida

Report Finds Improvements in Children's Access to Medicaid/CHIP. The Florida Agency for Health Care Administration announced on May 24, 2017, that the state has seen improvements in the number of children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) between 2013 and 2015, according to an *Urban Institute* report. Agency Secretary Justin Senior attributed the 7.1 percentage point increase in enrolled children to the implementation of Statewide Medicaid Managed Care. Meanwhile, national CMS-416 quality measures reported by states to the Centers for Medicare & Medicaid Services showed that Florida experienced improved children's access as well as gains across every metric in the report. Read More

Two Medicare Advantage Insurers Settle Overbilling Lawsuit for $32 Million. *Kaiser Health News* reported on May 30, 2017, that two Florida Medicare Advantage plans, Freedom Health and Optimum HealthCare, will settle a whistleblower lawsuit for $32 million. The lawsuit, filed in 2009 by Darren Sewell, a physician and former medical director at the two plans, alleges that the plans overbilled the federal government by more than $40 million, exaggerating patient acuity or falsifying claims. Medicare Advantage plans receive higher payments for patients of higher acuity through a risk score formula. Government auditors, including the Government Accountability Office, have repeatedly cited overbilling as a result of inflated risk scores. Freedom and Optimum denied any wrongdoing. Read More

Illinois

House Bill Could Slow Medicaid Managed Care Procurement. *The State Journal-Register* reported on May 29, 2017, that the Illinois House approved legislation that could slow down or even block the state's most recent Medicaid managed care procurement. The approval of Senate Bill 1446 would require the state to use the regular procurement process, rather than one used in the past when the state's Medicaid managed care program was much smaller. The procurement would expand Illinois' $9 billion Medicaid managed care program statewide, while reducing the number of contracted health plans. The state Department of Healthcare and Family Services is expected to announce contract awards at the end of June. Read More.

Indiana

Indiana Adds Work Requirement to HIP 2.0 Waiver Extension Application. *Modern Healthcare* reported on May 25, 2017, that Indiana posted an amendment to its Healthy Indiana Plan (HIP) 2.0 Waiver Extension Application to add work requirements for Medicaid beneficiaries. Under the amendment, the state would require all able-bodied HIP participants to work an average of 20 hours per week or be enrolled in job search, training, or education programs. Other states looking to add Medicaid work requirements include Maine, Kentucky, Arizona, Florida, and Ohio. Read More

Kansas

KanCare Waiver Renewal Request to be Submitted November 2017. Kansas announced on May 24, 2017, that the state intends to submit its KanCare waiver renewal proposal on November 1, 2017. The renewal, which must be approved by the Centers for Medicaid & Medicare Services, would extend the KanCare program for one year, effective January 1, 2018, through December 31, 2018. The Kansas Department of Health and Environment will hold the first round of public meetings in June and a second round in the fall to collect formal comments. Written comments can also be submitted from June 14, 2017, until October 15, 2017. Read More

Louisiana

House Budget Proposes Eliminating Certain Outpatient Mental Health Services. *The Times-Picayune* reported on May 28, 2017, that the Louisiana House proposed a state budget that would eliminate certain mental health services for people with schizoaffective disorder, bipolar disorder, and other serious mental illnesses, effective July 1. Inpatient services at hospitals would still be covered, but outpatient services would be eliminated. The budget reduces the state Department of Health funding by $235 million for fiscal 2018 or $920 million including federal matching. Advocates are warning the state that affected children and adults are more likely to end up in crisis if outpatient services are reduced. The state says cuts will allow the preservation of hospice, dialysis treatment, and prescription medication for Medicaid recipients. Read More

Missouri

BCBS of Kansas City Announces Exchange Exit, Leaving 25 Counties With No Options for 2018. *The Wall Street Journal* reported on May 25, 2017, that Blue Cross and Blue Shield of Kansas City will exit the Exchange market in the 30 counties where it currently offers plans in Missouri, impacting 67,000 current members. BCBS-KC reported more than $100 million in losses on Exchange plans through 2016. The move will leave 25 counties with no Exchange plan for 2018 unless another insurer steps in. UnitedHealth Group and Aetna both exited the state's Exchange before 2017. Humana and Anthem are still in the market. Read More

Nebraska

Medicaid Dental Managed Care Contract Awarded to MCNA. The Nebraska Department of Health and Human Services announced on May 25, 2017, that it had awarded MCNA Insurance Company a contract to manage the state's Medicaid dental benefits, replacing the state's existing Medicaid dental fee-for-service program for about 230,000 Medicaid enrollees. The capitated contract term is five years with two additional one-year optional extensions. MCNA will begin providing Medicaid dental benefits on October 1, 2017. Read More

CMS Approves Medicaid Waivers for Individuals with Developmental Disabilities. *Live Well Nebraska* reported on May 25, 2017, that the Centers for Medicare & Medicaid Services has approved Medicaid waivers in Nebraska for community-based services for individuals with developmental disabilities. Nebraska's adult day services waiver was approved for a five-year renewal and a state request to combine the adult and children's comprehensive waivers into one covering residential and day services throughout life was also approved. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Bill Establishes Medicaid Reimbursement Rate for Personal Care Services. *Politico* reported on May 25, 2017, that both Democratic and Republican lawmakers from both chambers of the New Jersey Legislature are supportive of S1018/A320, which would establish a minimum Medicaid reimbursement rate to be equal to the rate in the Medicaid fee-for-service program for personal care services. The current Medicaid rate is $18 per hour. Support for the bill increased following an announcement made by Amerigroup, one of the five Medicaid managed care organizations in New Jersey, to reduce rates for personal care services starting July 1 to "bring our rates in line with the market." Horizon NJ Health reduced its PCA reimbursement rates in 2012. According to Chrissy Buteas, president and CEO of the New Jersey Home Care & Hospice Association, home care workers" can make more money selling a hamburger or folding clothes than they can caring for a human being because it's tied to the Medicaid reimbursement." The proposed increase would cost an estimated $16 million in Medicaid funding, half of which would come from federal matching funds. The bill passed the Assembly and will be heard by the Senate Budget Committee this week.

New Mexico

Centennial Care 2.0 MCO Procurement Schedule Announced. New Mexico is scheduled to release a request for proposals (RFP) for the reprocurement of Centennial Care Medicaid managed care contracts on September 1, 2017. Proposals are due November 15, 2017, with award announcements set for March 15, 2018. Implementation of the Centennial Care 2.0 program is expected January 1, 2019.

New York

HMA Roundup – Denise Soffel (Email Denise)

Office of Mental Health Statewide Comprehensive Five-Year Plan. The New York Office of Mental Health (OMH) has released its Statewide Comprehensive Five-Year Plan for 2016-2020. The Comprehensive Plan includes a review of consumers, services and programs, and gross expenditures within the New York State public mental health system. The Plan also reviews several top priorities for OMH policy and planning efforts in the current and upcoming years. In 2015, an estimated 772,000 individuals were served in the New York State public mental health system. This estimate is a significant increase from prior years, with estimated annual service numbers of

729,000 in 2013 and 717,000 in 2011. Statewide mental health expenditures from all sources have grown over the most recent five-year period, from $6.7 billion to $6.8 billion. The plan includes sections on:

- Public Health and Clinical Strategies to Prevent and Intervene Throughout the Trajectory of Mental Health and Early Childhood Prevention and Pediatric
- New York State's Suicide Prevention Plan 2016-17
- Managed Care of Integrated Behavioral and Physical Health Services
- The OMH Transformation Plan: Advancing a Progressive Behavioral Health System
- OMH Forensic Services Initiatives
- The Mental Health Workforce: Strategies to Address the Shortages and Increase Access to Critical Professional Services
- Cultural Competence Read More

New York State Provider and Health Plan Look-Up. The New York Department of Health, in collaboration with New York State of Health, New York's official health plan Marketplace, has launched the New York State Provider & Health Plan Look-Up. The online tool helps consumers research provider networks and health plans by letting them search by their preferred providers and hospitals to see which plans include them in their network. The tool is updated with information sent to New York State directly by health plans. It can be searched by health plan or by provider and facility. The database includes all mainstream Medicaid plans, including managed long-term care plans, as well as all plans offered through the Marketplace. The database includes information on provider gender and languages spoken, as well as whether the site is wheelchair-accessible. Read More

Doctors Across New York Request for Applications Released. The New York State Department of Health's Office of Primary Care and Health Systems Management has issued a Request for Applications (RFA) for Doctors Across New York Ambulatory Care Training Program. The Doctors Across New York (DANY) initiative includes several programs collectively designed to help train and place physicians in underserved communities in a variety of settings and specialties to care for New York's diverse population. The DANY Ambulatory Care Training Program makes funding available to sponsoring institutions to provide clinical training of residents and medical students in freestanding ambulatory care sites (a non-hospital operated Diagnostic and Treatment Center or a private physician practice). The goal of the program is to enhance the clinical training experience and encourage residents and medical students to continue practicing in such settings. Approximately $6.3 million in state funding is available under this RFA to support training programs over a three and one-half year period. Two-thirds of available funding is reserved for awardees from New York City, and one-third of the funding is reserved for awardees from the rest of the state. The Department of Health anticipates funding up to 10 contracts for this initiative. Proposals are due June 22, 2017. Read More

Revisions to Patient-Centered Medical Home Incentive Payment Program. In 2010, New York established a statewide Patient-Centered Medical Home program whereby providers who are recognized by the National Committee for Quality Assurance (NCQA) are eligible to receive additional payments for services provided to Medicaid enrollees. The state is changing the reimbursement amounts for providers working at practices that are recognized as a Patient-Centered Medical Home (PCMH), effective July 1, 2017. The revised policy applies to both Medicaid Managed Care (MMC) and Medicaid Fee-For-Service (FFS). As part of on-going efforts to raise the bar on provider performance, all incentive payments for PCMH-recognized providers under NCQA's 2011 standards will be eliminated. Practices that are recognized as Level 3 providers under the 2014 standards will receive MMC incentive payments of $3.00 PMPM, and FFS add-on amounts will be $20.50 and $23.25 for professional and institutional claims, respectively. Level 3 providers recognized under the 2014 standards will receive MMC incentive payments of $7.50 PMPM, and the FFS add-on amounts will be $29.00 and $25.25 for professional and institutional claims, respectively. Policy discussions are underway regarding alignment of PCMH incentive payments with value-based principles and policies. Read More

New York State's Provider Network Standards. The United Hospital Fund released a report titled "Networks at the Nexus: Revisiting New York State's Provider Network Standards and Protections." The report looks at the provider network adequacy standards in place in New York, within the Medicaid program as well as for other payers. The report reviews the current network adequacy standards and consumer protections, including the Provider Network Data System (PNDS), the cornerstone of network regulation. The report identifies a number of steps to refine or supplement existing access standards and to strengthen consumer protections and disclosure, including:

- expanding current Medicaid Managed Care standards on minimum waiting times for appointments to enrollees in commercial markets;
- creating a central database that health plans and regulators can use to adjust network information to reflect deaths, retirements, and changes in practice among providers, to improve the accuracy of provider directories;
- improving access to New York's appeals process for accessing out-of-network providers; and
- supplementing new "provider look-up" tools for consumers with data that allow them to better compare their options. Read More

North Carolina

BCBS-NC Proposes 22.9 Percent Exchange Plan Rate Increase for 2018. Blue Cross and Blue Shield of North Carolina (BCBS-NC) announced on May 25, 2017, that is it requesting a 22.9 percent rate increase on individual Exchange plans for plan year 2018. BCBS-NC attributes 14.1 percent of the increase to the lack of funding for cost-sharing reduction (CSR) payments. If CSR payments were fully funded, the plan would have proposed an 8.8 percent increase. The remaining factors are an increase in medical costs, including physician services and prescription drugs, and the Federal Health Insurance Tax. Read More

Ohio

Attorney General Files Lawsuits Against Five Major Drug Companies Over Opioid Epidemic. *Business Insider* reported on May 31, 2017, that the Ohio State Attorney General is suing five major drug companies, accusing them of providing misleading information on the risks of opioids, thereby worsening the opioid epidemic in the state. Ohio filed suit against Purdue Pharma LP, Janssen Pharmaceutical (Johnson & Johnson), Cephalon (Teva Pharmaceutical Industries Ltd), Allergan Plc., and a unit of Endo International Plc. Similar lawsuits have also been filed in California, Chicago, New York, and Mississippi. Last year, more than 4,100 people were reported to have died from drug overdoses in Ohio. Read More

Oklahoma

1332 Waiver Bill Passes Joint Committee. *The Oklahoman* reported on May 24, 2017, that a bill authorizing Oklahoma to pursue a Section 1332 Innovation Waiver has passed the state House and Senate Joint Committee on Appropriations. House Bill 2406 would create the Individual Health Insurance Market Stabilization Act, and develop a 1332 Waiver for submission to the Centers for Medicare & Medicaid Services this year. The waiver would likely create high-risk pools or a reinsurance program to offset the kind of insurance plan risk that has left the state with only one Exchange plan and soaring premiums. A not-for-profit, state-created entity would manage the insurance program, with administrative support from state Insurance Commissioner. Read More

Oregon

Officials Estimate 32,000 Medicaid Enrollees May Have Been Ineligible. *The Oregonian* reported on May 24, 2017, that Oregon Health Authority officials are predicting that 28 percent of the state's Medicaid eligibility redetermination backlog may be ineligible for the program, or approximately 32,000 enrolled individuals. As previously reported, the state accumulated a backlog of eligibility redeterminations for 115,000 Medicaid beneficiaries due to technological issues with the Medicaid agency's computer systems, as well as a lack of regular eligibility redeterminations. The agency did not disclose how much spending was associated with the ineligible members, but it could reportedly be as much as $265 million a year based on PMPM costs. The agency must still complete redeterminations for another 84,000 participants. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

May 25th Meeting of Pennsylvania Medical Assistance Advisory Committee. Terri Cathers, Department of Human Services Director of Pharmacy, provided information on the covered outpatient drug final rule published by Centers for Medicare & Medicaid Services (CMS) in 2016. The rule, which lays out the requirements for payment methodologies, applies only in the Fee For Service program and will not be applicable to MCOs. The Pennsylvania Department of

Human Services (DHS) released proposed changes in March 2017 and to date has received 11 comments. Stakeholders have objected to the methodology as lacking cohesiveness. The department is currently reviewing comments and will submit a State Plan Amendment by June 30, 2017. Michael Hale, director of Quality and Provider Management Bureau, Office of Long Term Living (OLTL), shared that DHS has submitted 1915(b) and 1915(c) waivers to CMS to provide services through Community HealthChoices. Nancy Thaler, Deputy Secretary for the Office of Developmental Programs (ODP), provided an update including two large waivers that have successfully been submitted to CMS with plans to go live July 1, 2017. She explained the waivers would "enhance significantly" the options available other than 24-hour residential and are both programmatically and financially progressive. Dr. Dale Adair, acting Deputy Secretary and Medical Director for the Office of Mental Health and Substance Abuse Services, announced Rural Access to Medication Assisted Treatment (MAT) in Pennsylvania (RAMP), a three-year federal grant to improve and increase the number of prescribers in rural areas. He said the grant was projected to double the number of such prescribers to 75 and highlighted a map of affected counties "largely along the I-80 corridor."

Texas

HMA Roundup – Amy Einhorn (Email Amy)

Texas Legislature Passes Budget, Reducing Medicaid Spending by $1.9 Billion. At the close of the Texas Legislative Session, Texas lawmakers passed a budget for the 2018-2019 biennium which reduced Medicaid spending by $1.9 billion. Funding for Medicaid client services in 2018 includes estimates for caseload growth but keeps average cost estimates for most services at the same level as 2017 fiscal year costs. Fiscal year 2019 funding is maintained at 2018 levels and does not incorporate caseload growth. The only exception to this level of funding is for long-term care waivers, which are kept at the August 2017 level throughout the 2018-2019 biennium, except for the Texas Home Living (TxHmL) and Home- and Community-based Services (HCS) waivers. An additional 735 waiver slots for promoting independence are funded by the end of fiscal year 2019. TxHmL slots are assumed to decline throughout the 2018-2019 biennium. The budget also includes restorations of about 25 percent of the previous cuts made to therapy reimbursement rates in the 2016-2017 biennium; however, reimbursement reductions to therapy assistants will be phased in. The budget emphasizes cost containment strategies and includes specific direction to the Health and Human Services Commission (HHSC) to contain costs and realize savings. Direction to reduce the risk margin for Medicaid managed care is included. Read More

National

CBO Analysis of AHCA Finds Older Adults, Individuals with Greater Health Needs May Face High Premiums or Lose Coverage. *Kaiser Health News* reported on May 24, 2017, that according to a Congressional Budget Office (CBO) analysis of the American Health Care Act, individuals who are older or have greater health care needs will likely face high premiums or be unable to afford insurance at all. As passed by the House, the bill lets states waive some key provisions of the Affordable Care Act, including requirements

to cover essential health benefits and to provide insurance to people with preexisting conditions at no extra cost. As a result, CBO said that people who are less healthy "would face extremely high premiums." Furthermore, in states that waive coverage requirements, "the nongroup market would start to become unstable." Read More

Senate Republicans Work on New Capped Medicaid Contribution Model. *Modern Healthcare* reported on May 24, 2017, that Senate Republicans are working to create a new capped Medicaid contribution model as part of the Affordable Care Act repeal and replace legislation. However, there are challenges in creating a system that is equitable across states while maintaining adequate coverage. The House Republican American Health Care Act would convert federal Medicaid payments into per-capita contributions across five major categories of eligibility. The problem is that per-capita Medicaid spending varies greatly by state, which could penalize states with low spending and reward those with high spending. Another option to states under the AHCA would be block grants. Read More

Providers Concerned Over Medicaid Cuts, Per Capita Caps. *Modern Healthcare* reported on May 25, 2017, that health care providers are concerned over potential cuts to Medicaid funding and the ramifications of enacting per-capita caps. The American Health Care Act (AHCA), as passed by the House, stands to cut $834 billion from Medicaid by 2026. It is unclear what that entails, but providers fear that the remaining funding will not be enough to cover the costs of treating the Medicaid population. To offset the Medicaid cuts, the AHCA would reverse disproportionate share hospital (DSH) payment reductions; however, providers maintain this would not offset the significant reduction in overall funding. Read More

States Look to Hold Nursing Homes Accountable for Unnecessary Evictions. *NPR* reported on May 26, 2017, that some states are looking to hold nursing homes accountable for unnecessary evictions, known as involuntary discharges. Maryland is suing Neiswanger Management Services (NMS) for improperly sending residents with complex medical needs to homeless shelters or to unlicensed board-and-care facilities. Meanwhile, in Illinois, State Senator Daniel Biss is proposing legislation to crack down on nursing homes that improperly discharge residents. Nursing home evictions doubled over the last five years in the state. Read More

Industry Research

Low-Tech Outreach Tools Effective for Enrolling Medicaid Members, Study Finds. *Kaiser Health News* reported on May 26, 2017, that low-tech outreach tools, such as post cards, emails, and robocalls, can be as effective as personalized assistance to get people to sign up for Medicaid, according to a *Health Affairs* study. The study, which conducted randomized, controlled trials in Oregon, found that low-cost behavioral "nudges" substantially increased enrollment. Co-author Katherine Baicker, a professor of health economics at Harvard University, stated that extra personalization and individual-level contact did not boost total sign-ups by much. The study also compared costs of outreach efforts, finding low-intensity interventions to cost an average $1.75 per person, while high-intensity interventions cost up to $28 per person. Read More

ERs Charge More for Patients with Private Insurance, No Insurance. *The Baltimore Sun* reported on May 30, 2017, that a study conducted by Johns Hopkins University School of Medicine found that emergency rooms frequently charge marked-up rates to patients who are uninsured or have private insurance, with the greatest impact falling on the uninsured and minority populations. Using billing records, the study compared what patients with private insurance or no insurance were charged for emergency room services with what Medicare paid in 2013 at nearly 300 hospitals. The study revealed that patients with private insurance or no insurance were charged from 1 percent to 12.6 percent more for services than what Medicare paid. The study also found higher markups at for-profit hospitals in Southeastern and Midwestern states that tend to serve higher populations of uninsured, African-American, and Hispanic patient populations. Read More

Industry News

Community Health Systems to Sell Five Pennsylvania Hospitals to Reading Health System. Community Health Systems, Inc. announced on May 30, 2017, that it will sell five Pennsylvania hospitals to Reading Health System as part of the company's planned divestiture of 30 hospitals. The transaction is expected to close in the third quarter of 2017 and includes Brandywine Hospital, Chestnut Hill Hospital, Jennersville Hospital, Phoenixville Hospital, and Pottstown Memorial Medical Center. Read More

Anthem Weighing 2018 Exchange Participation. *The New York Times* reported on May 24, 2017, that Anthem is still weighing participation decisions for state Exchange markets in 2018, as uncertainty continues around insurer cost-sharing subsidies. Anthem currently provides Exchange coverage to 1.1 million members in 14 states, plus another 500,000 off-Exchange individual market members. Anthem chief executive Joseph Swedish stated a preference to remain in Exchange markets if it is viable. Read More

Molina Healthcare Investigates Potential Patient Data Breach. *California Healthline* reported on May 26, 2017, that Molina Healthcare is investigating a potential security breach that may have resulted in the unintended display of member data on the company's patient portal. Molina shut down the portal after learning that patient names, addresses, date of birth, and information on medical procedures and medications could potentially be viewed. Read More

Company Announcements

- ***"MCG Health and Children's Community Health Plan to Present on the Success of Health Care Automation at AHIP Institute and Expo."*** Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 15, 2017	Delaware	Proposals Due	200,000
June 30, 2017	Illinois	Contract Awards	2,700,000
June, 2017	Oklahoma ABD	Contract Awards	155,000
Spring/Summer 2017	Virginia Medallion 4.0	RFP Release	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 10, 2017	Delaware	Contract Awards (Optional)	200,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	New Mexico	RFP Release	700,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
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
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 15, 2017	New Mexico	Proposals Due	700,000
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	Delaware	Implementation (Optional)	200,000
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
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
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
March 15, 2018	New Mexico	Contract Awards	700,000
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
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
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
January 1, 2019	New Mexico	Implementation	700,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
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.

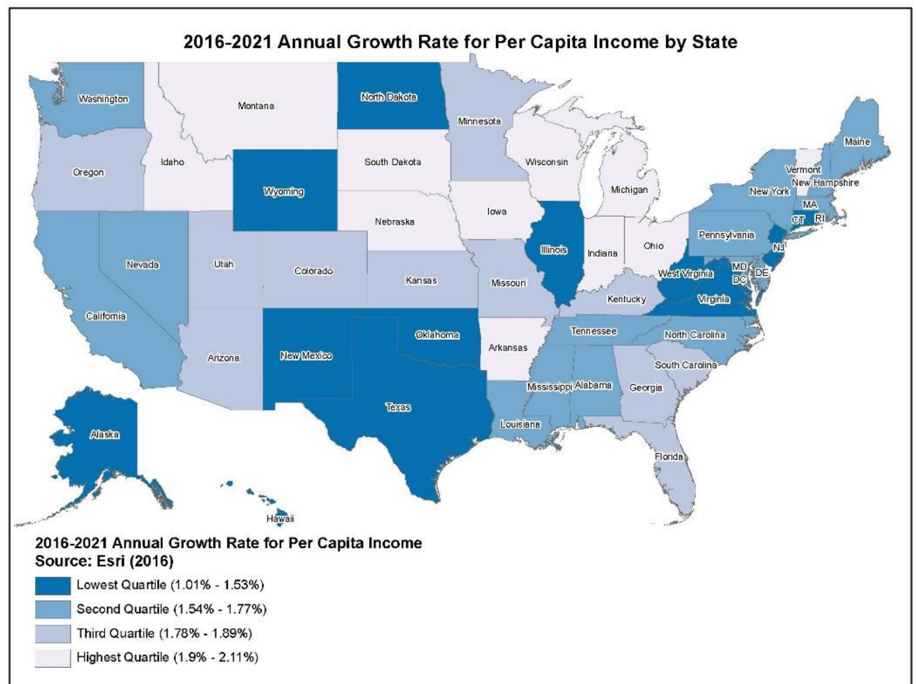
HMA NEWS

Medicaid Directors from Six States to Address Innovation, Waivers, Shared Responsibility, and Other Important Initiatives at HMA's Conference on the Future of Medicaid

State Medicaid directors will be among dozens of featured speakers at HMA's annual conference, *The Future of Medicaid is Here: Implications for Payers, Providers and States,* September 11-12, 2017, at the Renaissance Chicago Downtown Hotel**.** At least six Medicaid directors from states including California, Kansas, Hawaii, Michigan, Texas, and Washington, as well as the former Indiana Medicaid director and the head of the National Association of Medicaid Directors will discuss the future of state innovation in Medicaid, waivers, shared responsibility, and other important initiatives. **Early Bird registration is now open.** Last year's conference attracted more than 250 attendees. Visit the conference website for complete details: https://2017futureofmedicaid.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

HMA Weekly Informatics Series Continues

Over the next few weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) will showcase a series of maps and other key informatics. Our eighth map in the series highlights data on **the 2016-2021 annual growth rate for per capita income by state**. The economic resources of individuals and neighborhoods are intertwined with individual and population health because the local economy determines access to jobs, commerce, health services, and other key resources.



What does your service area look like? HMA can drill down to county, zip code, or census tract - adding to the depth and breadth of knowledge around the health indicators affecting your community. For more information, contact **Anissa Lambertino** at alambertino@healthmanagement.com or (312)641-5007.

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; San Antonio, Texas; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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

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