HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*May 3, 2017*




RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

**Edited by:**
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

## THIS WEEK

# In Focus

## Depression Mapping and "Hot-Spotting" Reveals Potential Best Practices

This week, our *In Focus* section comes to us from HMA's Anissa Lambertino, PhD, of our Chicago office, and Lori Raney, MD, of our Denver office, and Sarah Arvey, PhD, of our Austin office. May is Mental Health Month, and the first week in May is recognized as National Anxiety and Depression Awareness week. Anissa, Lori, and Sarah's work, highlighted below, utilized geospatial mapping of prevalence of depression among Medicaid beneficiaries and treatment with FQHC locations in rural southeastern Ohio, revealing potential best practices.

### Background

In the United States, sixty percent of the population with a diagnosable behavioral health condition do not receive any form of treatment. Behavioral health care access is especially difficult in rural areas where the geographical maldistribution of psychiatrists and other behavioral health specialists is most pronounced. In many rural areas, Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHCs), are the backbone of primary care, bringing much needed services to these communities. CHCs often use creative approaches to address the shortage of specialty services in their regions including the use of innovative models of integrating behavioral health into their practices through expansion grants and local community partnerships with community mental health centers or community based organizations. In addition, the robust use of technology such as telepsychiatry and Project ECHO can help build the competence of primary care providers in identifying and treating mild to moderate mental illnesses including depression.

### Mapping Hot Spots Reveals Potential Best Practices

HMA created a geospatial mapping project (see map at end of *In Focus* section) that layered comparative prevalence of depression among Medicaid beneficiaries and treatment with FQHC locations. The mapping results showed that a cluster of providers in rural Ohio were screening and treating depression, suggesting best practices in the integration of primary care and behavioral health care. The initial mapping project was conducted to evaluate the prevalence of depression among Medicaid beneficiaries across Ohio counties. Using publicly available data from the US Census and Centers for Disease Control Behavioral Risk Factor Surveillance Survey, our mapping exercise exposed a surprising pattern of higher depression prevalence in the southeastern corner of the state; a rural area over 60 miles away from the urban cities of Cincinnati or Columbus. To determine if this higher prevalence depression correlated with *treatment*, market data for prescription drug use for depression was visually overlaid as a hot spot analysis onto the depression density map. A hot spot analysis identifies statistically significant clusters of low values (cold spot) and high values (hot spot). On the map, the hot spot analysis revealed a cluster of counties with significantly high prescription drug use for depression that matched closely with the geographical distribution of

elevated depression, thus indicating that providers are appropriately treating depression in that rural Southeastern area of the state.

Because CHCs are often utilized in underserved areas and are federally mandated to screen for depression, we then overlaid the locations of Ohio CHCs onto the map to determine whether there was any pattern in integrated care delivery by provider groups. In doing so, another pattern emerged. Aa grouping of CHCs were identified in the same counties with a high prevalence of depression as well as the prescription drug hot spot in the southeast corner of the state, suggesting that this group of CHCs have an effective approach to *diagnosing and treating* depression. The mapping process revealed a pattern that could be used for further investigation into the findings. If the pattern uncovered a unique way of delivering depression screening and treatment in a geographically rural and underserved area it would be good news for the delivery system and could warrant replication in other places.

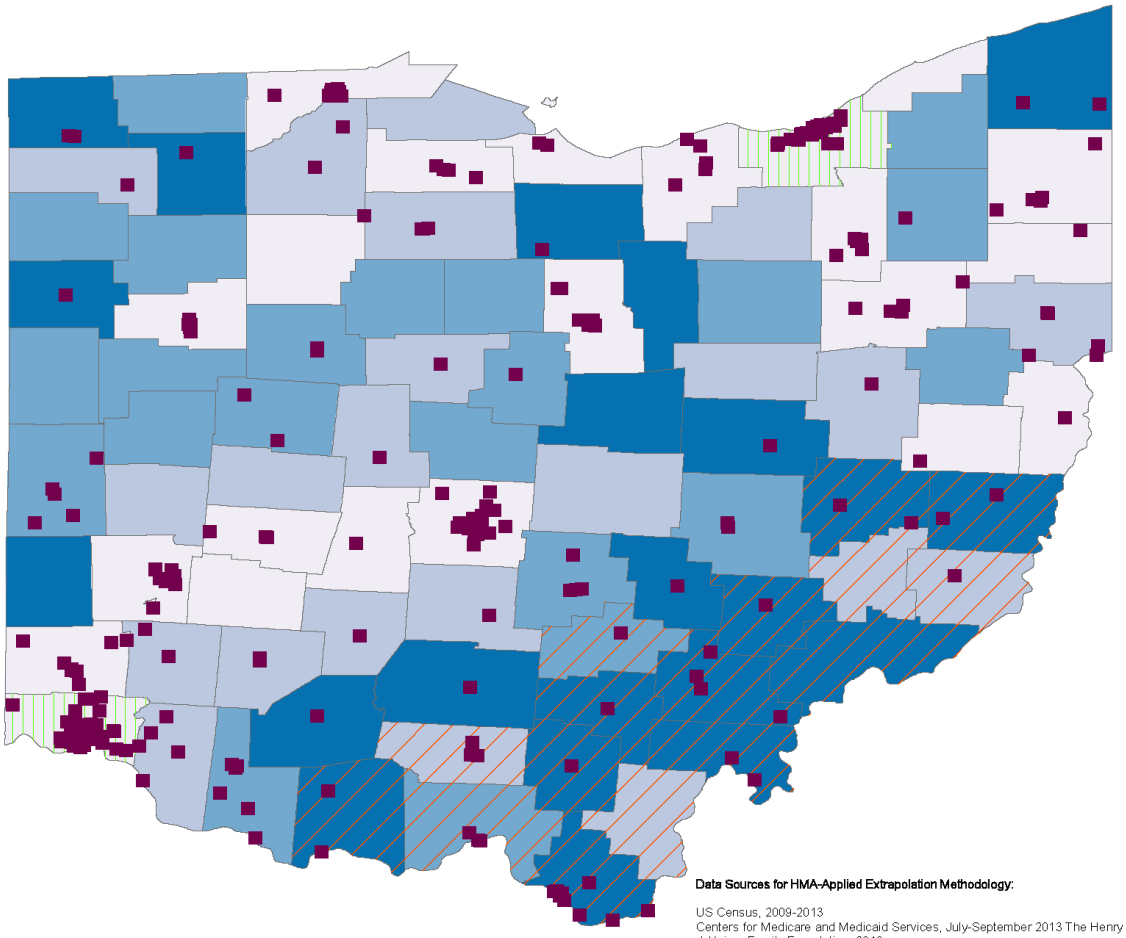
## More Information

For more information on the Ohio Hot-Spotting project, contact:

Anissa Lambertino (alambertino@healthmanagement.com),
Lori Raney (lraney@healthmanagement.com), or
Sarah Arvey (sarvey@healthmanagement.com).

For more information on HMA's geospatial mapping and data informatics work, contact Anissa Lambertino.

## OH Depression Prevalence and Prescription Drug Use with FQHCs



Data Sources for HMA-Applied Extrapolation Methodology:

US Census, 2009-2013
Centers for Medicare and Medicaid Services, July-September 2013 The Henry J. Kaiser Family Foundation, 2013
CDC Behavioral Risk Factor Surveillance System (BRFSS), 2013 Data Source for Getis-Ord Gi* Statistic Hot Spot Analysis: Esri and GfK MRI, 2015

**Estimated Prevalence of Adult Medicaid Beneficiaries Who Have Ever Been Told They Have Depression**

**Heat Map by Ohio County**

- Lowest Quartile (18.1% - 20.7%)
- Second Quartile (20.8% - 20.9%)
- Third Quartile (21% - 21.1%)
- Highest Quartile (21.2% - 21.8%)

**Benchmark: Ohio Depression Prevalence among Adults 20.2% (95% C.I.: 19.2 - 21.3)**

- Significantly Lower than Benchmark
- **Federally Qualified Health Center or Look-Alike**

**Percentage of Adults Who Used a Prescription Drug for Depression**

- Hot Spot - 99% Confidence

HMA Medicaid Roundup

# Arkansas

**State Projects $66 Million in Savings From Limiting Medicaid Expansion Eligibility.** *Arkansas Democrat-Gazette* reported on April 27, 2017, that Arkansas projects the state can save $66 million over four years by limiting Medicaid expansion eligibility to 100 percent of the federal poverty level, down from 138 percent. The change, proposed by Governor Asa Hutchinson, would result in approximately 60,000 individuals no longer qualifying for Medicaid coverage. Governor Hutchinson will seek approval for the eligibility changes as well as the addition of work requirements in next week's special legislative session. As of March 31, 320,000 individuals were enrolled in the Arkansas Works Medicaid expansion program. Read More

# California

HMA Roundup – Julia Elitzer (Email Julia)

**DHCS Issues Draft Plan for Transitioning Medi-Cal Eligible Patients to Managed Care.** The California Department of Health Care Services (DHCS) on April 26, 2017, released a draft plan for transitioning select Medi-Cal eligible patients, now served by three state developmental centers that the state is closing, into Medi-Cal managed care plans. The three development centers that are in the process of closing include: Sonoma Developmental Center, Fairview Development Center, and General Treatment Area of Porterville Developmental Center. DHCS is currently seeking public comment on the draft transition plan through May 5, 2017. Read More

**Bill Would Provide Housing Funds to More Medi-Cal Beneficiaries.** *California Healthline* reported on May 3, 2017, that California legislators are debating a bill that would provide an additional $90 million in state housing money over five years to help homeless Medi-Cal patients find stable housing. Because Medi-Cal cannot directly pay for housing, the bill's funds would be used to subsidize rent payments. Supporters of the bill say that the funds could help 1,500 individuals pay their rent and help cut down emergency room visits, saving the state millions. California has over one-third of the nation's individuals who are chronically homeless, nearly 30,000 individuals in 2015. A hearing on the bill is expected May 26. Read More

**California to Allow Two Sets of Rates for 2018 Exchange Plans; One if ACA Stays Intact, One if Plans Lose Cost-sharing Subsidies.** *Reuters* reported on April 28, 2017, that California Insurance Commissioner Dave Jones announced in a press release that he will allow health insurers to file two sets of proposed premium rates for 2018 Exchange plans. Insurers will be allowed to file a set of

lower rates that would be used if the Affordable Care Act stays intact. The other rates may be higher to account for the loss of federal cost-sharing subsidies and other variables impacted by repeal. Rates for the 2018 individual market are due May 1, 2017. Read More

## Delaware

**Medicaid Managed Care Delivery System Transformation RFQ Released.** The Delaware Division of Medicaid & Medical Assistance (DMMA) issued a request for qualifications (RFQ) on May 1, 2017, for Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) Delivery System Transformation. The RFQ solicits approaches for improving the quality and delivery of services in the state's Medicaid managed care programs. While the RFQ is an "informal" solicitation, DMMA may choose to contract with an organization based solely on the responses to this RFQ and bypass the formal RFP process. Alternatively, DMMA may choose not to award contracts resulting from this RFQ, and may proceed with a formal RFP process. Responses are due June 15, 2017, with a potential implementation date of January 1, 2018.

## Florida

### HMA Roundup – Elaine Peters (Email Elaine)

**Legislature Agrees on $650 Million in Medicaid Cuts to Hospitals.** *Miami Herald* reported on April 27, 2017, that Florida legislators have agreed to $650 million in combined state and federal cuts to Medicaid hospital reimbursement as part of a broader budget deal. The state will cut its share of Medicaid payments by $250 million, reducing federal matching dollars by $400 million. However, hospitals that serve a higher share of the state's Medicaid patients could recoup some of the cuts later in the year through the Low Income Pool (LIP). While the budget does not include LIP funding, the legislature is working on adding additional funds to the spending plan. Read More

**House, Senate at Odds Over How to Distribute $650 Million in Hospital Cuts.** *Tampa Bay Times* reported on May 2, 2017, that Florida budget talks are stalled between the state House and Senate over disagreements about how to implement $650 million in agreed upon cuts to Medicaid hospital payments. The House is pushing for a 7 percent rate cut as well as cuts to supplemental funding, while the Senate only wants supplemental funding cuts. The formula for distributing the cuts will determine how significantly safety net hospitals are impacted, given their reliance on supplemental funding for uncompensated charity care. Read More

## Georgia

**Court-appointed Observer Reports on Community Transitions for Individuals with I/DD.** *The Augusta Chronicle* reported on April 29, 2017, that a court-appointed observer has determined Georgia is doing a better job of moving certain individuals with intellectual or developmental disabilities (I/DD) out of state hospitals and into community settings. However, the observer added that the state has not improved reporting on and investigating deaths of patients who have been transitioned. Following a 2010 settlement

with the U.S. Department of Justice over conditions in state hospitals, Georgia was required to move certain patients out of state-run facilities and into community settings by June 2018. Read More

## Illinois

**Providers, MCOs File Affidavits with Federal Judge over Delayed Medicaid Payments.** *WBEZ* reported on May 2, 2017, that 25 Medicaid service providers in Illinois, including providers and Medicaid managed care organizations (MCOs), filed federal court affidavits over delayed reimbursement by the state. Aetna, in an affidavit dated April 15, stated that it is owed more than $650 million in capitation payments dating back as far as October 2016. Meanwhile, Meridian Health Plan, in an affidavit dated April 21, stated that it has been forced to delay reimbursement to providers due to the payment backlog. Federal Judge Joan Lefkow ordered the state to continue paying MCOs and providers, despite the absence of a budget deal, in 2015. A court hearing to address the affidavits is scheduled for May 9. Read More

**State Comptroller Criticizes Governor Over Medicaid Managed Care Reprocurement.** *Crain's Chicago Business* reported on May 2, 2017, that Illinois State Comptroller Susana Mendoza criticized the current reprocurement of the majority of the state's Medicaid managed care contracts in a letter to Governor Bruce Rauner. Comptroller Mendoza's letter cites the absence of a state budget and the current backlog in payments to Medicaid managed care organizations (MCOs). Illinois has not had a budget agreement since 2015 and the state's backlog of unpaid bills has passed $12 billion, with more than $2 billion owed to Medicaid MCOs. Comptroller Mendoza is calling for an extension of the procurement deadline and a legislative forum on the issue. Read More

## Iowa

**Medicaid Expansion Healthy Behaviors Program Had Few Participants, Difficult to Implement, Report Finds.** *Health Affairs* reported in its May 2017 issue that in Iowa's Medicaid expansion Healthy Behaviors Program's first year of implementation, there were "low levels of awareness of the program's existence, deficits in knowledge about how the program works, and a variety of barriers to activity completion." The program was designed to provide incentives to complete healthy behaviors and, in return, waive members' monthly premiums. However, a lack of knowledge of the program prevented the state from successfully incentivizing activities. The report analyzed claims data and interviews with members and clinic managers in the first year of implementation in 2014. Read More

## Michigan

**From the *HMA Michigan Update*: Behavioral Health and Physical Health Integration Update.** In recent editions of The Michigan Update, HMA has reported on activities related to efforts around improving integration of care for people with both behavioral health and physical health needs. The "Section 298 Integration Workgroup," named after the proposed language in the state fiscal year 2016-2017 appropriation measure that prompted its creation, met for several months, with Lieutenant Governor Brian Calley serving as its

chairman. The Michigan Department of Health and Human Services (MDHHS) submitted its "Final Report of the 298 Facilitation Workgroup" to the Legislature on March 15, 2017. The report included the 70 initial policy recommendations outlined in an interim report as well as several new recommendations on financing models and benchmarks for implementation. More recently, appropriations subcommittees in both the House of Representatives and the Senate have released their proposed budgets for the fiscal year beginning October 1, 2017, and both are suggesting that pilot projects around integration of physical and behavioral health care not be limited to models identified in the Final Report. None of the models identified in the final report would have a Medicaid HMO serving as the integrated manager of care and payer for all Medicaid services.

The House subcommittee, in HB 4238, replaced the 2016 budget language known as Section 298 with language asking that MDHHS develop a plan for a single statewide public behavioral health managed care organization instead of the current 10 prepaid inpatient health plans (PIHPs). The language also directs MDHHS to work with any willing community mental health agency and Medicaid HMO operating in Kent County to test an integrated service model. During deliberations by the full appropriations committee, an amendment was approved for up to three more pilots that could operate in areas outside of Kent County as well. The Senate subcommittee, in SB 135, also replaced the 2016 Section 298 language with a requirement that MDHHS continue working with stakeholders to improve coordination of publicly funded physical and behavioral health care. In addition, the subcommittee added language (Section 234) requiring MDHHS to advance pilots and demonstration models that integrate the Medicaid behavioral and physical health benefit. An amendment to this section was offered by Senator Mike Shirkey during the subcommittee meeting and passed on a partisan 5-0-2 vote. The amendment language states "the demonstration models are based on a goal to achieve total Medicaid benefit and financial integration by September 30, 2020 that will rely on a single contracting model between the state of Michigan and licensed health plans, regulated by both the department of financial and insurance services to assure financial viability and the department [MDHHS] to assure overall programmatic performance." Boilerplate language in appropriation bills has no legal impact beyond the fiscal year to which the appropriation applies; however, this amendment does appear to reflect the subcommittee's intent related to integrated care. It is unclear at present how the House and Senate will resolve differences between their approaches in these two bills. And, not surprisingly, behavioral health advocates and the current public specialty behavioral health managers (PIHPs and Community Mental Health Services Programs) have expressed strong opposition to the language in both bills. Link to April 2017 Michigan Update

## *Minnesota*

**Medica to Exit Medicaid Managed Care Market Effective May 1.** *Minnesota Public Radio* reported on April 27, 2017, that Medica will pull out of the Minnesota Medicaid market effective May 1, after losing nearly $200 million last year. As a result, the health insurer is cutting 110 jobs and opting not to fill 140 vacant positions. In March, Medica sued the Minnesota Department of Human Services for allegedly giving preferential treatment to competitors in contracts for Medicaid and other state-funded health care contracts –

increasing rates paid to other managed care organizations and allowing them to renegotiate contract terms – while refusing Medica's request to renegotiate. Read More

**Medicaid Funding Could be at Risk Unless it Access to Preventive Dental Care for Children Improves.** *Star Tribune* reported on May 1, 2017, that federal regulators have warned Minnesota that it could lose Medicaid funding unless it improves access to preventive dental care for children. The state has 90 days to come up with an improvement plan. According to the Centers for Medicaid & Medicare Services, about 37 percent of children on the state's Medical Assistance program received preventive dental care in 2015; about 62 percent were told dentists were not accepting new Medicaid patents. Minnesota has one of the lowest dental reimbursement rates in the country. Read More

# *Missouri*

**Medicaid Managed Care Expands to Remaining Counties as of May 1.** *The St. Louis Post-Dispatch* reported on April 27, 2017, that Missouri will expand the MO HealthNet Medicaid managed care program to all of the state's 115 counties beginning May 1, 2017. Currently, MO HealthNet is offered in 54 Missouri counties. Federal regulators approved a waiver on April 25, allowing Missouri to move ahead with the statewide rollout. Read More

**Lawmakers Propose Preferred Medicaid Drug List for Antipsychotic Medications.** *The Missourian* reported on April 30, 2017, that Missouri is proposing to create a preferred Medicaid drug list for individuals with mental illnesses. State Representative David Wood (R-Versailles), who proposed the legislation, says the bill would save the state money. Drugs not on the list would be available only after prior authorization. There would be no restrictions on access to atypical antipsychotic medications, which treat schizophrenia and bipolar disorder. According to the Committee on Legislative Research, Missouri spent $218 million on antipsychotic drugs last year. Read More

# *New York*

## HMA Roundup – Denise Soffel (Email Denise)

**Medicaid Transportation Management Contract Awarded.** The New York State Department of Health announced the award of a contract to Medical Answering Services LLC (MAS). Effective April 23, 2017, MAS will be the new Medicaid transportation manager for the New York City region. MAS will be responsible for administering, prior approving, and coordinating non-emergency medical transportation for Medicaid fee-for-service and mainstream managed care enrollees at the most medically appropriate, cost effective mode of transport. MAS is currently the Department of Health's Medicaid transportation manager for the Hudson Valley, Finger Lakes, Northern New York and Western New York regions. According to the NY Comptroller, MAS was awarded a contract for $74.8 million in August 2016, and an additional contract for $98.3 million in February 2017. Read More

**Deputy Secretary for Health and Human Services Presents Update on Health Policy Landscape.** Paul Francis, Deputy Secretary for Health and Human Services, presented an update on the New York health policy landscape at the

New York Academy of Medicine on April 24. He discussed the potential impact of several proposed federal actions included in the American Health Care Act, which would have significant negative impact on New York. Due to uncertainties in Washington, the state has withdrawn a waiver request that would extend Medicaid coverage to certain incarcerated individuals. Further, its State Plan Amendment allowing the state to add six new behavioral health services for children, has not yet been approved, potentially delaying implementation. He noted the state has made a significant investment in capital to build up a community-based health care delivery infrastructure to support the move away from in-patient care. Francis also noted that New York's DSRIP program is the most ambitious redesign project in the country. Francis discussed some of the key initiatives in the current budget, including the fact that this year's enacted budget has developed a high-cost drug cap within the Medicaid program The high-cost drug cap policy puts an absolute cap on the growth of spending on prescription drugs and allows for negotiations of supplemental rebates on high-cost drugs, and establishes a credible threat of penalties if negotiations are unsuccessful, including exclusion of certain drugs from plan coverage, and subjecting all drugs from that manufacturer to prior authorization. Francis noted the health care safety net is under increasing pressure, and that many individuals and institutions across the delivery system remain resistant to change. Although the budget proposal establishing a health care regulation modernization team, meant to review a whole host of regulations governing licensure and oversight of health care facilities, was not included in the final budget, Francis indicated that the state will nonetheless establish a Regulatory Modernization Team, which will undertake a serious review of long-term care services. Slides will be posted on the New York Academy of Medicine website. Read More

**Delivery System Reform Incentive Payment Whiteboard Video Posted.** The New York Department of Health has posted another in its series of whiteboard videos describing its Delivery System Reform Incentive Payment (DSRIP) program. The video discusses the DSRIP year 3 theme and goals. The theme for the year is "Design the Platform for Constant Design." Jason Helgerson, the state's Medicaid director, notes the volatility of New York's health care delivery system, and emphasizes the need for Performing Provider Systems to be prepared for constant innovation and change. PPSs need to develop nimble platforms to respond to evolving community needs. Helgerson also notes that payment through DSRIP begins to change during year 3, moving away from process metrics toward performance payments that are linked to improving health metrics, which he acknowledges will be harder to achieve. Link to Video

**Medicaid Drug Utilization Review Board (DURB) Openings.** As part of the 2017-18 enacted state budget, New York has established a Medicaid Drug Cap as a separate component of the Global Spending Cap under which New York's Medicaid program operates. The Department of Health is seeking to expand membership on the Medicaid Drug Utilization Review Board (DURB) to include one actuary and two health economists. The DURB establishes medical standards and criteria for Drug Utilization Review programs, develops educational interventions for physicians and pharmacists and reviews therapeutic classes in the Medicaid Fee-for-Service Preferred Drug Program (PDP). This increase in membership will enable the expansion of its role to include making recommendations for supplemental rebates for certain drugs that are impacting the ability of the Department to meet the budgetary goals of

the Medicaid Drug Cap. Letters of interest should be submitted to the DURB at dur@health.ny.gov.

**Population Health Spending in New York.** The New York State Health Foundation has released a new report that analyzes the New York State Department of Health's current funding for total population health. The report notes that New York State is often cited as a national model in public health because of its strong support for improving the health of its population. To maximize the value of the State's investments, the report reviews how resources are being allocated within New York State communities, and how they can create synergies from these investments. It also makes recommendations for how the State can gain more value for funds spent on achieving the Prevention Agenda, the state's strategy for pursuing population health, and identifies opportunities for the state to maximize the value of its investments in population health. Read More

# *Ohio*

## HMA Roundup – Jim Downie (Email Jim)

**Ohio House Moves to Rein In Medicaid.** The *Cincinnati Enquirer* reported on May 1, 2017 that the House Finance Committee approved budget amendments that will require the Administration to get approval for Medicaid expansion money every six months. The approval process requires the Medicaid Director to go before the Controlling Board, a panel of six lawmakers and a Governor appointee. The amendment specifies the Board would be allowed to release money for Medicaid if Congress reduces the percentage of lower-income Ohioans on Medicaid. If Congress makes no changes, the panel would release money if Kasich makes "progress" in several areas, such as ensuring Ohioans have more information about the cost of health care procedures. Read More

**Medicaid Expansion Enrollment Freeze Rejected by Republican Leaders.** *The Columbus Dispatch* reported on May 2, 2017, that a proposed Medicaid expansion enrollment freeze was rejected by the Ohio House Finance Committee. House Republican leaders led the move to reject the freeze as part of a broader two-year budget compromise. Republicans in the Ohio legislature did, however, vote to require approval from the state's bipartisan Controlling Board before funding coverage of expansion members. The budget bill also grants an additional $100 million to nursing homes over two years and adds $171 million to combat the opioid crisis. A full House vote on the budget is expected on May 2. Read More

**Kasich Administration Officials Defend Medicaid Managed Long Term Services and Supports Proposal.** The *Columbus Dispatch* reported on April 26, 2017 that the Director of the Ohio Office of Health Transformation and other Cabinet Directors testified before the Ohio Senate Finance Committee defending the administration's proposal to move individuals receiving community and facility based long term services and supports into managed care. Greg Moody, Director of the Office of Health Transformation referenced the third annual MyCare Ohio Progress Report to show the MyCare Demonstration is working. Read More

# Pennsylvania

HMA Roundup – Julie George (Email Julie)

**Governor Wolf Administration Launches DHHS Unification Informational Website.** Pennsylvania Governor Tom Wolf announced the launch of a website that details the proposed unification of the departments of Health, Human Services, Drug and Alcohol Programs, and Aging into the new Department of Health and Human Services (DHHS). The unification was part of Governor Wolf's 2017-2018 budget proposal and State Senator Judy Schwank (D, Berks County) and Representative Stephen Bloom (R, Cumberland County) have announced their intent to co-sponsor legislation that, if passed, will make the unification law. Information available on the website includes draft legislation, DHHS draft organizational charts, and details about the new agency's deputates. Highlights include:

- The creation of a cabinet-level position focused on coordinating state efforts relating to substance use and addiction policy;
- Consolidation of front office functions at each agency, including budgeting, procurement and contract management, auditing, and federal reporting;
- Streamlining eligibility assessments for TANF, LIHEAP, MA, SNAP PACE, AND WIC, all of which are proposed to be handled at local County Assistance Offices
- Providers who are currently subject to multiple inspections and audits will now have one point of contact, the Office of Health Care Quality & Licensure.
- The Office of Mental Health & Substance Use Disorder Services will provide more integrated services and systems for mental and behavioral health and substance use and addiction programs

Read More

# Puerto Rico

**Medicaid Funding Agreement Reached by Congress.** *Reuters/WHTC* reported on May 1, 2017, Puerto Rico may soon receive $295 million in Medicaid funding to avert a government shutdown. Congress is expected to approve the funding this week. Puerto Rico Health Secretary Rafael Rodríguez-Mercado, MD, said that an additional $300 million is needed to fund the program for the fiscal year. Read More

# Virginia

**State Joins Effort to Expand Opioid Addiction Treatment for Inmates.** *The Washington Post* reported on May 2, 2017, that Virginia was one of eight states selected by the National Governors Association to evaluate and develop initiatives designed to expand inmate opioid addiction treatment. Alaska, Indiana, Kansas, Minnesota, North Carolina, New Jersey and Washington are also participating. Since 2015, nine inmates have died in Virginia facilities from heroin or fentanyl overdoses. Read More

## Wisconsin

**Wisconsin Medicaid Considers Measures to Limit Drug Spending.** *Wisconsin State Journal* reported on April 27, 2017, that Wisconsin is considering ways to trim drug spending in light of rising costs and the potential loss of drug rebates under Medicaid block grants. One option being considered is a law requiring drug companies to justify significant price increases. Another possibility is state agencies joining forces to bargain for lower prices. The state is also planning to notify providers when patients are receiving doses above standard levels. Read More

## National

**House Republicans Discuss Changes to Stalled ACA Repeal, Replace Bill.** *The New York Times* reported on April 26, 2017, that House Republicans are discussing a compromise that could help them revive efforts to repeal and replace the Affordable Care Act. While much of the initial Republican bill – called the American Health Care Act – would remain unchanged, the legislation would be amended to allow states to seek federal waivers to modify essential benefits requirements and to charge higher premiums to older adults and individuals with chronic conditions. The amendment was drafted by Representative Tom MacArthur (R-NJ). Read More

**Hospitals, Insurers Lobby Against Revised House Health Care Bill.** *Modern Healthcare* reported on May 2, 2017, hospitals and some insurers are lobbying to stop renewed efforts by House Republicans to repeal and replace the Affordable Care Act. Additionally, around 20 House Republicans have voiced opposition to the latest version of the American Health Care Act, which they say would remove protections for individuals with pre-existing conditions, unravel state Medicaid expansions, and increase the uninsured rate. President Donald Trump and Republican leadership are pushing the House to vote on the bill this week before recess begins. Read More

**Trump Administration Remains Undecided on Cost-sharing Subsidies.** *The Hill* reported on May 2, 2017, that that the Trump administration is still undecided on whether it will pay cost-sharing subsidies to insurers, according to White House budget director Mick Mulvaney. The subsidies reimburse insurers for providing discounted deductibles and copays to low-income individuals. Insurers have said that without the subsidies, they would be forced to raise rates or leave the marketplaces. Read More

**Congress Pushes Improved Oversight of Medicaid Personal Care Services Spending.** *Modern Healthcare* reported on May 2, 2017, that Congress wants improved oversight of Medicaid personal care services spending, after learning that $14.5 billion was spent these services for 3.2 million beneficiaries in fiscal 2014. Personal care services provide help with daily activities such as bathing, dressing and meal preparation. About one third of investigations for Medicaid fraud concern personal care services, according to the Office of the Inspector General of the U.S. Department of Health and Human Services. Read More

**ACA Likely Helped Reduce Personal Bankruptcy Filings.** *Consumer Reports* reported on May 2, 2017, that personal bankruptcy filings fell 50 percent from 2010 to 2016, a period of time that corresponds to the implementation of the Affordable Care Act (ACA). Provisions under the ACA,

including mandated coverage for pre-existing conditions and an end to annual and lifetime coverage caps, provided significant financial protection for insured and uninsured individuals alike, which likely attributed to the decline in the number of bankruptcies. Read More

## *Industry Research*

**Access to Care for Medicaid Members Is Comparable to Private Insurance, Study Says.** The Commonwealth Fund on April 27, 2017, released its Biennial Health Insurance Survey, which found that access to health care for Medicaid beneficiaries was better than for individuals who are uninsured, and is comparable to those with private insurance. About 91 percent of Medicaid beneficiaries have a regular source of care, compared to 93 percent of privately insured individuals and 77 percent of the uninsured. Medicaid enrollees also had fewer problems paying medical bills than both the privately insured and the uninsured. The survey analyzed responses from 6,005 working-age adults who were either covered all year by employer-sponsored or individual insurance; covered by Medicaid for the full year; or uninsured for some portion of the year. Read More


## Industry News

**Molina Names Joseph White Interim CEO, CFO.** Molina Healthcare announced on May 2, 2017, the appointment of Joseph White as interim president, chief executive, and chief financial officer. White, who was most recently the company's chief accounting officer, replaces President and Chief Executive Officer J. Mario Molina, MD, and Chief Financial Officer John Molina. Company Director Dale Wolf will serve as the non-executive chairman. Mario and John Molina will remain on the board of directors. Read More

**WellCare Completes Acquisition of Phoenix Health Plan.** *PR Newswire* reported on May 1, 2017, that WellCare has completed the acquisition of the assets of Arizona-based Phoenix Health Plan, a subsidiary of Tenet Healthcare Corporation. About 44,000 Phoenix Health Plan Medicaid members are expected to transition to WellCare's Care1st Health Plan of Arizona subsidiary. Financial terms were not disclosed. Read More

**WellCare Completes Acquisition of Universal American.** WellCare Corp. completed its acquisition of Universal American Corp. on April 28, 2017, the company announced. WellCare gains 119,000 Medicare Advantage members in Texas, New York, and Maine. Universal American also partners with accountable care organizations (ACOs) in 10 states, five of which are WellCare Medicare Advantage markets. WellCare expects a one-time transaction-related expense of approximately $30 million and integration costs of approximately $25 million to $30 million. Read More

**Evergreen Health to be Acquired by Investor Group Including LifeBridge, Anne Arundel Health System.** *The Baltimore Sun* reported on May 2, 2017, that a group of private investors is partnering with LifeBridge Health and Anne Arundel Health System to acquire Maryland-based Evergreen Health, one of the remaining consumer-oriented and -operated (Co-Op) health insurance plans created under the Affordable Care Act. The deal must be approved by the Maryland Insurance Administration. Read More

**HCA to Acquire Five Texas Hospitals from Tenet, Community Health Systems.** HCA announced on May 1, 2017, an agreement to acquire three hospitals in Houston, Texas from Tenet Healthcare, as well as two from Community Health Systems in Houston and in the San Antonia area. HCA currently operates 10 hospitals in the Houston area and co-owns an eight-hospital system in San Antonio. Both transactions are subject to regulatory approval and are expected to close during summer 2017.

**Community Health Systems Divests 10 More Hospitals in Four States.** Community Health Systems announced on May 1, 2017, the sale of eight hospitals in Florida, Pennsylvania, and Ohio to Steward Health Care LLC and two in Mississippi to Curae Health, Inc. The transactions will take effect May 1, 2017.

**Anthem Presses Feds to Guarantee Exchange Plan Cost-Sharing Subsidies by Early June.** *ABC News* reported on April 26, 2017, that Anthem wants President Trump's administration and Congress to guarantee 2018 Exchange plan cost-sharing subsidies by early June, or the insurer says it may have to seek additional rate increases, eliminate certain plans, or exit state Exchange markets altogether. Anthem CEO Joseph Swedish said that without the subsidies, rates could increase 20 percent or more. Molina Healthcare is also urging the government to continue the subsidy payments. Read More

# RFP CALENDAR

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| May 15, 2017 | Illinois | Proposals Due | 2,700,000 |
| May 22, 2017 | Washington (FIMC - North Central RSA) | Contract Awards | 66,000 |
| Spring 2017 | Virginia Medallion 4.0 | RFP Release | 700,000 |
| June 12, 2017 | MississippiCAN | Contract Awards | 500,000 |
| June 15, 2017 | Delaware | Proposals Due | 200,000 |
| June 30, 2017 | Illinois | Contract Awards | 2,700,000 |
| July 1, 2017 | Wisconsin Family Care (GSR 1, 4, 5, 6) | Implementation | 14,000 |
| July 1, 2017 | Nevada | Implementation | 420,000 |
| July 1, 2017 | Georgia | Implementation | 1,300,000 |
| July 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 | 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 |
| 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 |
| 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, 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<br>7/1/2014<br>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

**HMA Upcoming Webinar: *"Merger Readiness: What Behavioral Health Providers and CBOs Need to Know Before Considering a Merger with Another Health Care Organization"***

***Wednesday, May 10, 2017***
***1 to 2 p.m. EST***

**Link to Registration**

Behavioral health providers and community-based organizations increasingly face an important decision. Can they continue to go it alone? Or is it time to consider merging with another entity to achieve the scale, scope and sophistication necessary to thrive in a healthcare system that continues to grow only more complex? The answer involves not only an honest assessment of your existing goals, values, market prospects, and potential partners, but a clear understanding of what's required from a strategic and operational standpoint to make your organization "merger ready." During this webinar, HMA Principals Josh Rubin and Meggan Schilkie will outline what behavioral providers and community-based organizations (CBOs) need to know when considering and ultimately pursuing a potential health care merger and the steps to take during each merger phase (Pre-Merger, Merger Execution, and Post-Merger).

# *HMA Welcomes…*

### Jim McEvoy, Senior Consultant – Lansing, Michigan

Jim joins HMA most recently from UnitedHealth Group where he served as a Senior IT Data Analyst since 2010. In this role, Jim managed cross-functional teams of up to 10 developers, programmers and analysts. He mitigated risk factors through careful analysis of data and a flexible technical solution set – anticipating and managing change effectively in rapidly evolving environments and coordinating knowledge among different business units. Jim defined processes and tools best suited to each project. He moved between agile and waterfall approaches depending on project specifics and client goals and created detailed project road maps, plans, schedules and work breakdown structures.

Jim has managed projects with Michigan's Department of Health and Human Services to develop web-based enrollment tools, federal reporting tools and data warehousing strategies for the department's 1915(c) waivers, health home projects, autism state plan amendment, and home & community-based services projects. Jim has been the subject matter expert for Michigan's pharmacy data warehousing strategy. He has been responsible for managing inbound data loads, pharmacy encounter processing, and extracts to health plans and Michigan's Fee-for-Service Pharmacy Benefits Manager. Jim also had the privilege of serving as the Project Manager for the CareConnect360 web application. This tool is responsible for delivering Medicaid claims and encounters information to a diverse user audience including health plans, community mental health agencies, health home providers and foster care workers.

Jim previously served as a Systems Analyst with UnitedHealth Group and a Programmer with Phoenix Workgroup Computing.

Jim received his Bachelor of Science degree in Psychology from Michigan State University. He is a Teradata Certified Professional.

### Mary Russell, Senior Consultant – Costa Mesa, California

Mary joins HMA most recently from L.A. Care Health Plan, where she served as a Clinical Project Manager. In this role, Mary implemented and evaluated quality improvement programs and activities for the dual-eligible population. She audited and revised the Cal MediConnect program (Medicare-Medicaid Plan) model of care. She liaised between product operations and clinical team to drive a high-touch care management approach and managed CMS application process from strategic planning through content submission. Additionally, Mary interpreted and operationalized CMS and DHCS regulatory policy to ensure program compliance. She established and maintained the project team workplan for launch of Cal MediConnect and ran cross-functional workgroups to address day-to-day product operations issues. Mary also served as a Policy Analyst and Project Manager with L.A. Care Plan.

Mary previously served as an Account Supervisor at Weber Shadwick in San Francisco where she collaborated with public health and pharmaceutical organizations to assess needs, establish strategic brand development plans, manage budgets, and execute tactics. She developed and implemented disease education and awareness programs in preparation for market launch of products including budget creation, partnership development, communication strategy, and evaluation. Mary executed client announcements and local and national media events around the release of new data and policies about cancer, mental health and violence prevention.

Prior to Weber Shadwick, Mary served as a Senior Account Executive at Ogilvy Public Relations Worldwide. In this role, Mary served as primary project support for multi-million dollar government public health initiatives. She collaborated with registered dietitians on the development and review of nutrition education materials for kidney disease patients to reduce End Stage Renal Disease diagnoses for the National Institute of Health's National Kidney Disease Education Program.

Mary received her Master of Public Health degree from the University of California, Berkeley and her Bachelor of Arts degree in Communications from Villanova University.

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

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

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