HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE SPENDING IN 2017

This week, our *In Focus* section reviews Medicaid spending data collected in the annual CMS-64 Medicaid expenditure report. After submitting a freedom of information act request to CMS, we have received a draft version of the CMS-64 report that is based on preliminary estimates of Medicaid spending by state for federal fiscal year (FFY) 2017. The final version of the report will be completed by the end of 2018 and posted to the CMS website at that time. Based on the preliminary estimates, Medicaid expenditures on medical

services across all 50 states and 6 territories in FFY 2017 exceeded $571 billion, with over half of all spending now flowing through Medicaid managed care programs. In addition, total Medicaid spending on administrative services was $27.8 billion, bringing total program expenditures to just under $600 billion.

Total Medicaid Managed Care Spending

Total Medicaid managed care spending (including the federal and state share) in FFY 2017 across all 50 states and 6 territories was $297 billion, up from $271 billion in FFY 2016. This figure includes spending on comprehensive risk-based managed care programs as well as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). PIHPs and PAHPs refer to non-comprehensive prepaid health plans that provide only certain services, such as dental services or behavioral health care. Fee-based programs such as primary care case management (PCCM) models are also counted in this total. However, comprehensive risk-based managed care organizations (MCOs) account for 95 percent of the total. Below we highlight some key observations:

- Total Medicaid managed care spending grew 9.5 percent in FFY 2017, the lowest year-over-year growth rate since at least FFY 2007.
- This slowing of spending growth, down from a peak of 31.4 percent in FFY 2015, is due in large part to fewer states expanding Medicaid under the Affordable Care Act (ACA).
- In dollar terms, the increase from FFY 2016 to FFY 2017 was $25.8 billion compared to $32.7 billion from FFY 2015 to FFY 2016.
- Medicaid managed care spending has increased at a 16.9 percent compounded annual growth rate (CAGR) since FFY 2007, compared to 6.1 percent growth in total Medicaid spending.
- Medicaid managed care spending represented 51.9 percent of total Medicaid spending in FFY 2017, exceeding half of total Medicaid medical services expenditures for the first time. Compared to FFY 2016, the penetration rate increased by 2.8 percentage points, the smallest annual increase since FFY 2011.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures FFY 2007-2017 ($M)

$M	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	CAGR
Medicaid MCO expenditures*	$60,663	$71,318	$78,644	$90,394	$102,478	$120,325	$141,998	$181,421	$238,343	$271,028	$296,806	**16.9%**
% y/y	*13.3%*	*17.6%*	*10.3%*	*14.9%*	*13.4%*	*17.4%*	*18.0%*	*27.8%*	*31.4%*	*13.7%*	*9.5%*	
Total Medicaid expenditures	$311,014	$337,055	$356,285	$381,615	$406,459	$408,850	$432,944	$467,426	$526,711	$550,881	$571,341	**6.1%**
% y/y	*4.0%*	*8.4%*	*5.7%*	*7.1%*	*6.5%*	*0.6%*	*5.9%*	*8.0%*	*12.7%*	*4.6%*	*3.7%*	
% of Total	**19.5%**	**21.2%**	**22.1%**	**23.7%**	**25.2%**	**29.4%**	**32.8%**	**38.8%**	**45.3%**	**49.2%**	**51.9%**	
Penetration rate increase	*1.6%*	*1.7%*	*0.9%*	*1.6%*	*1.5%*	*4.2%*	*3.4%*	*6.0%*	*6.4%*	*3.9%*	*2.8%*	

**Includes Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans*

Source: CMS-64

The data breaks down the state and federal share of Medicaid expenditures, which illustrates the impact that the Medicaid expansion, which was initially 100 percent federally funded in the states where it was implemented, has had on the sources of funding.

As the table below indicates, 61.6 percent of FFY 2017 spending was contributed by federal sources, which is 4.2 percentage points higher than the pre-Medicaid expansion share in FFY 2013, but 1.6 percentage points lower than FFY 2016 due to the matching rate reduction for Medicaid expansion enrollees from 100 percent to 95 percent.

Federal vs. States Share of Medicaid Expenditures, FFY 2012-2017

$M	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17
Federal Share	$235,070	$248,641	$281,269	$330,708	$346,325	$351,917
% of Total	*57.5%*	*57.4%*	*60.2%*	*62.9%*	*63.2%*	*61.6%*
State Share	$173,780	$184,303	$186,157	$195,063	$202,056	$219,424
% of Total	*42.5%*	*42.6%*	*39.8%*	*37.1%*	*36.8%*	*38.4%*
Total	**$408,850**	**$432,944**	**$467,426**	**$525,772**	**$548,382**	**$571,341**

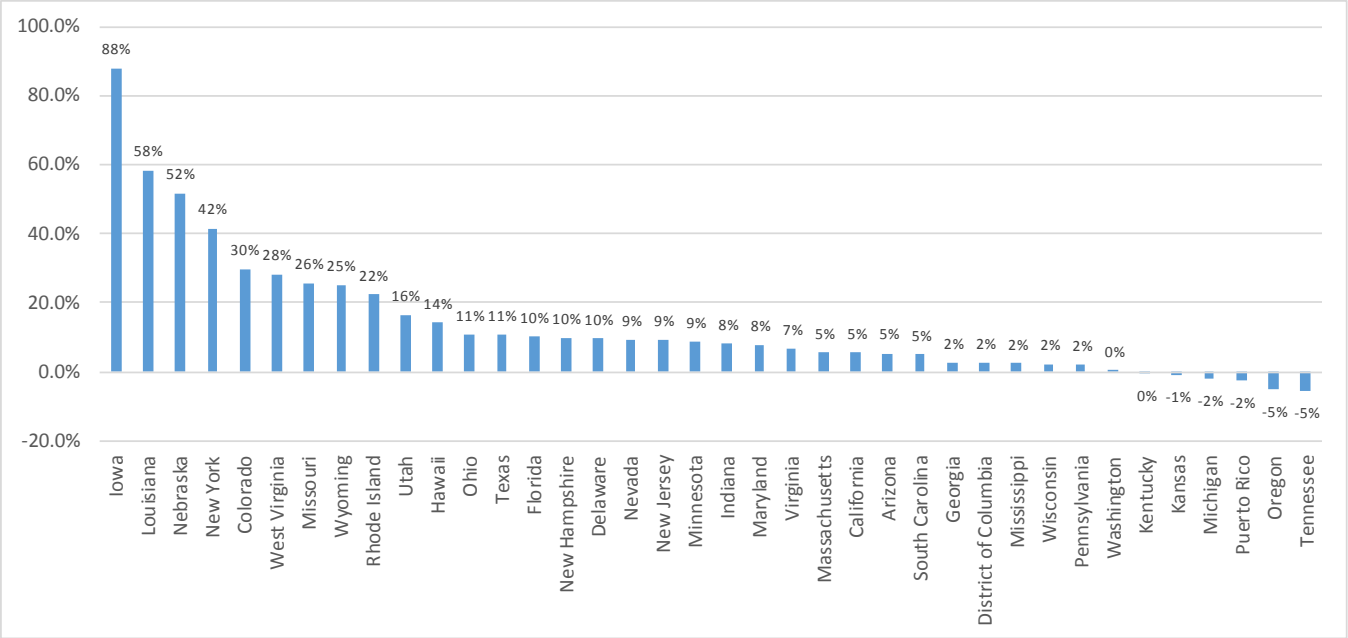
Source: CMS-64

State-specific Growth Trends

Fourty-five states and territories report MCO spending on the CMS-64 report of which five states (Alabama, Idaho, North Carolina, Oklahoma and North Dakota) utilize a PCCM and/or PIHP/PAHP model exclusively. Of the remaining 40 states and territories that contract with risk-based MCOs, average spending in FFY 2017 increased 10.3 percent. On a percentage basis, Iowa experienced the highest year-over-year growth in Medicaid managed care spending for the second consecutive year at 88 percent, which was attributable to the continuing roll-out of its managed care program that began in April 2016. Louisiana, Nebraska and New York all saw Medicaid managed care spending growth of more than 40 percent.

The chart below provides additional detail on Medicaid managed care spending growth in states with risk-based managed care programs in FFY 2017. Interestingly, six states reported year over year declines in spending compared to two in FFY 2016.

Medicaid Managed Care Spending Growth on a Percentage Basis by State FFY 2016-17

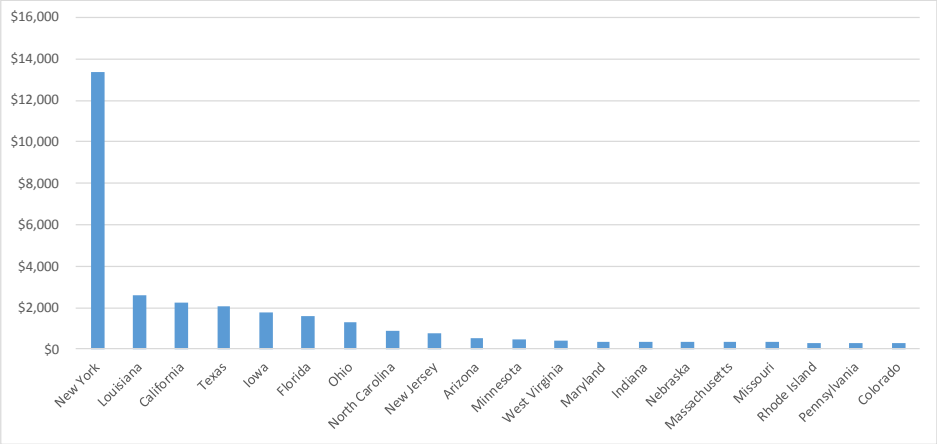


Source: CMS-64

Note: Not all states are included in the table due to incomplete data sets

Looking at year-over-year spending growth in dollar terms, New York experienced the largest increase in Medicaid managed care spending by far at over $13 billion. Other states with significant year-over-year spending increases in dollar terms included Lousiana ($2.6 billion), California ($2.2 billion) and Texas ($2.0 billion). All other states saw year-over-year spending growth of less than $2 billion. The chart below illustrates the year over year change in spending across the twenty states with the greatest increases.

Medicaid Managed Care Spending Growth on a Dollar Basis by State (Top Twenty States) FFY 2016-17 ($M)



Source: CMS-64

The percentage of Medicaid expenditures directed through risk-based Medicaid MCOs increased by more than 5 percentage points in eight states from FFY 2016 to FFY 2017. The managed care spending penetration rate rose 16.3 percentage points in Nebraska, and 12.5 percentage points in Louisiana.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures in States with a 5 percent or Greater Increase From FFY 2016 to FFY 2017 ($M)

	FFY 2016			FFY 2017			
Medicaid Expenditures	MCO	Total	% of Total	MCO	Total	% of Total	Pct. Point Change in % of total
Iowa	$1,994	$4,716	42.3%	$3,747	$4,066	92.2%	49.9%
Nebraska	$693	$1,969	35.2%	$1,050	$2,042	51.4%	16.3%
Louisiana	$4,451	$8,537	52.1%	$7,053	$10,914	64.6%	12.5%
Texas	$19,379	$39,563	49.0%	$21,426	$35,645	60.1%	11.1%
Rhode Island	$1,386	$2,411	57.5%	$1,696	$2,623	64.6%	7.2%
New York	$32,172	$60,996	52.7%	$45,531	$76,398	59.6%	6.9%
West Virginia	$1,399	$3,656	38.3%	$1,795	$4,001	44.9%	6.6%
North Carolina	$2,144	$12,158	17.6%	$3,026	$13,337	22.7%	5.1%

Source: CMS-64

The table below ranks the 40 states with risk-based comprehensive Medicaid managed care programs by the percentage of total Medicaid spending that is through Medicaid MCOs. Puerto Rico reported the highest such percentage at 98.6 percent, followed by Hawaii at 94.7 percent and Kansas at 93.5 percent. Iowa is fourth on the list having increased its Medicaid managed care spending penetration rate from 13.4% to 92.2% over the last two years.

We note that in many states, there are certain payment mechanisms which may never be directed through managed care such as supplemental funding sources for institutional providers and spending on retroactively eligible beneficiaries. Thus, the maximum acheivable penetration rate in each state will vary and may be below that achieved in other states. Nevertheless, we note that there are a few large states where the penetration rates are currently below two-thirds of total spending but where they have expanded their Medicaid managed care programs recently including Pennsylvania andVirginia. Accordingly, we expect that in FFY 2017 we will see continued growth in Medicaid MCO penetration, though likely at a more moderate pace.

Medicaid MCO Expenditures as a Percent of Total Medicaid Expenditures, FFY 2015-2017

Rank	State	2015	2016	2017
1	Puerto Rico	98.4%	99.3%	98.6%
2	Hawaii	86.3%	88.4%	94.7%
3	Kansas	87.5%	94.3%	93.5%
4	Iowa	12.2%	13.4%	92.2%
5	Arizona	82.7%	85.1%	86.3%
6	Delaware	72.0%	81.0%	83.0%
7	New Mexico	79.1%	84.1%	79.3%
8	Florida	37.0%	64.8%	74.6%
9	Kentucky	64.1%	71.9%	71.9%
10	Rhode Island	50.1%	57.1%	64.6%
11	Louisiana	22.6%	39.9%	64.6%
12	Michigan	55.9%	61.6%	64.3%
13	Tennessee	66.8%	67.1%	63.7%
14	New Jersey	45.4%	56.0%	63.1%
15	Texas	43.4%	50.4%	60.1%
16	New York	46.2%	48.7%	59.6%
17	Pennsylvania	54.6%	54.8%	58.5%
18	Ohio	48.8%	54.1%	57.1%
19	Oregon	56.8%	60.9%	57.0%
20	Washington	44.0%	49.8%	55.0%
21	California	35.2%	46.4%	52.8%
22	Nebraska	31.7%	34.1%	51.4%
23	Mississippi	16.9%	22.8%	50.9%
24	Utah	49.2%	49.3%	50.8%
25	Minnesota	48.8%	50.1%	48.7%
26	South Carolina	41.4%	46.1%	48.6%
27	Wisconsin	41.0%	45.2%	46.8%
28	Maryland	43.7%	45.1%	46.3%
29	Nevada	31.3%	42.0%	45.6%
30	West Virginia	17.8%	17.9%	44.9%
31	Illinois	13.9%	30.7%	44.3%
32	Indiana	20.5%	27.3%	43.2%
33	New Hampshire	18.4%	43.5%	42.8%
34	Virginia	33.4%	39.4%	39.9%
35	Massachusetts	37.3%	38.3%	39.6%
36	Georgia	35.2%	35.6%	38.5%
37	District of Columbia	33.6%	38.5%	36.9%
38	North Carolina	20.7%	20.1%	22.7%
39	Missouri	12.0%	12.0%	16.4%
40	Colorado	11.2%	12.8%	15.9%

Source: CMS-64

Non-MCO Expenditures

Despite the rapid growth in Medicaid managed care over the last ten years, program spending still represented just over half of total Medicaid expenditures in FFY 2017. So where is the remaining FFS spending (approximatley $275 billion) going? First, as noted above, there are many states/territorires with Medicaid managed care programs where certain beneficiaries or services are carved-out of the program, and these are typically associated with high-cost populations. The total amount of non-MCO spending in these 40 states in FFY 2017 was around $235 billion. If we were to assume for the sake of argument that "full penetration" was 85 percent of total Medicaid spending, then we estimate that an additional $200 billion in current FFS spending could shift to a managed care model just in the states that already employ managed care for a subset of services and/or beneficiaries.

Next, there are 16 states/territories that did not utilize a comprehensive risk-based managed care model in FFY 2017. One of these states, North Carolina, is planning to implement such a model in the next several years. In general, the 16 states/territories that do not utilize managed care today are smaller states, North Carolina being the largest at $13 billion of Medicaid spending in FFY 2017. Total Medicaid spending across all 16 non-managed care states was $34.7 billion. The 16 states/territories that did not employ a risk-based comprehensive Medicaid managed care model in FFY 2017 were Alabama, Alaska, American Samoa, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Northern Mariana Islands, North Dakota, North Carolina, Oklahoma, South Dakota, Vermont and Virgin Islands.

In terms of spending by service line, the largest remaining fee-for-service (FFS) category is inpatient services, at $61 billion or 22.4 percent of FFS spending. This amount is split fairly evenly between regular FFS payments (53 percent of total) and supplemental/Disproporate Share Hospital (DSH) payments (47 percent). Measured as a whole, however, we estimate long term care services and supports (including nursing facility, waiver and other home and community based services) represent the largest FFS funding category.

Fee for Service Medicaid Expenditures by Service Line, FFY 2017

Service	FFY 2017 FFS Spending	% of Total FFS Spending
Inpatient Services*	$61,548	22.4%
Home and Community Based Services	$52,916	19.3%
Other	$49,575	18.1%
Nursing Facility*	$43,122	15.7%
Medicare - Part B	$14,031	5.1%
Outpatient Services*	$13,991	5.1%
Intermediate Care	$9,172	3.3%
Physician and Surgical Services*	$8,720	3.2%
Personal Care Services	$7,631	2.8%
Clinic Services	$5,220	1.9%
Federally-Qualified Health Center	$4,669	1.7%
Dental Services	$3,941	1.4%
Total	**$274,534**	**100%**

** Includes regular payments, supplemental payments and DSH if applicable*

Source: CMS-64

Finally, we note that while the CMS-64 report provides valuable detail by service line for all FFS expenditures, it does not capture how spending directed to Medicaid MCOs is allocated by category of service. As such, it is not possible to calculate total spending by service line, a challenge that will only intensify as more spending runs through MCOs.

HMA Medicaid Roundup

Colorado

Medicaid Plans May Face Additional Oversight. *The Denver Post* reported on April 7, 2018, that Colorado Medicaid managed care plans may face additional oversight, following a federal audit. The October 2017 audit suggested that the state should increase oversight of Medicaid plans to improve safeguards against waste, fraud and abuse. Five percent of the state's Medicaid patients are in managed care plans. Read More

Florida

Florida Faces Opposition to Proposed Reduction in Medicaid Grace Period. *Health News Florida* reported on April 4, 2018, that Florida providers and advocates are opposing a proposal by Governor Rick Scott to reduce the grace period for retroactively paying Medicaid claims from 90 days to 30 days. The move is expected to impact about 39,000 Medicaid recipients and save $98 million. Read More

Indiana

Indiana Medicaid Expansion Evaluation Scaled Back. *Modern Healthcare* reported on April 9, 2018, that the Centers for Medicare & Medicaid Services (CMS) was granted permission by the White House's Office of Management and Budget to scale back efforts to evaluate Indiana's Medicaid expansion. The goal of the evaluation is to determine how the state's hybrid Medicaid expansion model impacted care. There are approximately 438,000 enrollees in the state's Medicaid program. Read More

Iowa

Iowa Fields Complaints Over Coverage of Medical Equipment for Individuals with Disabilities. *The Des Moines Register* reported on April 8, 2018, that Iowa Ombudsman Kristie Hirschman has been fielding complaints about inadequate coverage of medical equipment for individuals with disabilities. Medicaid beneficiaries and equipment providers say that Medicaid managed care plans in the state have low, inconsistent reimbursement rates for specialized medical equipment. The result, according to the *Register*, is hundreds being denied medically necessary wheelchairs, shower stools, and nutritional supplements. There are 680,000 poor or disabled Iowa residents, more than a fifth of the state's population. Read More

Kansas

Court Order Allows State to Expedite Takeover of 15 Nursing Homes. *KCUR* reported on April 5, 2018, that Kansas will be able to expedite its takeover of 15 Skyline Health Services nursing homes following a court order. The facilities, which are scattered in various state jurisdictions, would normally have required 15 separate judges' orders before the state could take control. The Kansas Supreme Court ruled that the cases could be consolidated under a single Johnson County District Court judge. As previously reported, Skyline said it was unable to make payroll. Read More

Kentucky

Lawsuit Challenging Kentucky Medicaid Work Requirements Gets Support from Scholars. *Modern Healthcare* reported on April 9, 2018, that over 40 public health scholars from Columbia, Yale, Boston University, and UCLA, among other institutions, filed an amicus brief in support of a federal lawsuit filed by Kentucky Medicaid beneficiaries challenging the state's plan to implement Medicaid work requirements. The scholars argue that the requirements violate the Medicaid statute and could result in up to 200,000 Kentucky members losing coverage. Read More

Maryland

Governor Signs Exchange Reinsurance Bill. *The Washington Post* reported on April 5, 2018, that Maryland Governor Larry Hogan signed legislation to create a reinsurance program aimed at stabilizing the state's Exchange market. The law authorizes the state to apply for a federal 1332 waiver to offer the reinsurance program. Read More

New Hampshire

New Hampshire Releases MLTSS Implementation Plan; RFP Expected Spring 2018. New Hampshire released in March 2018 an implementation plan for the state's planned transition to managed long-term services and support. A request for proposal (RFP) from the state Department of Health and Human Services is expected in Spring 2018. Under the program, New Hampshire will integrate LTSS services provided by the Choices for Independence (CFI) waiver and nursing facilities into the current Medicaid Care Management program. Medicaid managed care plans will cover acute care and non-LTSS services for Medicaid beneficiaries beginning July 2019 and cover CFI and nursing home services by December 2019. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Department of Treasury Posts Fiscal Year 2019 Detailed Budget. On March 29, 2018, the New Jersey Department of Treasury, Office of Management and Budget posted Governor Murphy's detailed budget book for Fiscal Year 2019 online. HMA previously reported on the Governor's budget message here. The detailed budget book, *Building a Stronger and Fairer New Jersey*, provides an in-depth summary of appropriations and highlights significant changes and policy initiatives for the next fiscal year. We offer highlights from the appropriations recommended for the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) in this update (see data package below).

DMAHS administers the NJ FamilyCare program for close to 1.8 million adults and children. State expenditures exceed $15 billion. Over 95 percent of enrollees receive their benefits through one of the five contracted managed care organizations: Horizon NJ Health, UnitedHealthcare Community Plan, Amerigroup New Jersey, WellCare Health Plans of New Jersey and Aetna.

Additional information can be found on the Department of Human Services and DMAHS in the detailed budget beginning on page D-177 (PDF page 256) here.

New Jersey Medicaid Proposes 1115 Waiver Amendment to Add Jersey Assistance Community Caregiving (JACC) Population. The Centers for Medicare & Medicaid Services (CMS) is providing a second public comment period from April 2, 2018 to May 2, 2018, on New Jersey's proposal to amend the 1115 New Jersey FamilyCare demonstration to add the existing, state-funded JACC population. The proposed amendment represents an administrative streamlining of the JACC program and the maximization of federal resources for the state-funded program. JACC is administered by the Division of Aging Services under the Department of Human Services and is like the state's Medicaid managed long term services and supports program (MLTSS) but for individuals who are not financially eligible for Medicaid or Medicaid waiver services. Individuals age 60 or older who live in their own home and are determined clinically eligible for nursing facility level of care who meet the income thresholds set by JACC may qualify today for a package of supports that may delay or prevent a nursing facility placement. JACC services are limited to a maximum of $600 per month. Comments may be submitted on the Medicaid.gov website here.

New Jersey Medicaid Seeks Public Comments on 1115 Waiver Amendment for Pilots/Benefit Enhancements. On March 10, 2018, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) posted a public notice to amend the Section 1115 demonstration "Comprehensive Waiver" to pursue three pilot programs:

1. To expedite financial eligibility determinations for individuals seeking long term services and supports (LTSS) who are under guardianship of the State office of the Public Guardian

2. To include a one-time allowance for pantry stocking and clothing of up to $1,000 to the community transition benefit under the managed LTSS benefit, and
3. To expand and enhance the state's current community health demonstration project to implement the New Jersey Home Visiting pilot program for high risk pregnant/postpartum women, infants and children up to age two. Read More

Governor Outlines Plans for $100 Million Spend on Anti-Addiction Programs. *NJ Spotlight* reported on April 4, 2018, on the elements in New Jersey Governor Murphy's holistic approach for responding to the state's opioid epidemic. Murphy seeks to set program priorities by using "facts and data" and fortifying community-based outpatient treatment alternatives and addressing the underlying social determinants that contribute to addiction. Read More

Medicaid Officials Issue SPA Public Notice to Cover New Diabetes Benefits. On April 2, 2018, the New Jersey Division of Medical Assistance and Health Services (DMAHS) released a notice for public comment of its plans to seek approval from the Centers for Medicare & Medicaid Services (CMS) for an amendment to the State Plan (SPA) to cover Diabetes Self-Management Education, Diabetes Prevention Programs and Medical Nutrition Therapy, effective July 1, 2018. Medicaid enrollees would need to be referred for the service by a licensed, registered or certified healthcare professional and are intended to promote optimal metabolic control, prevent and manage complications, and maximize quality of life. Comments are due within 30 days from the notice date. Read More

New Jersey Publishes Audit of Medicaid Transportation Broker Services Contract. On March 28, 2018, the New Jersey Office of Legislative Services, Office of the State Auditor released findings of an audit of service utilization and related financial activities from July 2014 – June 2017 related to the Medicaid program's transportation broker. The report cites the following opportunities for improvement:

1. Adopt procedures for assessing liquidated damages for failure to meet any of the 12 performance standards defined in the contract
2. Strengthen controls over mileage reimbursements to avoid improper payments
3. Eliminate unintended duplicate capitation payments to the broker
4. Revise NJMMIS edits to prevent valid encounter claims from being denied, and to enable Medicaid to reconcile encounter claims to the broker's profit and loss statements to verify that the broker does not exceed the 80 percent direct transportation expense threshold. Read More

New Jersey Department of Health Releases Updated DSRIP Data Book. On March 9, 2018, the New Jersey Department of Health released an updated DSRIP Data book with appendices and changes to the June 2017 edition. A redlined version has been posted along with a final clean version. The Databook provides an exhaustive review of DSRIP performance measurement specifications including for chart/electronic health records and MMIS. Among the revisions are references throughout to the appendices which provide a master list with crosswalks, codes and medication value sets, and programming assumptions. Databook 4.0 and the appendices can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Legislature Approves Final SFY 2018-19 Budget. The New York legislature approved the final budget agreement on March 29, 2018, prior to the start of the new state fiscal year on April 1. Despite predictions of a $4.4 billion budget gap, the budget is balanced, due to a combination of re-estimating revenues (up), re-estimating spending (down), and a levy being imposed on the transaction between not-for-profit Fidelis Care and for-profit Centene. The budget holds spending growth to 2 percent or less for the eighth year in a row. Total Medicaid spending in SFY 2019 (federal, state and local) is estimated at $70 billion, an increase of $1.6 billion from SFY 2018. Projected Medicaid spending under the Global Spending Cap, based on a 3.2 percent rate of growth, will increase from $18.27 billion in SFY 2018 to $18.86 billion in SFY 2019. The Medicaid program has been operating under a global spending cap since 2012, calculated as the 10-year average of the medical care consumer price index.

The Executive Budget proposal for SFY 2019 included a series of new revenue streams to mitigate against potential losses in federal Medicaid funding which were included in the final budget.

Health Care Facility Transformation Fund

The FY 2019 Executive Budget creates a new fund of $1 billion. Originally intended to be held in reserve against federal health care spending cuts, the Health Care Facility Transformation Fund is meant to ensure the system's financial sustainability, "to support health care delivery, including for capital investment, debt retirement, or restructuring, housing and other social determinants of health, or transitional operating support to health care providers." Decisions about spending are at the sole discretion of the Commissioner of Health.

Excise Tax on Vapor Products and Opioid Epidemic Surcharge

The governor proposed a 10 cent per fluid milliliter excise tax on vapor products at the distributor level and a 2 cent per milligram surcharge on opioids that would be charged to manufacturers. The Assembly bill increased the proposed opioid surcharge from two cents per morphine milligram to two and a half cents per morphine milligram, which would generate an additional $31.75 million. The Senate rejected both approaches. In the end, the budget creates an opioid stewardship fund that is to total $100M annually to be funded by an assessment on manufacturers and distributors. The amount of

the assessment is determined by calculating each manufacturer/distributors proportion of total morphine milligram equivalent (MME) manufactured or distributed in the state. These funds will be deposited in the stewardship fund for use by the Office of Alcohol and Substance Abuse Services (OASAS) and OASAS-certified agencies for treatment, recovery, prevention and education services and to support the prescription monitoring program.

Other Budget Proposals

Pharmaceutical Pricing Efficiencies

In last year's budget New York passed legislation that set a spending limit on pharmaceuticals, and provided the state with enhanced authority to negotiate additional rebates with manufacturers to maintain spending within the spending limit. Manufacturers that don't reach rebate agreements are subject to Drug Utilization Review (DUR) Board referral for a value-based review and recommendations for targeted supplemental rebates. The budget extends the pharmacy drug cap within the Medicaid program for an additional year, while adding additional reporting requirements.

Health Home Incentives

The budget proposed an initiative that would provide incentive payments to Health Home members for participating in wellness programs, and for avoiding unnecessary hospitalizations and unnecessary use of the Emergency Department. While that language was not included in the budget, the Department of Health has committed to implementing these measures administratively. The budget also establishes penalties for managed care plans and health homes who fail to enroll a targeted number of high-risk enrollees into the Health Homes program.

Statewide Health Care Facility Transformation Program

The third phase of the program includes $525 million to health care providers that fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community. A minimum of $60 million of this total amount is available for community-based health care providers, which are defined as diagnostic and treatment centers, mental health and alcohol and substance abuse treatment clinics, primary care providers and home care providers, $45 million for nursing homes, and $20 million for assisted living providers. The objective of the Statewide Health Care Facility Transformation Program is to support capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including merger, consolidation, acquisition or other activities intended for a number of functions: to create financially sustainable systems of care, to preserve or expand essential health care services, to modernize obsolete facilities, to foster participation in value-based payment, to increase the quality of care in residential facilities, and to improve health information technology infrastructure.

Children's Medicaid System Transformation

While the executive budget did not include funding for the Children's Medicaid System Transformation, the Legislature added funding to the budget that was passed. The plan, which has been under development for seven years, would simplify the delivery system for high needs children currently served under a number of different waiver programs, expand care management, and

add new Home and Community Based Services to the Medicaid benefit. The administration had announced its plan to delay the implementation for two years due to budget constraints, but both houses of the legislature included funding to allow for the implementation of the transformation agenda, and $15 million was included in the final budget. Read More

New York Creates Health Care Facility Transformation Fund. *City and State* reported on April 5, 2018, that the creation of a new health care shortfall fund, intended to provide an alternate source of funding should the Trump administration cut health care funding to New York, was likely a result of a major lobbying push by 1199 SEIU, a union representing healthcare workers. According to *City and State*, the union spent over $2.8 million on lobbying and related expenses in January and February of 2018. The fund was also the highest priority for the Greater New York Hospital Association, the trade group representing hospitals in the greater New York City area. The shortfall fund will provide funding for health care in New York in the event of federal budget cuts. The Health Care Facility Transformation Fund is meant to ensure the system's financial sustainability, "to support health care delivery, including for capital investment, debt retirement, or restructuring, housing and other social determinants of health, or transitional operating support to health care providers." Its funding will initially come from state revenues realized through the sale of Fidelis Care, the largest Medicaid managed care plan in the state, to Centene Corporation.

In the Governor's original proposal, the fund was financed from a portion of the anticipated revenues from any insurer conversion to a for-profit entity, which was targeted at the planned Centene-Fidelis acquisition announced in September of 2017. After significant back and forth, the final deal represents an agreement that will result in Fidelis and Centene paying the state approximately $2 billion over four years. The state expects $1.35 billion in revenues this year as result of the Fidelis-Centene sale. These funds are generated from a variety of mechanisms including a change in the law to allow the Commissioner of Health to collect approximately $500 million of Fidelis Care's excess reserves. Separately, in an updated SEC filing, Centene indicates it will make a $340 million contribution to NYS over a five-year period "for initiatives consistent with Centene's mission of providing high quality healthcare to vulnerable populations in NYS" and expects that upon closing of the Fidelis transaction an additional $160 million being paid to NYS in the form of premium taxes and fees. Read More

NYC Establishes Program to Link Previously Incarcerated Individuals to Primary Care. Manhattan District Attorney Cyrus Vance, Jr., announced on April 9, 2018, the investment of $7.2 million to expand healthcare, education, housing, and employment opportunities for New Yorkers reentering their communities from jail or prison. This includes an award of $3,075,000 to the New York City Department of Health and Mental Hygiene's NYC Health Justice Network. The NYC Health Justice Network will link primary care sites to community based organizations in Upper Manhattan to serve the primary care and social service needs of reentering justice-involved individuals. The Network will implement trauma informed care in primary care clinics and train practices on the criminal justice system and associated health risks. Additionally, persons with a history of justice involvement will be recruited and employed as patient advocates and navigators of primary care and other necessary services, including housing, transportation, and employment

services. The Manhattan District Attorney's Office is providing these grants through its Criminal Justice Investment Initiative, which was created using criminal forfeiture funds obtained through the settlements with international banks for violating U.S. sanctions. Read More

Ohio

Ohio Medicaid To Investigate Pharmacy Benefit Manager Pricing. *The Columbus Dispatch* reported on April 4, 2018, that the Ohio Department of Medicaid (ODM) plans to review pricing data showing how much Medicaid managed care companies paid their pharmacy benefit managers (PBMs) and how much PBMs paid pharmacies for the last year. Additionally, ODM added provisions to contracts with managed care companies requiring additional prescription drug pricing data to be provided beginning July 1, 2018. Read More

Ohio Mental Health Parity and Addiction Equity Act (MHPAEA) Enforcement Questioned. The *Dayton Daily News* reported on April 9, 2018, that mental health advocacy groups are pushing Ohio to do a better job of enforcing MHPAEA, calling Ohio's approach "hands off." The Ohio Department of Insurance reported they have received very few complaints and have not identified systemic issues with MHPAEA compliance. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Court Rules in UnitedHealth's Favor on Protest of HealthChoices Award. The Commonwealth Court of Pennsylvania reversed a decision by state regulators, which had denied UnitedHealthcare's protest of the state's HealthChoices Medicaid managed care contract awards. The court agreed with United's argument that a meeting between representatives of the Pennsylvania Department of Human Services and competing health plans prior to the award announcement was a violation of the state's procurement rules. United was not among the health plans awarded a HealthChoices contract. It is unclear what action DHS will take as a result of this ruling but a cancellation of the solicitation and the issuance of a new RFP is a possibility.

Pennsylvania Governor Renews Opioid Disaster Declaration. Pennsylvania Governor Tom Wolf renewed his 90-day opioid disaster declaration. This initial declaration was set to expire on April 10. The renewal allows for the 13 initiatives introduced in the past 90 days to continue without interruption and for the introduction of new initiatives to help those suffering from opioid use disorder (OUD). Read More

Centene to Open $20 Million Claims Center in Pennsylvania. *The Inquirer* reported on April 5, 2018, that Centene Corp. plans to establish a $20 million, 53,300 square-foot claims center near Altoona, PA. Read More

South Carolina

Autism Program Is Under Investigation for Alleged Fraud. *Greenville News* reported on April 9, 2018, that a South Carolina program for autistic children is under investigation by state and federal regulators for alleged fraud. State Senator Thomas Alexander (R-Walhalla) said the state Medicaid agenda may have given the mistaken impression that provider access and payments for autism treatment were in better shape than they were. In recent years, the program has been criticized for low provider rates, resulting in a shortage of providers, according to autism advocates. There are about 7,500 children ages 3 to 21 in the state diagnosed with autism spectrum disorder, according to the Department of Disabilities and Special Needs. Read More

Texas

Texas Releases RFP for STAR, CHIP. The Texas Health and Human Services Commission has released a Medicaid managed care request for proposals (RFP) for its State of Texas Access Reform (STAR) program and Children's Health Insurance Program (CHIP). A vendor conference will be held April 12, 2018, proposals are due July 2, 2018, and the anticipated contract effective date is January 24, 2019. The initial operational period of the contract is anticipated to be January 1, 2020 through December 31, 2021. The state may execute contract extensions, but the total length of the contract may not exceed eight operational years.

The STAR program covers preventive, primary, acute, behavioral health and pharmacy services for pregnant women, newborns, children, and parents who meet income requirements. STAR enrollment was nearly 3 million as of January 2017. Texas CHIP enrollment was 391,000.

Texas Cancels CHIP Rural, Hidalgo Service Area Managed Care Contract Awards. *The Dallas Morning News* reported on April 10, 2018, that after finding errors in a spreadsheet used to evaluate health plan bids, the Texas Health and Human Services Commission (HHSC) announced the cancellation of five recently awarded managed care contracts for the CHIP population in the state's three Medicaid Rural Service Areas and a 10-county region of the Rio Grande Valley called the Hidalgo Managed Care Service Area. These 16-month contracts were awarded in December and were supposed to begin on September 1, 2018, and end December 31, 2019. The awarded contracts, which are now being canceled, were with Blue Cross Blue Shield of Texas, Driscoll Children's Health Plan, Texas Children's Health Plan, Molina Healthcare of Texas, and Superior HealthPlan. Instead, the incumbent plans Molina and Superior (Centene) will continue to provide CHIP coverage in these regions through contract extensions until new contracts can be awarded. HHSC currently has an active statewide RFP (due July 2) for its STAR and CHIP programs, which will begin January 1, 2020, and which includes the CHIP Rural and Hidalgo Service Areas.

HHSC terminated an associate commissioner (for procurement operations) and two staff members for their involvement in this procurement. Texas House Speaker Joe Straus, has asked the House Appropriations Committee, which meets this Friday, to further examine HHSC's contracting practices. The

Governor also announced that investigations will be conducted by the State Auditor's Office and the Office of Inspector General. Read More

Texas Releases Draft RFP for Medicaid Dental Managed Care for Children. The Texas Health and Human Services Commission (HHSC) released on April 9, 2018, a draft request for proposal (RFP) for statewide dental managed care plans for children enrolled in Medicaid and the Children's Health Insurance Program. Current dental plan providers are MCNA Dental and DentaQuest. The state expects to award contracts to at least two dental plans. A final RFP is expected to be released on June 18, 2018, with implementation set for January 2020. Read More

Texas Re-Examines Maternal Mortality Deaths. The Texas Department of State Health Service (DSHS) announced the publication of a new peer-reviewed paper which re-examined the maternal mortality deaths of Texas residents in 2012. The paper, published in Obstetrics & Gynecology, utilized data matching and record review to verify pregnancy or delivery within 42 days for all deaths associated with an obstetrics code in 2012. This enhanced review found that there were 56 maternal deaths among Texas residents, less than half of the 147 deaths previously reported.

The Texas Tribune reported on April 9, 2018 that, according to the most recent report from DSHS, black women are still at the highest risk of dying during or after their pregnancy. In 2012 the maternal mortality rate was 27.8 per 100,000 live births for black mothers, 13.6 per 100,000 live births for white mothers, and 11.5 per 100,000 live births for Hispanic mothers. Read More

Virginia

Virginia Moves Closer to Medicaid Expansion as Another Republican State Senator Breaks Ranks. *The New York Times* reported on April 6, 2018, that Virginia is closer to expanding Medicaid as two state Senate Republicans are now open to the notion. Supporters of expansion in the Senate, where Republicans hold a 21-19 majority, now include Frank Wagner (R-District 7), who joins long-time expansion supporter Emmett Hanger (R-District 24). News that Wagner was breaking ranks comes after Virginia Governor Ralph Northam ordered a special session to address expansion by June 30 as part an overall budget compromise. About 400,000 Virginia residents would be eligible for Medicaid expansion. Read More

Wisconsin

Governor Signs Welfare Reform Bill. The *Journal Sentinel* reported on April 10, 2018, that Wisconsin Governor Scott Walker signed a welfare reform bill, increasing work and training requirements as well as asset limits on public assistance programs. Existing work requirements in effect since 2015 have resulted in 24,000 finding jobs and 86,000 losing benefits. Read More

National

CMS Issues Final Rule Allowing States Flexibility in Defining 'Essential Health Benefits.' *Modern Healthcare* reported on April 9, 2018, that the Centers for Medicare & Medicaid Services (CMS) issued a final rule allowing states more flexibility in defining which "essential health benefits" individual and small group heath plans must offer. The rule also eases medical loss ratio requirements and allows states to increase rates up to 15 percent without review. Read More

Trump Signs Executive Order to Bolster Welfare Work Requirements. *The Washington Post* reported on April 10, 2018, that President Trump signed an executive order aimed at bolstering work requirements for public assistance and welfare programs like food stamps, cash, and housing assistance programs. The order calls on federal agencies to propose additional requirements and to strictly enforce current requirements. Recommendations are due in 90 days. Read More

Landmark Health CEO Adam Boehler Named CMMI Director. *Modern Healthcare* reported on April 6, 2018, that Landmark Health chief executive Adam Boehler was named director of the Center for Medicare & Medicaid Innovation by U.S. Health and Human Services Secretary Alex Azar. Boehler replaces Patrick Conway, who headed the agency from 2013 to September 2017. Read More

Senate Panel Releases Draft Bill to Address Opioid Crisis. *The Hill* reported on April 4, 2018, that the Senate Health Committee released a discussion draft of the bipartisan Opioid Crisis Response Act of 2018 to address the opioid epidemic. The draft bill includes measures on opioid grants and restrictions of opioid dosage and length of prescription. The panel will hold a hearing on the measure next week. Read More

Medicaid Enrollees Have Better Access to Care Than Uninsured, AHIP Study Says. America's Health Insurance Plans (AHIP) released a study on April 9, 2018, showing that members of Medicaid managed care plans had significantly better access to care and preventive services than the uninsured. According to AHIP, the findings "refute outdated, less rigorous studies that question the value of Medicaid." The study relied on data from various sources, including the Medical Expenditure Panel Survey (MEPS). Read More

Industry News

Palladium to Sell Jordan Health Services to Kelso & Company, Blue Wolf Capital Partners. Palladium Equity Partners announced on April 10, 2018, that it has entered into a definitive agreement to sell Jordan Health Services, a home care provider, to Kelso & Company and Blue Wolf Capital Partners. Jordan will be merged with Great Lakes Caring Home Health and Hospice and National Home Health Care, creating one of the largest privately held home care providers in the U.S. Financial terms were not disclosed. Read More

Netsmart to Acquire Change Healthcare Home Care, Hospice Products. *Modern Healthcare* reported on April 6, 2018, that Kansas-based Netsmart, a behavioral health information technology company, has signed a definitive agreement to acquire the home care and hospice product lines of Tennessee-based Change Healthcare. The deal is expected to close in the second quarter of 2018. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Spring 2018	North Carolina	RFP Release	1,500,000
Spring 2018	New Hampshire	RFP Release	160,000
April 2018	Alabama ICN (MLTSS)	RFP Release	25,000
April 11, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Proposals Due	~1,600
April 24, 2018	Iowa	Contract Awards	600,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
April 12, 2018	Washington FIMC (Remaining Counties)	Proposals Due	~1,600,000
May 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
May 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
June 2018	Alabama ICN (MLTSS)	Contract Award	25,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 2018	North Carolina	Contract awards	1,500,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA News

New on Health Management Information Services (HMAIS) this week:

Public Documents:
Medicaid Program Reports and Updates

- North Carolina's Vision for LTSS Under Managed Care Concept Paper, Apr-18
- New Hampshire Implementation Plan for Medicaid Care Management – Nursing Facility/Choices for Independence Services, Mar-18
- New Jersey Audit of the Transportation Broker Services Contract, Mar-18
- California 2016 CAHPS Medicaid Managed Care Survey Summary Report, Jan-18
- California Medi-Cal Managed Care Performance Dashboard, Mar-18
- Mississippi Medicaid Annual Reports, 2013-17
- Pennsylvania Medical Assistance Advisory Committee Meeting Materials, Mar-18

Medicaid RFPs, RFIs, and Contracts

- MississippiCAN RFP Contracts, Scoring, and Related Documents, 2017
- Wisconsin Family Care, Family Care Partnership RFP for GSRs 2, 3, 11, and 12, Proposals, Scoring, and Contracts, 2017
- Texas STAR and CHIP RFP, Apr-18
- Texas Dental Services for Children's Medicaid and CHIP Draft RFP, Apr-18
- Texas Notice of Intent to Post Proposed NEMT RFP, Apr-18

Medicaid Data and Updates

- Florida Medicaid Managed Care Enrollment is Down 1.0%, Mar-18 Data
- Florida Medicaid Managed Care Enrollment Share by Plan, Mar-18 Data
- Indiana Medicaid Managed Care Enrollment is Flat, Jan-18 Data
- Indiana Medicaid Managed Care Enrollment Share by Plan, Jan-18 Data
- Arizona Medicaid Enrollment by MCO by County, Mar-18

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