
# Session 102, Medicaid Hot Topics

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# 2019 SOA Health Meeting
# Medicaid Hot Topics
## Session 102
Tuesday, 6/25/2019, 3:45 pm – 5:00 pm

Presenters:

Rylan Austin, FSA, MAAA
Tim Caldwell, FSA, MAAA
Ed Mailander, FSA, MAAA
Mike Nordstrom, ASA, MAAA
Sudha Shenoy, FSA, MAAA, CERA

Moderator: Sabrina Gibson, FSA, MAAA

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# Planned Topics

- Medicaid Work Requirements and Other State Flexibility
- ACA Court Battles Around Medicaid
- High Cost Drugs and Risk Sharing
- Changes in Pharmacy Transparency
- Social Determinants of Health
- Medicaid Buy-In
- Redetermination Trends
- Mega-Rule Changes
- VBP Payment Models in Medicaid

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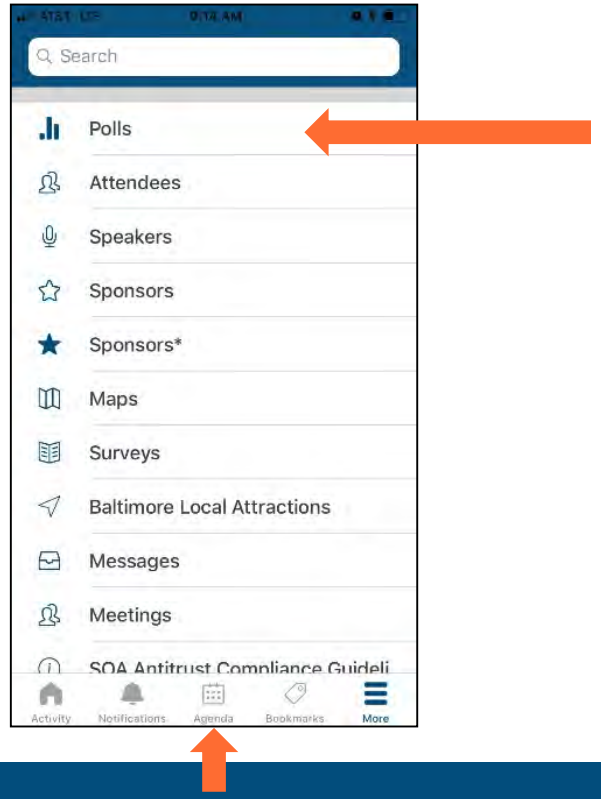
Find The Polls Feature Under **More** In The Event App or Under This Session in the Agenda

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## Session 102 - Medicaid Hot Topics

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# Poll: In what area do you work?

# Panel Bios

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# Sabrina Gibson, FSA, MAAA

- Vice President and Chief Medicaid Actuary for WellCare Health Plans.
- Health care for 20+ years.
- Medicaid for 13 years - mostly with a health plan but also as a consulting actuary.
- Experience with 27 Medicaid and CHIP programs in 17 states.
- Active member of the American Academy of Actuaries Medicaid workgroup and on the committee that developed the Actuarial Standard of Practice on Medicaid Managed Care Rate Setting – ASOP 49.
- Active with the Medicaid SOA committee as a presenter of current Medicaid topics at SOA meetings and webinars.

# Rylan Austin, FSA, MAAA

- Senior Director and Lead Medicaid Actuary for Nebraska and Hawaii for WellCare Health Plans.
- Medicaid for 5 years, all with WellCare.
- First time presenting at the SOA Health Meeting.
- Participate in various workgroups.

# Tim Caldwell, FSA, MAAA

- Senior Director, Actuarial Services with Centene Corporation
- 23 years of actuarial experience
- Have worked with Centene in the Medicaid space since 2013 with responsibility for 7 Southeastern states
- Previously experience primarily in Commercial Pricing and Product Development roles with:
  - Florida Blue
  - Independence Blue Cross
  - Coventry/Aetna

# Ed Mailander, FSA, MAAA

- Senior Consulting Actuary, Wakely Consulting Group
- Health care for 35+ years.
- Medicaid for 12 years - mostly with health plans but also as a consulting actuary.
- Experience with Medicaid and CHIP programs in 15 states.
- Areas of focus: risk adjustment, rate review, provider contracting, VBP, Rx.

# Mike Nordstrom, ASA, MAAA

- Partner and Actuarial/Financial (A/F) Sector Leader for Mercer Government. A/F includes ~ 50 Credentialed Actuaries and another 50 Actuarial Students.
- Health care actuarial work for 30+ years, the last ½ devoted exclusively to Medicaid and CHIP.
- Direct actuarial lead consulting and certifications to 7 state programs, non-lead work with multiple other states.
- Chair of the American Academy of Actuaries Medicaid Subcommittee since 2010, and Member of the Academy's Health Practice Council.
- Member of the Actuarial Standards Board's Task Force that developed the Actuarial Standard of Practice on Medicaid Managed Care Rate Setting and Certification – ASOP 49.

# Sudha Shenoy, FSA, MAAA, CERA

- Independent Consultant with over 20 years of experience (Medicare & Medicaid SME)
- Experience with healthcare rate-setting, pricing, valuation of blocks of business, product development launches, provider risk models & accountable care programs
- Clients include provider groups, State Governments and the Center for Medicare and Medicaid Services (CMS).
- Active in the Medicaid space
- Sudha is an active volunteer for the SOA and has served on the SOA Board of Directors

# Medicaid Work Requirements and Other State Flexibility

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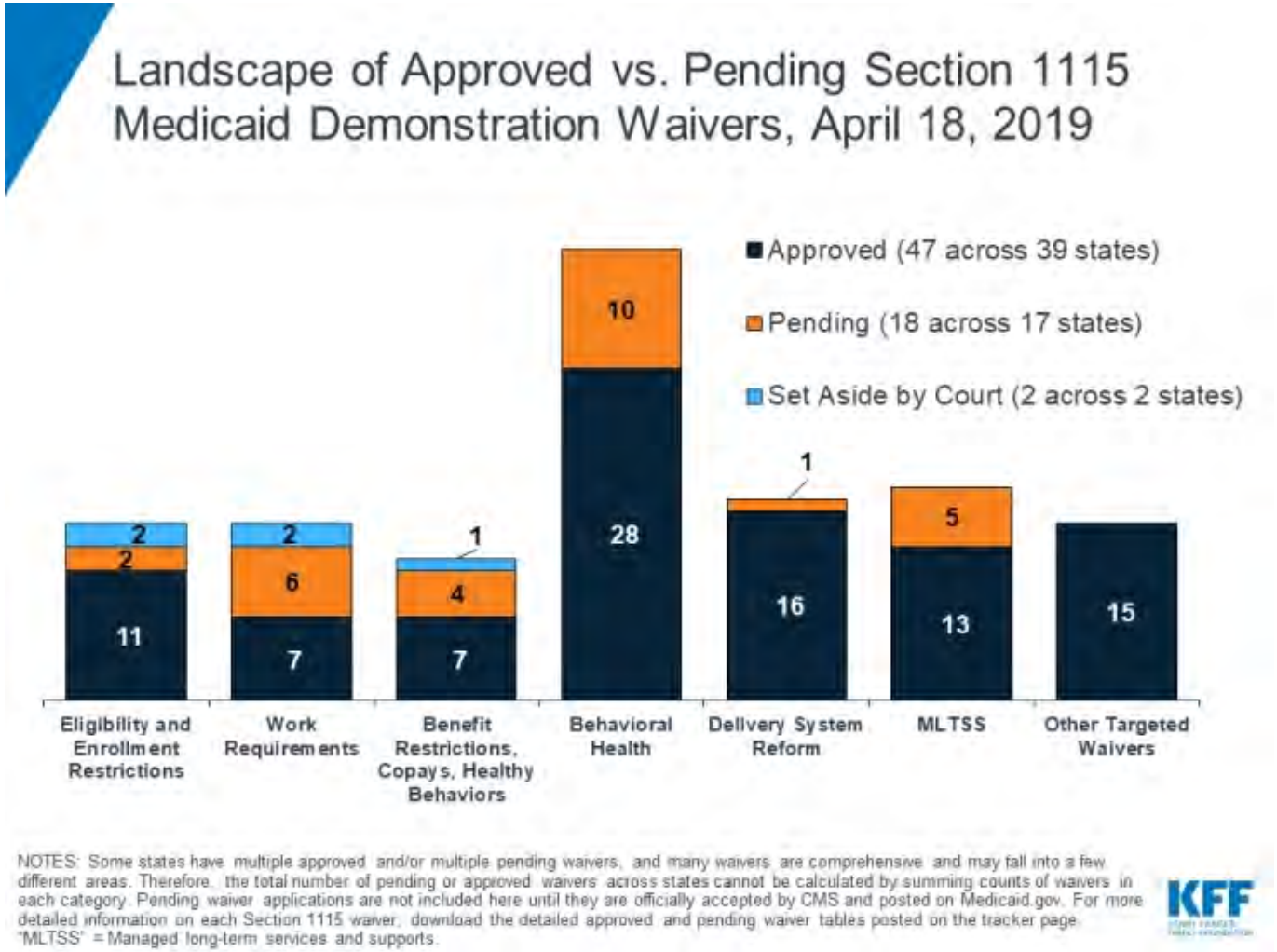
# Sec. 1115 Waivers

- Sec. 1115 of SSA HHS can waive provisions of Medicaid giving flexibility of the states in how they use federal dollars.



# Status of Work Requirements

- Approved and Implemented:
  - AR (set aside by federal judge 3/27):
    - June to September 2018 phase-in for ages 30-49 Expansion Population
    - Ages 19 to 29 in 2019
    - Age 50+ exempt
    - Monthly status reporting, coverage terminated after 3 months
    - 18,000 dis-enrolled in 2018 out of 65,000; 1,900 regained coverage in 2019
  - IN:
    - 2019 implementation: expansion and traditional adults
    - No hours requirement for first 6 months, months 7-9: 5 hours/week, then 20 hours/week
- Approved & Not Implemented: AZ, KY, MI, NH, OH, UT, WI
- Pending: AL, MS, OK, SD, TN, VA

# Status of Work Requirements

- Lawsuits, Court Rulings & CMS Approvals Update
  - March 27, 2019: District Court Judge rules Arkansas and Kentucky work requirements are illegal. Judge says promoting health was not the objective of Medicaid.
  - March 29, 2019: CMS Administrator Seema Verma approves Utah permission for work requirements. Approval letter states requiring Medicaid enrollees to work was allowed because it makes them healthier.
  - Latest update

# Status of Work Requirements

- General characteristics:
  - Who is exempt: aged, pregnant, disabled, medically frail, students, other
  - Hours: typically 80/month
  - Reporting frequency: Typically monthly
  - Months of non-compliance before termination: 1 or more
  - Penalty of non-compliance: suspension till recertified, suspended rest of the year or for x months
- Common concerns:
  - Will this cause member health issues
  - Admin vs cost savings
  - Reduce total cost but increase PMPM: another form of redetermination
  - Compliance reporting
- Controversial

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# Poll: Do you believe work/community engagement requirements are appropriate for the Medicaid population?

# ACA Court Battles Around Medicaid

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# Cases of Interest

- Texas v. Azar
- Texas v. United States (HIPF)
- Maryland vs. United States
- Gresham v. Azar

# Texas v. Azar

- Lawsuit by 20 Republican Attorneys General and Governors and 2 Individuals
- Challenges the constitutionality of the Individual Mandate
- If the Individual Mandate cannot be enforced then the remainder of the law crumbles
- Dec. 14, 2018 – Ruling for the Plaintiffs rendered the ACA invalid in it's entirety
- Dec 30, 2018 – Stay granted and the law remains intact as it works it's way through the appeals process

# Texas vs. United States

- Lawsuit filed by 8 states challenging the requirement to cover the cost Health Insurance Provider Fees incurred by Managed Medicaid plans
- States claim the requirement violates the Administrative Procedures Act, unconstitutionally “coercing and taxing” the sovereign states
- Federal government is “delegating legislative authority” to the Actuarial Standards Board, which requires HIF reimbursement in order to meet actuarial soundness requirements
- US District Court ruled in August 2018 that 6 states were entitled to HIPF refunds of $840M
- An appeal has been filed and a stay of the District Court ruling was granted on January 11, 2019

# Maryland v. United States

- Reaction to TX v. Azar case, asking court to declare the ACA constitutional and enforceable
- Premise of the lawsuit is that the Maryland would suffer irreparable harm if TX case ruled in favor of the plaintiff
- Case dismissed in Feb of this year since the State has not yet been harmed by a case that has yet to be decided
- Lawsuit can be refiled if/when the Texas case is decided for the plaintiff

# Gresham v. Azar

- Lawsuit filed in Sept. 2018 challenging Medicaid work requirements in Arkansas
- Similar lawsuit filed in Kentucky (Stewart v Hargan)
- Upwards of 50K AR Medicaid members could lose coverage
- There are concerns that the reporting process put in place could be flawed, causing members to be unfairly dis-enrolled
- Kentucky requirement was successfully blocked in June 2018 but that decision is being challenged
- District Court ruled in April to overturn the work requirements

# Drugs and Risk Sharing

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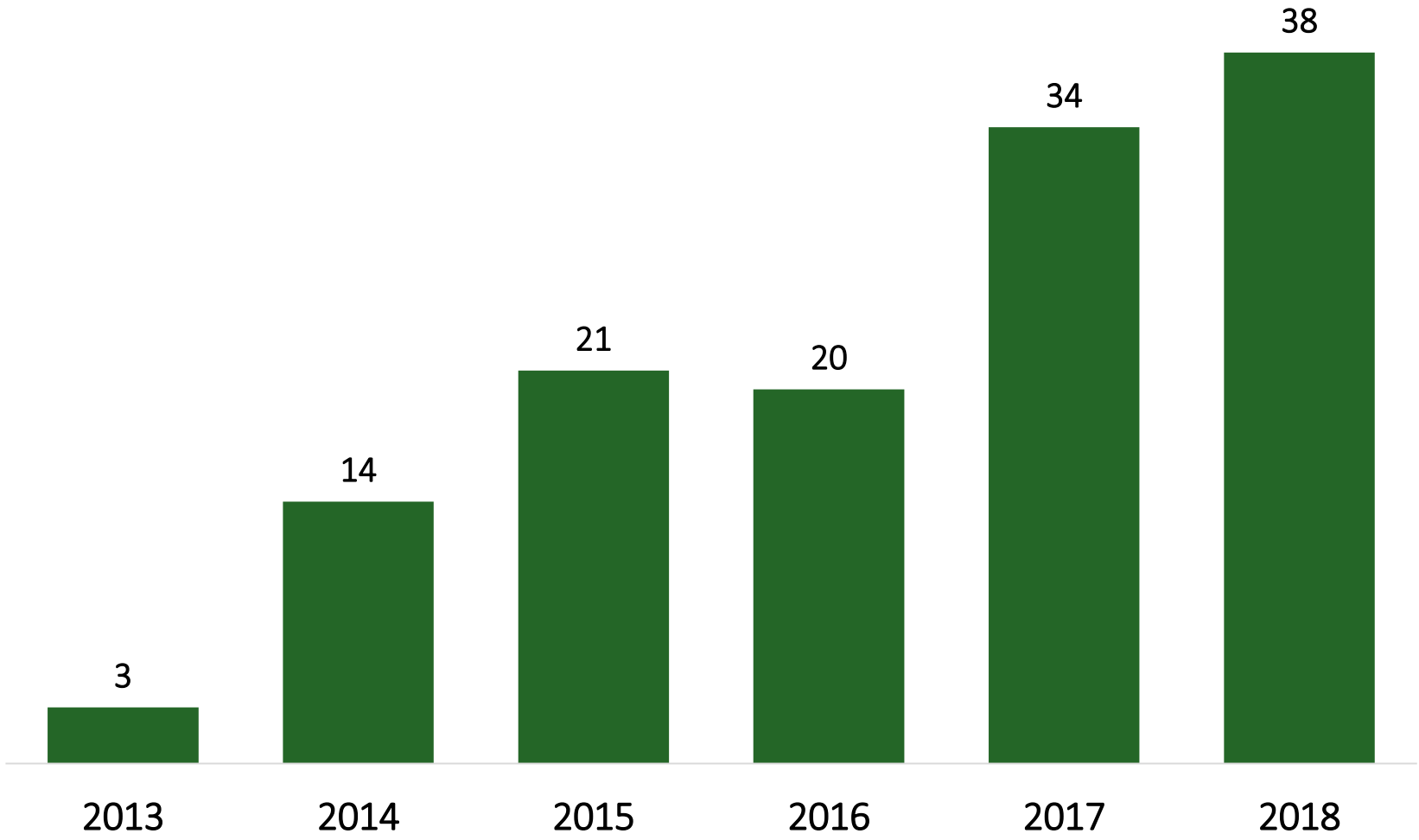
# Poll: Brand drug cost per script in Medicaid increased by how much from 2014 to 2017?

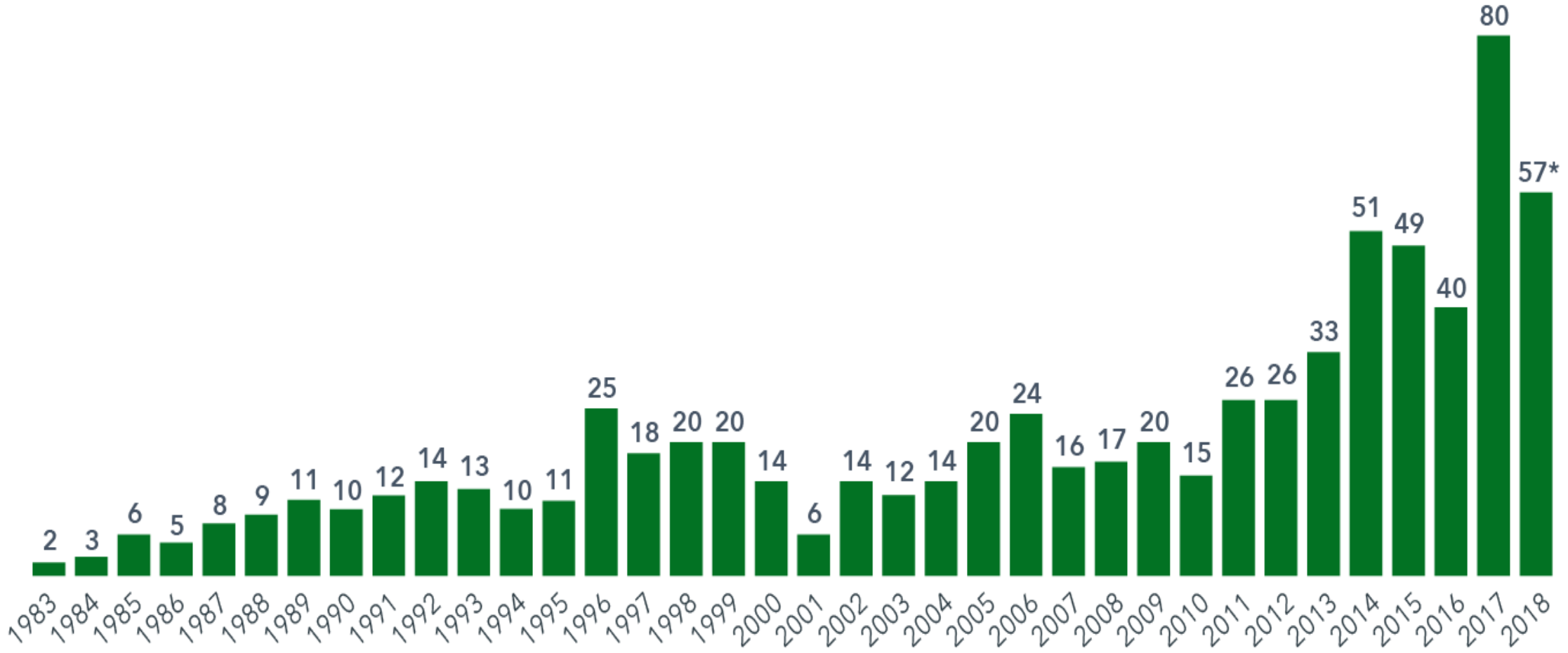
# Breakthrough Therapy Designations




**Source: FDA. Search Breakthrough Therapy Approvals.**

**Note: Breakthrough Therapy Designation was enacted on July 9, 2012. There were no approvals in CY 2012.**

# Orphan Drug Designations




Source: FDA. Search Orphan Drug Designations and Approvals. 2018 Sep. Available from: https://www.accessdata.fda.gov/scripts/opdlisting/oopd/
Note: * Reflects drug approvals through Aug 2018. Exhibit displays designated and marketing approved indications by marketing approval date.

Report: Orphan Drugs in the United States Growth Trends in Rare Disease Treatments. IQVIA Institute for Human Data Science, Oct 2018

# Breakthrough Therapy/Orphan Drug Designation Examples

| Designation | Drug Name | Indication | Cost | Additional Information |
|---|---|---|---|---|
| Breakthrough | Symdeko | Cystic Fibrosis | $292,000 | WAC $/Year |
| Breakthrough | Zolgensma | Spinal Muscular Atrophy | $4M-$5M | One time treatment, estimated cost |
| Orphan | Revcovi | ADA-SCID | $1M | WAC $/Year |
| Orphan | Luxturna | Retinal Dystrophy | 850K | One time treatment, WAC $ |

# Medicaid Rate Setting Challenges

- Increasing volume of high cost/catastrophic drugs receiving approvals
- Infrequent utilization and typically not evenly distributed among Health Plans
- Rates reflect average expected expense for a given rate cell
- Risk adjustment cannot account for expected cost difference

# Types of Risk Sharing Arrangements

- High Cost Drug Carve-Out
- High Cost Drug Pool
- High Cost Drug Risk Corridor
- Kick Payment/Case Rate
- Co-insurance
- Stop Loss

# “Installment Plan”

- Health Plans remit a payment over multiple years.  Considered by Massachusetts to handle Zolgensma.
- Considerations
  - Rate setting
  - Terms of payment
- Health Plan
  - Pro: Reduces cash flow shock
  - Con: Still at-risk for full price of drug
- State
  - Pro: Lessens risk of Health Plan insolvency
  - Con: Budget risk

# APPENDIX

# High Cost Drug Carve-Out

- Exclude High Cost Drugs from Managed Medicaid Program
- Considerations
  - Criteria
  - Mid-Year changes
- Health Plan
  - Pro: Retains no risk
  - Con: Fragmented care for members, confusing reimbursement for providers/pharmacies
- State
  - Pro: Flexibility to cover high cost drugs, regardless of PDL ownership
  - Con: Budget risk
- SC utilizes this methodology for Hep C

# High Cost Drug Pool

- Funding pool established; funds distributed based on actual versus expected experience
- Considerations
  - How is funding pool developed
  - Criteria for eligibility
- Health Plan
  - Pro: Accounts for distribution risk
  - Con: Risk associated with an underfunded pool
- State
  - Pro: Maintains budget neutrality
  - Con: Timing of distribution of funds
- FL and NE currently utilize this methodology

# High Cost Drug Risk Corridor

- Actual costs compared to a defined range around expected costs.
- Considerations
  - Width and risk sharing levels of the corridor
  - Criteria for eligibility
- Health Plan
  - Pro: Accounts for distribution and mispricing risk
  - Con: Timing of settlement; cash flow risk for smaller plans
- State
  - Pro: Health Plans retain risk
  - Con: Budget risk
- HI currently utilizes this methodology

# Kick Payment/Case Rate

- Reimbursement triggered when High Cost Drug is dispensed
- Considerations
  - Level of reimbursement
  - Criteria for eligibility
- Health Plan
  - Pro: Less time between drug/treatment and reimbursement
  - Con: Reimbursement may not cover full cost
- State
  - Pro: May be easiest to operationalize and administer
  - Con: Budget risk
- NJ currently utilizes this methodology

# Co-insurance

- Reimbursement is X% of the drug/treatment expense
- Considerations
  - Level of reimbursement
  - Criteria for eligibility
- Health Plan
  - Pro: Accounts for utilization risk
  - Con: Reimbursement may not cover full cost
- State
  - Pro: Health Plans retain incentive to manage costs
  - Con: Budget risk
- AZ currently utilizes this methodology

# Stop Loss

- Health Plans retain risk under a predetermined threshold
- Considerations
  - Deductible level
  - Criteria for eligibility
- Health Plan
  - Pro: Accounts for utilization risk
  - Con: Reimbursement may not cover full cost
- State
  - Pro: Health Plans retain incentive to manage costs until deductible is met
  - Con: Budget risk

# Changes in Pharmacy Transparency

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# Anti-Kickback & Statute & Safe Harbors

Anti Kickback Statute(AKS): Criminal penalties for acts involving Federal health care programs- whoever knowingly & willfully solicits, receives, offers or pays any renumeration in return for referring business that is reimbursable under such programs.

- AKS Safe Harbor – currently allows drug manufacturers to pay rebates to PBMs (Pharmacy Benefit Manufacturers) & protected against AKS when safe harbor conditions are met. The safe harbor has been relied upon for favorable positioning of the drug through design of a pharmacy benefit plan such as inclusion in formulary or lower cost sharing
- Additional language proposed for AKS safe harbor 42 CFR § 1001.952(h)

# Proposed Changes to AKS Safe Harbors

- **Removal of safe harbor protection of drug rebates to Medicare & Medicaid MCOs & contracted PBMs**
  - Excludes rebates required by law – State Medicaid rebates
  - Excludes hospitals, pharmacies, physicians, federal healthcare programs, drug wholesalers,
- **Add safe harbor protection for beneficiaries at POS**
  - Discounts contracted & agreed upon in advance by plan sponsors or PBM & discounts/reduction in price given to retail pharmacies. These should be reflected as reduction in price and be reflected in the patient's out-of-pocket costs
- **Add safe harbor protection for fixed fees** that drug manufacturers pay to PBMs for services rendered
  - All services provided should be listed and be fee based ( not a percent of list price, sales or volume.
  - PBM should provide health plan with written disclosure of services

# AKS Safe Harbor Proposed Rule Impact

- Effective 60 days following publication of final rule
- Increase transparency for some stakeholders & facilitate net cost comparisons for public
- Reduce out of pocket costs for consumers and reduce drug costs for federal heath care programs
- Significant disruption to the drug supply chain – manufacturers, PBMs, pharmacies, markets & health plans
- PBMs negotiate with drug manufacturers and help health plans to manage cost & utilization
- Reduce incentives for manufacturers to increase list prices

# Impact to Medicaid Programs – Open Discussion

1. What would the impact of the proposed rule be on Medicaid Programs, Medicaid MCOs & beneficiaries?
2. How would various Medicaid populations be impacted by the rule (including access to current medications)?
3. Various States have various risk sharing, high risk drug pools and other value based programs – what would the impact be on these programs?
4. How  would this to affect drug manufacturers behavior?
5. How do we expect  this to affect drug trends by category-brand/generic/specialty?

# Social Determinants of Health

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# Let's Start With Two Definitions

- "Social determinants of health (SDOH) are the conditions in which people are born, grow up, live and work that shape health outcomes. These conditions include a wide spectrum of life factors—income, housing, education, food access, transportation, social support and stress, just to name a few."

  https://theactuarymagazine.org/when-life-affects-health/

- "The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."

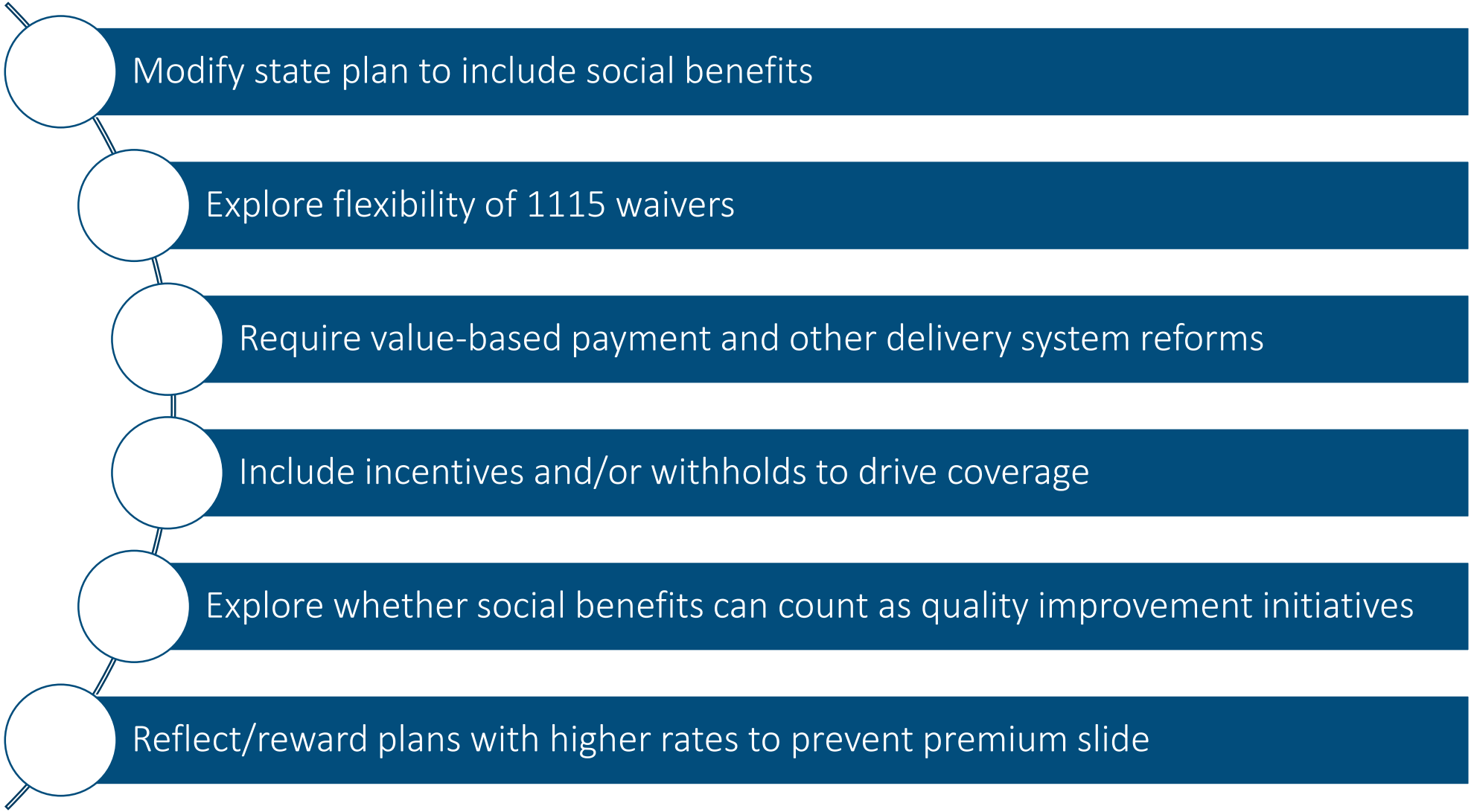
  https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

# Social Determinants of Health & Capitation Rate Development

- The Commonwealth Fund's report "Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools" was issued in January, 2018
  - Summary of a literature review and interviews with state officials, health plan leaders, actuarial experts, and other stakeholders
  - Discussed ways rates could be developed so MCOs are incentivized, required and/or have the resources to address social issues
  - 6 strategies states can employ to support MCOs in addressing social issues

http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting

# Social Determinants of Health & Capitation Rate Development



# American Academy of Actuaries Recent Communication to CMS

- CMS has identified ways to financially support states developing SDOH programs.
  - MassHealth's Flexible Services Program scheduled to begin January 2020.
  - North Carolina's waiver provides a federal match for services that will affect determinants of health.
- MCOs historically built community partnerships and added SDOH value-added benefits.
- Recommend that CMS formally examine how plan investments focused on affecting SDOH might be included in Medicaid capitation rates.
- Evidence suggests that the value and return on investment (ROI) directly correlated to SDOH investments benefits states, Medicaid programs, and Medicaid populations.

# American Academy of Actuaries Recent Communication to CMS

After a thorough vetting of implications, some initial recommendations potentially could be:

- **Allow appropriate costs related to SDOH to be included in the numerator of the MLR calculation**. This would encourage more spending on evidence-based items that would help the overall health of the beneficiaries.
- **Provide flexibility for states to include in capitation rate setting** all or a portion of the cost of services avoided as a result of investments in SDOH, based upon CMS-developed guidance to states.
- It would also be helpful if CMS could **facilitate the collection of data related to SDOH and support research regarding how they can be incorporated into risk adjustment mechanisms**. This will help states pay health plans more appropriately for populations with variations in social determinants impacting health care costs.

# Using SDOH in Risk Adjustment

- Massachusetts using SDOH in risk adjustment since October 2016
  - Adding SDOH to risk adjustment model improved predictability of cost/utilization
  - Creative data mining was used such as 3 different addresses in 12 months = unstable housing and development of a neighborhood stress score measuring the economic stress of the member's neighborhood
- SDOH is difficult to capture
  - No standard way/place to collect data
  - Can be scattered in various state departments
  - SDOH providers have no standard way to report
- ICD-10 has a few SDOH diagnosis codes (Z55.x-Z65.x) that could be captured through claims if more widely used, but they do not cover all types of SDOH – could be expanded

# SDOH ICD-10-CM Code Categories

| | |
|---|---|
| Z55 – Problems related to education and literacy | Z62 – Problems related to upbringing |
| Z56 – Problems related to employment and unemployment | Z63 – Other problems related to primary support group, including family circumstances |
| Z57 – Occupational exposure to risk factors | Z64 – Problems related to certain psychosocial circumstances |
| Z59 – Problems related to housing and economic circumstances | Z65 – Problems related to other psychosocial circumstances |
| Z60 – Problems related to social environment | |

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# Poll: What do you think will be the biggest barrier to implementing solutions for Social Determinants of Health into Medicaid funding?

# Medicaid Buy-In

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# Poll: Which will happen first?

# Program Design Issues/Considerations

"What decisions and actuarial assumptions need to be finalized before a Medicaid Buy-in program can be turned from concept into reality, Johnny?"*

"Whaddya got?!" – Marlon Brando as Johnny Strabler in 1953's "The Wild One"

* Minor modification to actual question posed to Johnny in the movie.

# Program Design Issues/Considerations

- Who Administers?
  - Given Medicaid eligibility and benefits vary by state, seemingly must be administered by them.
    - But federal approval and oversight as well if federal funding utilized via State Innovation Waiver under Section 1332 or a Section 1115 Demonstration Waiver.
- Who's Eligible?
  - Beyond ***not*** those currently eligible for Medicaid, how narrow or broad does a state want to go?
- What are the benefits? Cost sharing?

# Program Design Issues/Considerations

- What are provider reimbursement levels?
- Premium payments by the individual.
  - Any subsidization available?
  - How are premiums allowed to vary?
- Risk profile of Medicaid Buy-in individuals?
  - Impacts/selection issues on other insurance markets?
  - Risk adjustment if multiple entities (MCOs) part of program?

# OK, Enough Actuarial Whining! Who's Doin' What?

- Studies, Legislation
  - Hawaii
  - Nevada
  - New Mexico
  - Delaware
- And a whole lot more… "Map: State Efforts to Develop Medicaid Buy-In Programs"

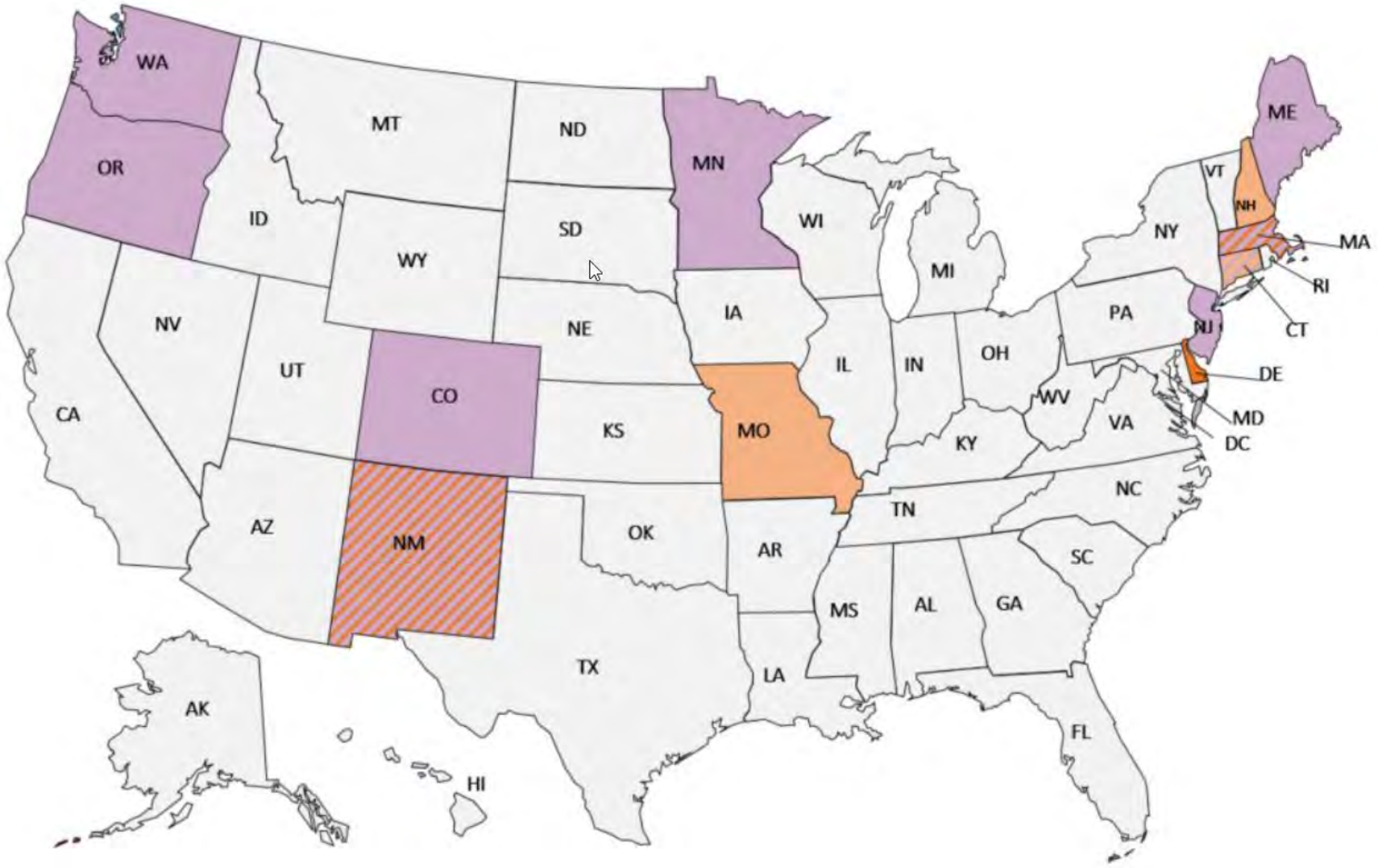
(see next page)

Buy-In/Public Option Plan Proposed [Active Legislation]

Legislation Stalled in 2018-2019 Legislative Session

Task Force Study Group Proposed [Active Legislation]

Task Force Study Group Established Legislatively



# Redetermination Trends

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# Redetermination

- What is it: periodic recertification of a member's eligibility
- Typical mature process:
  - 1/12$^{th}$ of the population is recertified each month
  - State agency sends a letter to member requesting eligibility certification information
  - Follow-up letter if no response
  - Termination if no response
- MCOs may get involved in assisting their members if they are in the loop.
- Medicaid expansion caused a problem for several states because they could not handle the volume of new enrollees so resulted in a backlog of recertification.

# Redetermination

- Financial Impact:
  - Typically those redetermined and not eligible have lower health care cost than similarly situated eligible—could be 50% lower.
  - For the state the enrollment reduction is a positive financially
  - For the MCOs, it is an increase in claim PMPM and negative financially.
- Various ways to estimate cost impact
  - Risk scores
  - Prior year claim cost
  - Other approaches
- Related concepts
  - Reclassification:  moving members into the right aid category, e.g. SSI into ACA.
  - Work requirements

# Redetermination? Enrollment Change By Year

| State | 1/14 to 1/15 | 1/15 to 1/16 | 1/16 to 1/17 | 1/17 to 1/18 | 11/17 to 11/18 |
|---|---|---|---|---|---|
| Tennessee | 13% | 10% | 2% | -4% | -10% |
| Wyoming | -3% | -6% | -4% | -4% | -7% |
| Mississippi | 1% | -3% | -2% | -2% | -7% |
| Missouri | -17% | 10% | 3% | -2% | -7% |
| Ohio | 25% | -1% | -5% | 1% | -7% |
| Illinois | 15% | 0% | -1% | -1% | -6% |
| Idaho | 2% | 3% | 4% | -2% | -6% |
| Arkansas | 10% | 3% | 11% | -5% | -6% |
| Utah | 0% | 4% | -1% | -3% | -5% |
| Massachusetts | 13% | 3% | -2% | 1% | -5% |
| Hawaii | 3% | 8% | 2% | 1% | -5% |
| New Hampshire | 30% | 13% | 0% | -1% | -5% |
| Texas | 6% | 1% | 2% | -7% | -4% |
| Kentucky | 16% | 8% | 5% | 3% | -4% |
| New Jersey | 26% | 5% | 2% | -1% | -4% |
| Vermont | 8% | 6% | -12% | -2% | -3% |
| West Virginia | 15% | 5% | 3% | -3% | -3% |
| California | 24% | 1% | 1% | -1% | -3% |
| Colorado | 27% | 12% | 4% | -3% | -3% |
| Indiana | 7% | 19% | 5% | -3% | -3% |
| United States | 14% | 4% | 3% | -1% | -3% |

https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/

# Mega-Rule Changes

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# Medicaid & CHIP Proposed Changes - Payment & Rate Setting Topics

| | Current Regulation | Proposed Regulation |
|---|---|---|
| Rate Ranges | Capitation rates must be specific to payments for each rate cell within the contract. | Develop rate cell ranges instead of a single rate per cell under specific conditions & limitations. |
| FPL | Proposed differences in capitation rates for covered populations must be based on valid rate development standards and not on the Federal financial participation rate associated with these populations. | May not vary capitation rates based on federal financial participation match for a covered population (prohibits States from increasing in any way that increases Federal costs) |
| 1.5% Freebie | States may increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification. | Revised rate certification not needed within a rating period if rates are revised to within + 1.5% of the approved rates but CMS could require documentation from States. |

# Medicaid & CHIP Proposed Changes - Payment & Rate Setting Topics

| | Current Regulation | Proposed Regulation |
|---|---|---|
| Dual COB | States that enter into a coordination of benefits agreement with Medicare for FFS/MCO/PIHP/PAHP contract should require these organizations to enter into a COB agreement & participate in the automated claims cross over process. | Health plans covering dual-eligible would receive cross over claims instead of coordination of benefits and participate in the Medicare automated process. |
| IMD | Costs in capitation rates are limited to 15 days for IMD stays. | CMS requests state comments & data on challenges associated with 15 day length of stay limitation for managed care beneficiaries in an IMD. |

# VBP Payment Models in Medicaid

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# Value Based Payments

- What is VBP:  Capitation, bundled payments, provider risk sharing, ACOs
- Goal:  Providers at (some) risk for cost and quality
- Delivery System Reform Incentive Payment (DSRIP)
  - NY: $8B  for system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.
  - MA: $1.8B for ACO, CPs and other initiatives.

# Value Based Payments

- Provider Challenges:
  - Reporting
  - Claim variability (credibility)
  - Provider readiness
  - Infrastructure
  - Mindset
  - Management
  - Adequate financial incentive
- Medicaid challenges:
  - Low reimbursement provides less money to work with

# Other Quick Topics?

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# Recommended Resources

- https://www.kff.org/state-category/medicaid-chip/
- https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/
- http://www.actuary.org/files/publications/ProposedMedicaidCHIPRuleComments_01.15.2019.pdf
- http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting
- "At the Intersection of Risk Adjustment and Social Determinants of Health", Health Watch, Issue 88, February 2019, https://sections.soa.org/publication/?i=569321&p=&pn=#{"issue_id":569321,"page":26}
- https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs/