Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

June 28, 2017

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This Week

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- HMA Conference Session on Healthcare Investing to Feature Leading Wall Street Analysts, Private Equity Investors; Focus on Opportunities in Medicaid, Publicly Sponsored Healthcare

The HMA Weekly Roundup will be off next Wednesday, July 5th. We will resume our regular weekly publication on July 12th. The Roundup team wishes all our readers a happy and safe holiday!

In Focus

Better Care Reconciliation Act of 2017 Summary

This week, our *In Focus* section comes to us from HMA Senior Fellow Jack Meyer, PhD, and Senior Consultant Rachel Patterson, both of HMA's Washington, DC office, with contributions from HMA colleagues Eileen Ellis, Melisa Byrd, Kathleen Nolan, Tim Beger, Aimee Lashbrook, and Barbara Smith. On June 22, Senate leadership released a discussion draft of the Better

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Care Reconciliation Act of 2017. The bill is technically an "amendment in the nature of a substitute" to HR 1628, meaning that it replaces wholesale the language from the House while continuing to use the same bill number, allowing the Senate to avoid the committee process and bring the reconciliation bill straight to the floor. The House's AHCA had two major policy areas important to HMA and our clients: 1) treatment of the ACA's Exchange markets, plans, benefits, and regulations, and 2) treatment of Medicaid in the per-capita-cap and expansion. The Senate's BCRA includes private market provisions that more closely mirror the original ACA, but has much deeper Medicaid cuts and reforms than the House.

Medicaid

The Senate bill includes Medicaid reforms not included in the House bill, including a roll-back of provider taxes, reforms to the managed care waiver process, a new quality performance bonus payment program, partial roll-back of the IMD exclusion, and increased power of national associations (such as NAMD) in the Medicaid regulatory process. It includes reforms offered in the AHCA, including state option work requirements and optional block grants for Medicaid.

Per Capita Cap and Optional Block Grant

The per capita cap formula is largely like the House-passed bill, but at a lower growth rate. Key changes include:

- **Base year:** House-passed bill included FY16 as the base year for determining future caps. Senate bill allows states to choose any eight consecutive quarters from 2014-2017.
- **Growth Rate:** Growth rates are the same as House bill until 2024. From 2020-2024, the growth rate is medical CPI for children and adult populations, and medical CPI plus one percentage point for elderly and disabled populations. After 2024, the growth rate is the standard CPI (CPI-U) for all eligibility categories.
- **Disabled Children Excluded:** Blind and disabled children are excluded from caps (including updates to state reporting in CMS-64 to identify them).
- **Target Adjustments:** States' overall spending cap under the per capita cap will be adjusted, based on their spending compared to national averages. States with mean per capita expenditures more than 25 percent higher (or lower) than the national average will receive a 0.5 percent – 2 percent reduction (or increase) in their overall target. This does not apply to low-density states, defined as less than 15 individuals per square mile. These states are Alaska, Wyoming, Montana, North Dakota, and South Dakota.

In addition to the mandatory per-capita-cap funding formula, the bill includes a state option to opt-in to a block grant funding formula. Beginning in 2020, states could submit applications to CMS for the block grant. Block grant amounts would be based on the amount the state would have received under the per-capita cap formula for the year they apply, then increased in future years by the CPI-U. The House bill also included a block grant option, but excluded elderly and disabled enrollees. The Senate bill excludes elderly,

disabled, children, and expansion enrollees. It only includes the category known as non-disabled, non-elderly, non-expansion adults. (We suspect this may be a drafting error that will be changed in future amendments).

Assistance provided under the block grant must have an aggregate actuarial value of at least 95 percent of the actuarial value of benchmark coverage used for Medicaid alternative benefit plans. States may impose cost sharing, deductibles, or premiums, so long as total cost sharing is limited to five percent of family income. States will still be required to provide:

- Inpatient and outpatient hospital
- Laboratory and X-ray
- Nursing facility for enrollees 21 and over
- Physician
- Home health (including nursing, equipment, supplies, and appliances)
- Rural health clinic
- Federally qualified health center
- Family planning services and supplies
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services
- Emergency medical transportation
- Non-cosmetic dental
- Pregnancy-related services, including postpartum for 12 weeks

Expansion

On the Medicaid expansion, the Senate bill phases out the enhanced match, but at a slower rate from 2020 to 2024 and with more eligibility flexibility for states. The House bill only allowed continued enrollment of expansion enrollees without a break in coverage; the Senate bill does not include this provision. Like the House bill, the Senate bill eliminates essential health benefit requirements for Medicaid Expansion benefits (provided under the alternative benefit plan).

Matching Rates in Senate Bill	
Year	Expansion FMAP
2019	Current law
2020	90%
2021	85%
2022	80%
2023	75%
2024	Regular FMAP

Other Medicaid Reforms

The Senate bill takes on many of the same Medicaid changes as the House bill, and includes new reforms that have been on the Congressional "wish list" for many years.

- **Disproportionate Share Hospital (DSH)**: Like the House bill, the Senate bill ends future DSH cuts for non-expansion states. Unlike the House bill, the Senate bill continues planned DSH cuts for expansion states past 2020. Non-expansion states will also receive an increase in

DSH payments in 2020 if their FY 2016 DSH allotment per capita was lower than the national average.

- **Provider taxes**: From 2021 to 2025, the six percent cap on net revenues collected in provider taxes is gradually reduced to five percent. All states but Alaska utilize provider taxes.
- **Managed care waivers**: States with existing 1915(b), 1932, or 1115 managed care waivers will not need to seek renewals from CMS unless the state would like to make changes to the waiver.
- **Medicaid and CHIP Quality Performance Bonus Payments**: The bill creates a new quality bonus payment program. From 2023 to 2026, states will be eligible for bonus payments if they 1) keep their spending below their overall cap, 2) collect quality information on each enrollee category, and 3) submit information to the Secretary about how they will use the increased payments to improve quality.
- **Work requirements**: The Senate bill includes the same optional work requirement for non-disabled, non-elderly, non-pregnant beneficiaries as the House bill. Like the House bill, definitions of work follow those used in TANF. Exemptions include the 60 days after the end of a pregnancy, single-parents of children under the age of six, and individuals under age 20 who are married or head of household and in school.
- **Eligibility redeterminations**: The House bill required eligibility redeterminations for expansion enrollees every six months. The Senate bill permits (but does not require) redeterminations every six months (or less) for non-elderly non-disabled populations. This is the low-income, or modified adjusted gross income (MAGI) population, primarily children, pregnant women, parents, and other adults.
- **Retroactive eligibility**: Like the House bill, the Senate bill eliminates retroactive eligibility for Medicaid benefits, effective October 2, 2017.
- **Safety Net Fund for Non-Expansion States:** From FY18 to FY22, non-expansion states may increase their provider payments up to the cost of furnishing services. They will receive 100 percent FMAP for the costs of these increases in FY18-21, and 95 percent FMAP in FY22. The total funding for this increase is not to exceed $2 billion, allocated among the states based on their share of the total US population under 138 percent of the FPL living in non-expansion states.
- **CMS Regulatory Process:** The bill would limit the promulgation of any new Medicaid regulations unless the Secretary 1) has established a regular, ongoing process for soliciting the advice of State Medicaid Directors, and 2) has accepted and considered written and oral comments from a "bipartisan, nonprofit, professional organization that represents State Medicaid Directors." (Provisions are frequently written this way when Congress wants to specify a non-governmental organization. Here we presume this to mean that CMS would be required to consult with the National Association of Medicaid Directors).
- **IMD Exclusion:** Effect October 1, 2018, the bill includes a new "Qualified Inpatient Psychiatric Hospital Services" state plan option

which allow states to include coverage of qualified inpatient psychiatric hospital services for up to 30 consecutive days and 90 total days in a calendar year, for individuals ages 21-65. States that choose this option must maintain their current level of funding for inpatient and outpatient services in psychiatric hospitals. The federal matching rate for Qualified Inpatient Psychiatric Services is 50 percent.

Exchanges (Marketplaces) and the Private Market

The Better Care Reconciliation Act makes important changes to subsidies for purchasing private coverage, while maintaining much of the structures of the ACA.

- The ACA-provided subsidies (advance premium tax credits) would be based on household income and the cost of insurance in the area (see the point on benchmarks below). The House-passed AHCA would have replaced this with tax credits based only on age. The Senate BCRA returns to an income and geographic-based system, but age is also factored in.
- The average value of the federal subsidy for plans purchased in Marketplaces will decline. Current law offers multiple "metal levels," with the percentage of plan costs covered by the plans ranging from 60 percent to 90 percent. The benchmark plan under ACA is the second-lowest cost 70 percent actuarial-level silver plan. *The Senate bill changes this to be the median-cost plan in the individual market in the enrollee's rating area that provides benefits actuarially equivalent to 58 percent of the full actuarial value of ACA's essential health benefits. Thus, for people receiving tax credits, both the coverage and the subsidy are reduced.*
- Starting in 2019, individuals who had a break in continuous insurance coverage for 63 days or more in the prior year will be subject to a six-month waiting period before coverage begins. Consumers will not have to pay premiums during this six-month period.[1]
- The top of the income range for receiving subsidies in Marketplaces is lowered from 400 percent of the federal poverty line (FPL) to 350 percent, beginning in 2020; this is much lower than the AHCA cap of $115,000 after a phase out that begins at an income of $75,000.
- The Senate bill also limits APTC eligibility to "qualified aliens," a much smaller category of people than ACA's category of aliens: those who are "lawfully present in the United States." But unlike some means-tested programs today, the Senate bill does not have a five-year waiting period.
- Under current law, an adjustment would be made to reduce tax credits if the total of APTC credits and cost-sharing reductions exceed 0.504 percent of GDP. The Senate bill would lower this threshold to 0.4 percent of GDP.
- The cap on premium contributions for older people buying coverage in the Marketplaces, while comparable to ACA for those living in

[1] https://www.budget.senate.gov/bettercare

poverty, is higher for people further up the income ladder, and this gap widens with age.

- Under current law, people with incomes under 133 percent of the FPL have their premium costs capped at two percent of their incomes, and the maximum cap for the highest income group eligible for subsidies is 9.5 percent. Under the Senate bill, the two percent cap holds only for those with incomes under 100 percent of the FPL; those in the 100-133 percent of FPL range would start at a two percent cap, but under what the Senate bill calls a "Final Cap," this would be 2.5 percent at some later date. Note that people in poverty may be eligible for Marketplaces, which is not the case under current law.
- In the Senate bill, except for those living in poverty, the "applicable percentage," which determines how much a person must spend to become eligible for APTC tax credits, provides more assistance for younger people and less assistance for older, non-elderly people. For example, among those with incomes in the range of 200-250 percent of the FPL, a person 60-64 years old would have to pay 8.3 percent to 10.0 percent of income to be eligible for APTC tax credits while an adult who is under the age of 29 would only have to pay 4.3 percent of income before becoming eligible for the APTC subsidy. For those in the income range of 300-350 percent of poverty, the corresponding Initial Cap is 11.5 percent and the Final Cap is 16.2 percent (this compares to the 9.5 percent cap for the highest-income group eligible for subsidies under ACA).

- Cost sharing subsidies (CSR) are appropriated for two years under the Senate bill, then repealed starting in 2020.
- The Senate bill would remove the ACA cap on the repayment obligation for people who underestimate their income and therefore, receive more in APTC credits than they should, and impose a 25 percent penalty on tax credit claims that turn out to be erroneous.
- Anyone who has an offer of employer-sponsored health coverage is ineligible for Marketplace subsidies even if employer contributions under ESI are relatively low (e.g., the firm pays only half the premium). Thus, many workers who would benefit greatly from Marketplace subsidies would be screened out of eligibility for these subsidies by the Senate bill. This provision would substantially broaden the "family glitch" under ACA.
- The "Cadillac" excise tax on high-cost employer coverage would be delayed until 2026.
- The ERISA preemption would be extended to "small business health plans" such as Association Health Plans.
- All Qualified Health Plans (QHPs) must not cover abortions, except in cases of when necessary to save the life of the mother, or rape and incest.

Mandates

- The individual mandate is repealed, retroactive to December 31, 2015. This would seem to imply that people who paid these penalties for 2016 in the recent tax filing period ending in April 2017 would get their penalties refunded although that is not explicitly stated.
- The employer mandate is repealed, retroactive to December 31, 2015, with the same implication for refunds for the year 2016.

Taxes and Insurance Market Rules

- The Senate bill eliminates a whole range of taxes used to help fund ACA. These include taxes on insurers, medical device manufacturers, pharmaceutical manufacturers, and tanning salons, among others.
- The two key tax provisions related to payroll taxes would be repealed. This includes the Medicare payroll tax surcharge on high-income people (individuals with greater than $200,000 in annual income and families with more than $250,000). The net investment income tax surcharge on these same high-income households would also be repealed.
- The ACA $2,500 limit on tax-free contributions to flexible savings accounts would be repealed.
- Unlike AHCA, states cannot apply for waivers to allow pre-ex exclusions or medical underwriting. States may apply for waivers to change the essential benefits package.
- Age rating could go to 5 to 1 instead of ACA's limit of 3 to 1; this is the same as AHCA.
- Medical loss ratio requirements under ACA would sunset in 2019. States could set up their own versions.
- The provisions of ACA subject to Section 1332 of ACA could now include essential health benefits, actuarial value, and out-of-pocket limits. The new version of 1332 gives states much more leeway in developing alternative approaches to national health legislation and could allow them to make coverage less comprehensive and cost sharing substantially higher.

State Stabilization and Innovation Fund

The Senate bill includes two sources of funding designed to stabilize private markets and assist people with complex and expensive medical conditions. One program would provide funding to States to assist high-risk individuals lacking access to employer coverage get health coverage in the non-group markets; stabilize these markets; pay providers; or help patients with out-of-pocket costs. Another program provides funds to CMS to fund health arrangements "to address coverage and access disruption and respond to urgent health care needs." Funding for this program would be $15 billion for 2018 and 2019 and $10 billion in 2020 and 2021.[2]

[2] Timothy Jost and Sara Rosenbaum. Unpacking The Senate's Take on ACA Repeal and Replace. June 22, 2017. http://healthaffairs.org/blog/2017/06/22/unpacking-the-senates-take-on-aca-repeal-and-replace/

HMA Medicaid Roundup

Alabama

Department of Corrections Ordered to Improve Mental Health Care. *The New York Times* reported on June 27, 2017, that a U.S. District Court judge has ordered Alabama to improve mental health care for inmates in state correctional facilities. The court determined that the state was in violation of the U.S. Constitution's ban on cruel and unusual punishment. The case, filed in 2014, claimed that the worsening health conditions and increased violence and suicide rates of inmates were caused by untreated mental health conditions and lengthy lockdowns of inmates. Read More

Arizona

AHCCCS Says Senate Health Care Bill Could Cost State $7.1 Billion. An analysis by the Arizona Health Care Cost Containment System (AHCCCS) projects that the proposed Senate Better Care Reconciliation Act of 2017 could cost the state $7.1 billion between fiscal 2018 and 2026. Changes in federal matching funds for Medicaid (including the early-expansion penalty) would have the biggest impact at $2.9 billion, followed by the impact of per capital cap inflation at $2.2 billion, and the hospital assessment replacement at $2.0 billion. Read More

Chamber of Commerce Says Senate Health Care Bill Would Hurt State Budget, Economy. *AZ Central* reported on June 26, 2017, that the U.S. Senate's Better Care Reconciliation Act of 2017 would have a negative effect on Arizona's economy and state budget, according to the Arizona Chamber of Commerce. In a letter to Senators John McCain (R-AZ) and Jeff Flake (R-AZ), the Chamber said the state's Medicaid program would lose approximately $7.1 billion in funding by 2026 under the Senate bill. The resulting cuts to health care would have a ripple effect on the economy, per the Chamber's analysis. Read More

California

Governor Brown Signs $183.2 Billion Budget, Increases Medi-Cal Rates for Physicians, Dentists. *Los Angeles Times* reported on June 27, 2017, that California Governor Jerry Brown approved a $183.2 billion fiscal 2018 state budget. The budget raises Medi-Cal rates for physicians and dentists through the use of tobacco tax funds. Read More

Single-Payer Bill Dies Amid Concerns Over Senate Health Care Reform Effort. *California Healthline* reported on June 26, 2017, that a bill to establish a

single-payer health care system in California has died in the state Assembly, as the focus of the bill's supporters turns to the potential fallout of the U.S. Senate's Better Care Reconciliation Bill. Instead of moving the bill forward to the Assembly Rules Committee, Assembly Speaker Anthony Rendon (D-Lakewood) suggested the state Senate take some time clarify how such a health care system would be financed, contain costs, and deliver care. The bill may be taken up again by the Assembly in 2018. Read More

Delaware

Six Plans Responded to Diamond State Health Plan RFQ. The Delaware Department of Health and Social Services said six Medicaid managed care plans responded to the state's Diamond State Health Plan and Diamond State Plus Delivery System Transformation Request for Qualifications (RFQ). Bidders included AmeriHealth Caritas, Delaware Physicians Care (Aetna), Health Partners Plans, United Healthcare, Centene, and Anthem's Amerigroup. The RFQ solicits approaches for improving Medicaid managed care through the integration of traditional Medicaid and long-term services and supports. While the RFQ is an informal solicitation, the state may choose to contract with an organization based solely on the responses to this RFQ and bypass a formal RFP process. The initiative was developed by the state Division of Medicaid and Medical Assistance and the Division of Services for Aging and Adults with Physical Disabilities.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

SMMC Reprocurement ITN Expected July 14. The Florida Agency for Health Care Administration announced on June 22, 2017, that the Statewide Medicaid Managed Care (SMMC) Re-Procurement Invitation to Negotiate is expected around July 14, 2017.

Illinois

House Democrats Propose Fiscal 2018 Budget. *Reuters* reported on June 27, 2017, that Illinois House Democrats have proposed a $36.5 billion budget for fiscal 2018, the latest attempt to end a two-year budget impasse. The disagreement on a budget between the Democratic-controlled legislature and Republican Governor Bruce Rauner has recently impacted the state's ability to pay Medicaid claims. Read More

Medicaid Members Ask Court to Force State to Pay Providers. *The New York Times* reported on June 26, 2017, that attorneys for Illinois Medicaid recipients have asked a federal judge to force the state to begin paying down its $3.1 billion backlog of unpaid Medicaid claims. A filing in the U.S. District Court for the Northern District of Illinois asks the court to order Illinois to make four monthly catch-up payments of $500 million to Medicaid managed care organizations in order to maintain the flow of reimbursements to Medicaid providers. Illinois faces a budget impasses, which threatens the state's ability to deliver services. Read More

Iowa

Democratic Legislators Propose Allowing Individuals to Buy Into Medicaid. *The Des Moines Register* reported on June 21, 2017, that two Democratic legislators are proposing to allow individuals to buy into the state's Medicaid program as an alternative to the individual health insurance Exchange. Under the Medicaid buy-in proposal, individuals with moderate incomes would be able to use federal subsidies to pay premiums for Medicaid. Read More

Optimae LifeServices Announces Layoffs, Pay Cuts. *The Des Moines Register* reported on June 21, 2017, that Iowa-based mental health agency, Optimae LifeServices, announced it will be cutting worker pay and laying off 25 people. The company blamed the state's transition to Medicaid managed care. Optimae, which primarily serves individuals with mental illness and intellectual disabilities, will cut most wages by 10 percent, managers by 15 percent, and executives by 20 percent. Opitmae President Bill Dodds stated that the managed care rollout was too focused on saving money and not enough on improving quality. Read More

Massachusetts

Co-op Minuteman Health Seeks Shift to For-Profit Status. *The Boston Globe* reported on June 23, 2017, that not-for-profit Minuteman Health, a Massachusetts-based consumer-owned and operated (co-op) health plan created under the Affordable Care Act, is seeking a transition to for-profit status. Minuteman blamed burdensome regulations and slow membership growth. Under current rules, the co-op cannot expand its business beyond individual and small business lines. Minuteman, which serves 37,000 individuals in Massachusetts and New Hampshire, has faced financial struggles since its launch in 2013. Read More

Missouri

State Files Lawsuit Against Three Drug Companies for Misrepresenting Dangers of Opioids. *The New York Times* reported on June 21, 2017, that Missouri has filed state a lawsuit accusing three drug companies of misleading the public on the risks of opioids. The suit claims that Purdue Pharma LP, Johnson & Johnson, and units of Endo International Plc violated consumer protection laws and Medicaid statutes. Similar lawsuits have been filed in Ohio, Mississippi, Chicago, Illinois, Dayton, Ohio, and counties in New York. Read More

Nebraska

Medicaid Managed Care Program Continues to Face Issues. *Omaha World-Herald* reported on June 28, 2017, that Nebraska's transition to a statewide integrated Medicaid managed care program continues to face issues, primarily related to behavioral health and home health services, according to state Nebraska Medicaid director Thomas "Rocky" Thompson. One of the state's three contracted Medicaid health plan has until June 30 to submit a plan for

correcting certain issues, including maintaining prompt and accurate payments to behavioral health and home health care providers. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Potential Budget Impasse Linked to Horizon "Piggy Bank" Dispute. *Politico* reported on June 26, 2017, that a $34.7 billion New Jersey budget for state fiscal year 2018 cleared the Senate Budget and Appropriations and Assembly Budget Committees. Its fate has been tied to the resolution of a proposal by Governor Christie to revise the non-profit insurer Horizon Blue Cross Blue Shield's governance structure and give state officials access to its "surplus reserves," which Horizon maintains is necessary to cover claims and other outstanding liabilities. In response, and as an alternative to Governor Christie's proposal, Senator Vitale introduced S-4, a bill that would amend Section 3 of P.L. 1985, c.236 (C.17:48E-3) to: 1) strengthen the charitable mission of health service corporations, 2) provide for annual informational filings similar to IRS 990 filings with the Department of Banking and Insurance, information which will be made available to the public on its website, and 3) revise board representation to include three members elected by policyholders. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Advisory Review Panel. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for New York's Medicaid managed care program, held its quarterly meeting on June 22nd. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the Department of Health, provided a program update. In addition, the panel received a report on the integration of behavioral health into managed care, a tutorial on mainstream managed care rate-setting, and an update on the status of managed long-term care. Slides are available on request.

Program Updates:

- United HealthCare has expanded to Franklin and Schenectady counties.
- Elderwood Health Plan has expanded to Wyoming county.
- School-based health services are scheduled to be carved into managed care in July 2018. Billing guidance has been posted on the Medicaid Redesign website. [Link]
- Clotting factor has been added to the managed care benefit.
- Human breast milk has been added to the managed care benefit.

Behavioral Health and Health Homes:

- New York carved behavioral health benefits into the mainstream Medicaid managed care benefit beginning in October 2015 in New York City, and all other counties across the state in July 2016.

- Some plans are lagging significantly in paying claims, particularly in New York City. The state is working with individual plans to develop remediation.
- Plans continue to lag in connecting individuals enrolled in Health and Recovery Plans (the Medicaid managed care product for individuals with serious mental illness and/or substance use disorder) with home and community-based services (HCBS). Over 87,000 people are enrolled in HARPs, yet as of June only 1,813 people had completed the assessment necessary to access those services. Only 311 people had received any HCBS services, the majority for short-term crisis respite.
- The state is launching a consumer education effort including peer-to-peer presentations to increase awareness of HARPs.
- As part of the 2018 budget, the state is restructuring Health Home outreach. A cut in the health home budget has required that the state reduce the per member per month payment to health homes during the outreach phase of engagement, from $135 to $100. They are reducing the amount of time an individual can remain in "outreach" status from 90 days to 60 days, and requiring a face-to-face contact in the second month of outreach. The Department had adopted more liberal rules during the initial years of health home operation as a way of building enrollment in the program; the focus now is on a bottom-up, community-based outreach. They are focusing on HARP members, and linking health homes to providers as a way of more effectively identifying clients. About 30 percent of HARP enrollees are currently linked to a health home, which is necessary to undergo the assessment and become eligible for the enhanced HCBS benefit package.

Managed Long-Term Care Update

- Managed Long-term care enrollment continues to grow, and is approaching 200,000.
- The Fully Integrated Duals Advantage program saw an uptick in individuals opting into the program, with over 200 people opting in during June 2017; but overall program enrollment remains low.
- FIDA has expanded to Region 2 (Suffolk and Westchester counties). One plan, AgeWell, has been approved in Region 2; two additional plans will be operational in Westchester as of July 1.
- A FIDA stakeholder meeting was held in April 2017. The webcast can be found on the Medicaid Redesign website. [Link]
- The Community First Choice option will be implemented in January 2018. Plans remain concerned about coordination, and the state has convened a number of work groups to address those concerns.

Public Comment Sought on New York Value-Based Payment Roadmap. The Centers for Medicare and Medicaid Services (CMS) recently provided feedback on the July 2016 approved New York State Value-Based Payment Roadmap. CMS has suggested that "…the next version of the Roadmap include a strategy to work toward an alternative payment model that includes both upside and downside risk for providers." As a result, the Department of Health is requesting feedback and/or recommendations related to CMS' request for

payment model strategy for upside/downside risk providers. The public feedback period is open through July 25th; comments can be submitted to vbp@health.ny.gov. Read More.

Governor Cuomo Reacts to Senate's Better Care Reconciliation Act. Governor Cuomo sent a letter to the members of the New York Congressional delegation that states "The Senate Republican's health care plan will be crippling for New York." He goes on to attack the Faso-Collins amendment, which would end county contributions to Medicaid for all New York State counties outside of New York City. The amendment was designed to encourage New York's nine Republican congress members to support the bill. NY is unusual in the role counties play in financing the state's Medicaid program, which historically had counties providing 25 percent of the cost (along with the state's 25 percent share and the federal 50 percent match). Counties currently contribute about 13 percent of New York's $65 billion Medicaid program. The amendment requires New York to take over the Medicaid costs currently covered by counties by 2020, shifting $2.3 billion a year from counties to the state. Cuomo indicated that he would institute a "Faso-Collins Federal Tax," added onto local property taxes to make up the difference. As reported in the Buffalo News the details would have to be worked out with the state Legislature. It could take one of several forms: a property tax not tied to Medicaid that the state would dictate that the counties collect, or perhaps the state could leave it up to the counties to decide how to pay that new assessment. Read More (1); Read More (2)

Legislature Passes Bill Requiring Medicaid MCOs to Cover Prescriptions at Two Not-for-Profit Pharmacies. *Times Union* reported on June 26, 2017, that the New York legislature has passed a bill requiring Medicaid managed care organizations (MCOs) to cover prescriptions at two not-for-profit pharmacies operated by the Albany College of Pharmacy and Health Sciences. The bill, now headed to Governor Andrew Cuomo for signature, follows a decision by Medicaid managed care plan CDPHP to limit its pharmacy network. CDPHP called the legislation a "narrow special interest bill." Read More

Ohio

State Senate Passes Medicaid Expansion Freeze. *The Sacramento Bee* reported on June 21, 2017, that the Ohio Senate has passed a $65 billion state budget that would freeze Medicaid expansion enrollment effective July 1, 2018. As previously reported, the state would hold a year-long open enrollment prior to the freeze. Lawmakers have until June 30 to pass a final budget. Read More

Governor Considers Veto of Medicaid Expansion Freeze Bill. *Cincinnati.com/ USA Today* reported that Ohio Governor John Kasich is considering the veto of a bill that would freeze Medicaid expansion enrollment. Lawmakers later added an exception for individuals with mental illnesses or substance use disorders. Governor Kasich has been a proponent of Medicaid expansion, saying it improves access to care and provides substance use disorder treatment to more people in the wake of the opioid epidemic. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Home and Community-Based Services Loan Program Accepting Applications. Pennsylvania's Home and Community-Based Services (HCBS) Loan Program is accepting applications from qualified providers of long-term services and supports (LTSS). The goal of the HCBS program is to expand opportunities for receiving services in the community, particularly as Pennsylvania prepares to transition LTSS to managed care with the rollout of Community HealthChoices. Loan amounts can vary from $50,000 to $200,000. As of mid-June, the department had not received any applications. Questions can be directed to ra-oltlstreamlining@pa.gov. Read More

Texas

IDD Managed Care Pilot Contract Awards Announced. The Texas Health and Human Services Commission announced on June 19, 2017, that it intends to award contracts for the Intellectual and Developmental Disability (IDD) Pilot Program to Molina Healthcare of Texas and United Healthcare Community Plan of Texas. Awards must be approved by the Centers for Medicare & Medicaid Services. Read More

Hospitals Fear Loss of Funds for Uncompensated Care. *Kaiser Health News* reported on June 26, 2017, that Texas hospitals are concerned about the potential loss of significant funding for uncompensated care, which could occur if the Trump administration declines to renew the state's 1115 Medicaid waiver. More than $6 billion in waiver funds help hospitals care for individuals who are uninsured and fund regional health care pilot programs. Texas submitted a renewal request in January 2017 to extend funding through September 30, 2019. Without approval, the current waiver will expire this December. Read More

Virginia

Virginia Takes Steps to Improve Mental Health Care in Jails. *Wavy-TV* reported on June 20, 2017, that Virginia is taking steps to improve mental health care in jails, following the death of an inmate who had a mental illness. Under new rules, jails are now required to use validated mental health screening instruments and the state Compensation Board is now responsible for reviewing staffing standards in jails. Last month, Governor Terry McAuliffe signed legislation authorizing the Board of Corrections to investigate deaths in jails. Read More

National

Senate Delays Health Bill Vote Until After July 4 Recess. *Modern Healthcare* reported on June 27, 2017, that Senate Majority Leader Mitch McConnell has delayed a planned vote on the Better Care Reconciliation Act of 2017 until after the July 4 recess. The decision comes as Republican Senators from Maine, Nevada, Utah, and Wisconsin have indicated they would vote

against the bill. Senate leaders are now pushing for a vote by the end of July. Read More

CBO Projects 22 Million Would Lose Health Care Coverage under Senate Bill; Federal Deficit Reduced by $321 Billion. *Modern Healthcare* reported on June 26, 2017, that the Congressional Budget Office (CBO) released its scoring of the Senate health reform bill, the Better Care Reconciliation Act of 2017. CBO projects the legislation would cause 22 million people to become uninsured by 2026, compared to 23 million under the House bill passed in May. The cumulative federal deficit would be reduced by $321 billion over the 2017-2026 period. Read More

NAMD Board Says Per Capita Caps Under Senate Bill are Insufficient, Unworkable. The board of the National Association of Medicaid Directors (NAMD) released a letter on June 26, 2017, stating that Medicaid per capita caps as proposed under the Senate Better Care Reconciliation Act of 2017, "would be a transfer of risk, responsibility, and cost to the states of historic proportions." The letter goes on to call the plan insufficient and unworkable. The board recommends prioritizing the stabilization of Exchange markets. Read More

Hospitals Voice Opposition to Senate Health Care Bill. *Modern Healthcare* reported on June 22, 2017, that members of the hospital and health system industry, including one of the nation's largest for-profit chains, Tenet Healthcare Corp., are lining up to oppose the Senate health care bill. Initial hospital criticisms claim that the Better Care Reconciliation Act of 2017 will reduce volume and increase levels of uncompensated care. Read More

AMA Expresses Concerns Over Key Components of the Senate Health Care Bill. The American Medical Association (AMA) issued a letter to Senate leaders Mitch McConnell (R-KY) and Charles Schumer (D-NY) on June 26, 2017, expressing concern over the proposed Senate Better Care Reconciliation Act of 2017. The letter warns that the bill would decrease coverage for Americans and limit the growth of Medicaid expenditures. James Madara, MD, chief executive of the AMA, citied proposed reductions in subsidies, the shift to Medicaid per-capita caps, and the defunding of preventative services. Read More

Kaiser Family Foundation Says Individual Premiums Could Rise 74 Percent by 2020 Under Senate Bill. The Kaiser Family Foundation released an analysis on June 26, 2017, estimating that the proposed Senate Better Care Reconciliation Act of 2017 could result in a 74 percent increase in average monthly premiums by 2020 for Silver-level Exchange plans. Individuals age 55-64 could see premiums rise 115 percent, and individuals making under 200 percent of the federal poverty level could see premiums rise 177 percent. Eight states – Alabama, Alaska, California, Louisiana, North Carolina, Oklahoma, South Dakota, and Virginia – could see average premiums more than double. Meanwhile, New York, Massachusetts, Vermont, and the District of Columbia are estimated to have the lowest increases. Read More

Senate Plan to Address Coverage Gap May Fall Short, Health Experts Say. *Kaiser Health News* reported on June 23, 2017, that an attempt by Senate Republicans to address the Affordable Care Act's coverage gap may fall short, according to some health law experts. The Senate's Better Care Reconciliation Act of 2017, which is designed to repeal and replace the ACA, would subsidize health insurance premiums for individuals earning up to 350 percent of the

federal poverty level, compared to 100 percent to 400 percent under the ACA. Those under poverty were expected to be covered by Medicaid expansion; however, a coverage gap emerged when some states chose not to expand. While the Senate bill appears to address the gap, certain provisions could result high deductibles, copayments, and out-of-pocket costs, making make it difficult for individuals to afford insurance. One provision would shift the calculation for subsidies from being tied to a Silver plan to a Bronze plan, which covers an average 60 percent of health care costs. A second provision would discontinue cost sharing subsidies in 2019 for individuals earning under 250 percent of the poverty level. Read More

Two Republican Lawmakers Introduce Bill to Study Higher Medicaid Provider Reimbursements. *California Healthline* reported on June 22, 2017, that U.S. Representatives David Valadao (R-CA) and Jeff Denham (R-CA) introduced legislation to study ways of increasing Medicaid provider reimbursement rates in an unspecified region that fits the description of several counties of California. Denham stated that the bill would build upon the federal Affordable Care Act repeal-and-replace legislation. Read More

Industry News

Cigna to Exit Maryland Health Exchange in 2018. *Washington Business Journal* reported on June 21, 2017, that Cigna will exit Maryland's Exchange in 2018, citing increasing losses and the instability of the market. According to Maryland Insurance Commissioner Al Redmer, Cigna indicated that it may return to the market in 2019. Plans remaining in the Maryland Exchange include CareFirst BlueCross BlueShield and Kaiser Permanente; Evergreen Health has applied to rejoin the exchange in 2018. Read More

Anthem Voices Support for Senate Health Bill. *The Hill* reported on June 26, 2017, that Anthem, Inc., one of the nation's largest insurers, has endorsed the Senate Better Care Reconciliation Act of 2017. Anthem stated that the bill would stabilize the individual insurance market and control premium increases. Anthem has recently announced plans to exit the Exchange markets in Indiana, Wisconsin, and Ohio. Read More

Health Systems WellStar, Sutter Health Propose Bond Offerings Totaling $1.3 Billion. *Modern Healthcare* reported on June 22, 2017, that WellStar Health System and Sutter Health are proposing separate bond offerings totaling $1.3 billion. Georgia-based WellStar expects to raise $860 million, with $740 million going to refinance higher interest debt and $120 million going to expand the emergency department at Kennestone Hospital. Meanwhile, California-based Sutter expects to raise $440 million to refinance debt. Bond offerings from not-for-profits is the latest trend to fund delayed, post-recession expansion projects. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Early Summer 2017	Virginia Medallion 4.0	RFP Release	700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 10, 2017	Delaware	Contract Awards (Optional)	200,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
Summer 2017	Illinois	Contract Awards	2,700,000
Summer 2017	Florida Statewide Medicaid Managed Care (SMMC)	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
September 1, 2017	New Mexico	RFP Release	700,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 15, 2017	New Mexico	Proposals Due	700,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
January 1, 2019	New Mexico	Implementation	700,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

Dual Eligible Financial Alignment Demonstration Implementation Status

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

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	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	50,064	36.8%	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	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York*	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 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	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	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	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**391,440**	**31.2%**	

** 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 Conference Session on Healthcare Investing to Feature Leading Wall Street Analysts, Private Equity Investors; Focus on Opportunities in Medicaid, Publicly Sponsored Healthcare

During a special breakout session titled "Investor Views on the Future of Publicly Sponsored Healthcare," leading investors will discuss some of the key market trends and investment opportunities they are tracking in the Medicaid and publicly sponsored healthcare market. They will also assess scenarios for Medicaid reform, with an eye toward how these various possibilities inform their investment priorities.

The session will feature David Caluori, Principal, General Atlantic; Josh Raskin, Managing Director, Barclays Capital; Todd Rudsenske, Managing Director, Cain Brothers & Company LLC; David Schuppan, Private Equity Investor, (Formerly with Cressey & Company LP); Tim Sheehan, Managing Director, Beecken Petty O'Keefe

The session will take place during HMA's annual conference on *The Future of Medicaid is Here: Implications for Payers, Providers and States,* September 11-12, 2017, at the Renaissance Chicago Downtown Hotel**.**

The event, which features more than 35 industry-leading speakers, will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress

Early Bird registration is now open. Last year's conference attracted more than 250 attendees. Visit the conference website for complete details: https://2017futureofmedicaid.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

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.