HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

HMA News

Edited by:
Greg Nersessian, CFA
Email

Annie Melia
Email

Alona Nenko
Email

Anh Pham
Email

THIS WEEK

IN FOCUS

BALLOT INITIATIVE REQUIREMENTS IN NON-MEDICAID EXPANSION STATES

This week, our *In Focus* section examines the 10 states that have not expanded Medicaid under the Affordable Care Act but where citizens can initiate a public vote on the issue. In November, nearly 60 percent of Maine voters approved a ballot initiative expanding Medicaid. Advocates in Idaho,

Missouri, and Utah have filed paperwork to begin collecting signatures to place Medicaid expansion on the ballot in November 2018.

State laws affecting these citizen initiatives vary regarding the number of signatures required to place an issue on the ballot, the percent of votes needed for approval, the ability of the legislature to amend or appeal the measure after passage, and whether states allow initiated statutes or constitutional amendments. These variations in the law, along with other issues examined below, may affect the likelihood that Medicaid expansion ballot initiatives will be pursued and/or ratified.

Florida

In Florida, citizens can initiate a public vote on Medicaid expansion through a proposed constitutional amendment. Advocates attempted to place the issue on the 2016 ballot but gathered less than 1 percent of the necessary signatures. State law requires that proponents of a citizen-initiated constitutional amendment gather signatures equal to 8 percent of votes cast in the last presidential election. The state sets a high bar for votes needed to pass a ballot initiative: a 60 percent supermajority of votes is needed, and if the initiative imposes a new tax or fee, Florida requires a two-thirds supermajority. A 2017 poll by the University of Maryland found that 67 percent of Floridians favored Medicaid expansion compared with 64 percent nationally, as reported by the Miami Herald.

Idaho

Advocates of Medicaid expansion in Idaho submitted the necessary paperwork in October to begin collecting signatures to place the issue on the ballot in November 2018. For the issue to be placed on the ballot, state law requires proponents gather the number of signatures equal to 6 percent of registered voters as of the last general election. Only a simple majority of votes is needed for passage. A poll conducted by Boise State University in December 2016 found nearly 71 percent of Idahoans were "[in] favor of the state legislature taking action to provide access to quality health care for low income Idahoans who currently lack affordable comprehensive health coverage."

Maine

Nearly 60 percent of Maine voters approved Medicaid expansion through a November ballot initiative. Governor Paul LePage immediately announced his intention to block expansion, stating "[his] administration will not implement Medicaid expansion until it has been fully funded by the Legislature at the levels DHHS has calculated." While LePage lacks the power to veto a citizen-initiated statute that was altered by the legislature and presented to voters, he can cause funding problems and delay implementation. For example, citizen-initiated measures typically take effect 30 days after the vote, but if funding is insufficient, the law will take effect 45 days after the start of the next legislative session.

Mississippi

Mississippians can initiate a public vote on an issue through a proposed constitutional amendment. To place an issue on the ballot, state law requires proponents gather signatures equal to 12 percent of votes cast for governor in the last general election—a relatively high bar compared to other states. For a measure to pass, it must receive a majority of votes, and supportive votes must

equal at least 40 percent of votes cast in the last election. Upon failure of an initiative, proponents must wait two years to place a measure on the ballot again.

Missouri

Advocates of Medicaid expansion in Missouri filed the necessary paperwork in September 2017 to begin collecting signatures to place the issue on the ballot in November 2018. Although Mississippians can initiate legislation as either a state statute or constitutional amendment, the initiative was filed as an initiated statute. Initiated statutes require collection of signatures equal to 5 percent of votes in the last gubernatorial election in two-thirds of congressional districts, compared to 8 percent for initiated constitutional amendments. While the legislature can vote to repeal both an initiated statute and amendment, repealing an initiated amendment requires subsequent public vote.

Nebraska

Nebraskans can initiate legislation as either a statute or constitutional amendment. Proposed statutes require proponents to gather signatures equal to 7 percent of registered voters, compared to 10 percent for proposed amendments. Because the requirement is tied to the number of registered voters at the signature filing deadline, proponents do not know the exact number of signatures required to get an issue on the ballot prior to submitting the signatures. A Democratic state senator indicated in November that he would introduce legislation to legislatively refer a constitutional amendment, which means the legislation must pass the legislature with a three-fifths majority, after which it would appear on the ballot. While the state's unicameral legislature is officially non-partisan, members affiliated with the Republican party dwarf the number affiliated with Democrats, making the success of legislative referral unlikely.

Oklahoma

While Oklahomans can initiate legislation by proposed statute or constitutional amendment, state law makes it difficult for citizens to initiate legislation. For example, proponents have only 90 days to gather the required number of signatures. Critics, including a previous Oklahoma secretary of state, have complained about the lack of clarity surrounding the process. As a result, few initiated measures make it to the ballot in the state.

South Dakota

South Dakotans can initiate legislation by proposed statute or constitutional amendment. Proposed statutes require proponents to gather signatures equal to 5 percent of votes in the last gubernatorial election, compared to 10 percent for constitutional amendments. Passage requires a simple majority of votes.

Utah

Advocates of Medicaid expansion in Utah submitted the necessary paperwork in October to begin collecting signatures and holding public hearings in preparation for placing the initiative on the November 2018 ballot. The initiative will require the number of signatures equal to 10 percent of votes cast for president in the last election. After passage of a direct initiated statute (i.e., a statute that goes directly to the ballot after signature and not to the legislature), the legislature may amend an initiated statute with a simple majority vote. Seats in the Utah state Senate and state House of Representatives

are overwhelmingly held by Republicans, which would likely reduce chances for Medicaid expansion.

Wyoming

While citizens of Wyoming can initiate legislation as a statute, the state sets a high bar for signature requirements—proponents must gather the number of signatures equal to 15 percent of votes in the previous general election. Additionally, after the initiative makes the ballot, state law requires that the majority of voters in the election vote for the measure, not just those voting on the measure. Upon failure of a ballot initiative, proponents cannot reattempt placing the issue on the ballot for five years.

Nine non-expansion states do not allow citizens to initiate ballot measures: Alabama, Georgia, Kansas, North Carolina, South Carolina, Tennessee, Texas, Virginia and Wisconsin.

Source: Ballotpedia, accessed November 2017; state laws.

Non-Expansion States Where Citizens May Initiate Legislation

Non-Expansion State	Signatures needed[1] for initiative to appear on ballot	Votes needed for approval	Restrictions/Legislatures' Power to Amend, Repeal	Status
Florida	8% of votes cast in last presidential election	60% supermajority; If initiative imposes a new tax or fee, needs 2/3 supermajority	Initiativs imposing new tax or fee need 2/3 supermajority. Single-subject rule[2] applies. Legislature can overturn by amendment process, which requires 3/5 majority in each chamber before going back to ballot.	State advocates attempted to place issue on the ballot in 2016, but gathered less than 1% of necessary signatures.
Idaho	6% of registered voters as of last general election	Simple majority	No limits on legislative repeal of measure. No limits on re-attempt	Advocates submitted paperwork in October to begin collecting signatures to get initiative on 2018 ballot.
Maine	10% of votes cast in last gubernatorial election	Simple majority	Measures take effect 30 days after election; but if state funds are insufficient, effective date delayed to 45 days after start of next legislative session. No limits on legislative repeal of measure.	58.9% of Maine voters approved the Medicaid expansion ballot initiative on November 7, 2017. Governor stated he will not implement the expansion until it is fully funded.
Mississippi	At least 12% of votes cast for governor in last general election	Must have majority of votes for measure and receive supportive votes equal to 40% of votes cast in last election.	Legislature can repeal by amendment process, which requires 2/3 vote in each chamber and ballot approval. Initiatives may not be reattempted for two years.	
Missouri	Initiated statutes: 5% of votes cast in the last gubernatorial election Initiated amendments: 8% of votes cast in the last gubernatorial election	Simple majority	Legislature may repeal statutes; for an amendment, a majority vote is required in each chamber then put to voters. Single-subject rule[2] applies and limits number of sections of constitution revised; no limit on re-attempts.	Advocates filed the necessary paperwork with the state in September 2017 to begin signature gathering in order to get the initiative on the ballot in Nov- 18.
Nebraska	Proposed statutes: 7% of registered voters; proposed amendments: 10% of registered voters	Simple majority with additional requirement that number of affirmative votes must be greater than 35% of total votes cast in last election.	Single-subject rule[2] applies. Because state ties required signature to registered voters, it is difficult to know the number of required signatures. Legislature must have 2/3 supermajority to repeal or amend initiative.	Democratic State Senator stated he will introduce legislation that would legislatively refer the issue to a ballot initiative.
Oklahoma	Constitutional amendments: 15% of votes cast for governor; statutes: 8% of votes cast for governor	Simple majority	Single-subject rule(2) applies. Proponents have only 90 days to gather the required signatures. Lack of clarity around the process.	
South Dakota	Statues: 5% of votes in last gubernatorial election; constitutional amendment: 10%	Simple majority	Legislature can repeal initiated statutes with simple majority vote.	
Utah	Direct initiated statutes: 10% of votes cast for president; indirect initiated statutes: 5%[3]	Simple majority	Single-subject rule[2] applies. Legislature can amend initiated statutes with a simple majority; with an indirect initiative, the legislature may make technical corrections.	Advocates submitted paperwork in October to begin collecting signatures and holding public hearings in order to get the initiative on the ballot in Nov-18.
Wyoming	15% of votes in the previous general election	Majority of those casting votes in general election, not just those voting on measure.	Highest threshold of signatures of any state. Single-subject rule[2] applies. Legislature cannot repeal approved measure for two years, but can be amended by simple majority vote. No re-attempt for five years.	

Source: Ballotpedia, accessed November 2017; state laws; HMA

(1) Beyond the signature percent thresholds required for issues to appear on the ballot, most states have distribution requirements that require that threshold in a specific number of geographies.

(2) Single-subject rules require initiatves to contain only one issue. This may create difficulties for proponents of initiatives, such as needing to submit multiple petitions to change one section of a law.

(3) Direct initiatives go to a vote after enough signatures are collected; indirect initiatives are referred to legislature and referred to popular vote if not enacted.

HMA Medicaid Roundup

Arizona

State Supreme Court Upholds Medicaid Expansion Funding. *Tuscon.com* reported on November 17, 2017, that the Arizona Supreme Court has upheld the state's use of a hospital assessment to fund Medicaid expansion. In a unanimous decision, the court rejected arguments by Republican lawmakers that the assessment was a tax that required approval by a two-thirds majority in the state legislature. Instead, the court found that a simple majority is sufficient for assessments that are approved by a state agency. Arizona's Medicaid expansion covers 400,000 individuals. Read More

Arkansas

State Approves Medicaid MCO Forevercare as a Provider-owned Arkansas Shared Saving Entity (PASSE) for IDD, SMI Populations. *Arkansas Online* reported on November 22, 2017, that Arkansas approved newly formed Forevercare to operate as a Medicaid managed care organization for individuals with intellectual or developmental disabilities (IDD) and individuals living with a serious mental illness (SMI). Forevercare is owned by Gateway Health Plan and a coalition of providers. It is the fourth plan to be approved under a state initiative to reduce the cost of care for 30,000 high-cost Medicaid beneficiaries. The other plans are Arkansas Advanced Care, Arkansas Total Care, and Empower Healthcare Solutions. A fifth plan, Arkansas Provider Coalition, has also applied for approval. Read More

California

California Fines Insurer for Failing to Resolve Consumer Grievances. *Kaiser Health News* reported on November 15, 2017, that the California Department of Managed Health Care is fining Anthem Blue Cross $5 million for failing to respond to consumer grievances in a timely manner. An investigation found 245 violations from 2013 to 2016. Anthem will contest the fine. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Proposed Governor's Budget for Fiscal Year 2018-19. Florida Governor Rick Scott unveiled on November 14, 2017, a nearly $87.4 billion budget for 2018-19, which is 2.8% above the current $85 billion budget. The proposed General

Revenue budget is $32.2 billion, a 4% increase. The Governor's "Securing Florida's Future" recommended budget cuts taxes and fees by $180 million, sets aside $5.1 billion in state reserves, and invests in Florida's education system, transportation, and environmental protection. Read More

Below are highlights of the Medicaid budget.

- Low Income Pool – Provides $1.5 billion to continue the charity care program that covers the costs of uncompensated care for uninsured individuals.
- Medicaid School Faculty Physician Payments – Provides $246 million to continue medical school faculty physician supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of these doctors.
- Florida Medicaid Management Information System (FMMIS) – Provides $25.2 million to develop a strategic phased-in process for the modernization of the Medicaid Enterprise Systems. The funding is for the second year of this six-year project.
- Preadmission Screening and Resident Review (PASRR) – Provides $1.5 million to continue contract with a vendor to implement and operate the federally required PASRR program.
- Actuarial Consulting Services – Provides $850,000 to continue an increased allocation for ongoing actuarial services.
- Prepaid Dental Health program – Provides $700,000 to implement a statewide Medicaid Prepaid Dental Health program for children and adults.
- Claims Data Analytics Solution – Provides $925,000 to enhance analysis and transparency of health care claims data.
- APD (iBudget) Waiver – Provides $18.1 million to enroll onto the waiver 900 developmentally disabled individuals from the Home and Community Based Services Waiver waiting list.

Florida is Ordered to Expand Treatment for Inmates with Hepatitis C. The *Daily Commercial* reported on November 19, 2017, that U.S. District Judge Mark Walker ordered Florida to devise and implement a plan to screen, evaluate, and care for inmates with Hepatitis C (HCV). The ruling came after Walker learned that 7,000 to 20,000 inmates are believed to be infected with HCV; however, only 13 received antivirals since 2013. The Florida Department of Corrections has requested $19 million from the state legislature to expand treatment for inmates with HCV. Read More

Illinois

IlliniCare to Cut DME Reimbursement Rates Up to 50 Percent. *Crain's Chicago Business* reported on November 17, 2017, that IlliniCare, Centene's Medicaid managed care plan, will reduce reimbursement rates to durable medical equipment suppliers by up to 50 percent in 2018, including suppliers of wheelchairs, oxygen tanks and ventilators. Read More

Iowa

Iowa Health Link RFP Attracts LOIs from Two Medicaid Plans. The Iowa Department of Human Services announced on November 22, 2017, that Centene/Iowa Total Care and Medica Health Plans submitted Letters of Intent (LOIs) indicating they will submit bids to participate in the Iowa Health Link Medicaid managed care program. Iowa is seeking additional Medicaid plans to serve the market. The LOIs were not mandatory so other plans may still bid.

State to Move 10,000 Medicaid Managed Care Members Back to FFS. *The Des Moines Register* reported on November 27, 2017, that about 10,000 Iowa Medicaid members who had opted to enroll in Anthem/Amerigroup will be moved to the state's fee-for-service program. Anthem/Amerigroup stated that it would be unable to take on additional members after AmeriHealth Caritas exits the program. AmeriHealth's departure will impact a total of 215,000 members, most of whom will be auto-assigned to UnitedHealth. Read More

Medicaid Plan Says It Is Operating at Membership Capacity. *The Des Moines Register* reported on November 21, 2017, that Anthem/Amerigroup is unable to take on additional members in Iowa because its Medicaid plan there is operating at capacity, according to the company. About 215,000 Medicaid members in the state will need a new plan when AmeriHealth Caritas exits the market. The state will auto-assign these members to UnitedHealthcare effective December 1, 2017. Read More

Lawmakers May Reevaluate Cuts to Retroactive Medicaid Eligibility. The *Press-Citizen* reported on November 19, 2017, that Iowa lawmakers may face pressure to back-peddle on the decision to reduce the window for retroactive Medicaid eligibility from 90 days to the first of the month in which an individual applies. The Iowa Department of Human Services initially estimated that the move would save the state $9 million and impact 40,000 Iowans; however, lawmakers, state officials, and health care groups fear the impact may be greater. The Republican-controlled state legislature is likely to revisit the topic in January. Read More

Iowa Appoints Michael Randol as Medicaid Director. The *Des Moines Register* reported on November 17, 2017, that Iowa has appointed Michael Randol as Medicaid director. He was most recently Medicaid director in Kansas. He will succeed Mikki Stier, who was promoted to deputy director of the Iowa Department of Human Services. Read More

Amerigroup of Iowa Medicaid Members May Lose Access to UnityPoint Hospitals, Providers. *The Courier* reported on November 15, 2017, that Amerigroup of Iowa Medicaid members may lose access to hospitals, clinics, and home care services of UnityPoint Health, potentially impacting 54,000 patients. The contract between the two organizations expires at the end of 2017. UnityPoint stated that the two organizations are still in negotiations and hope to reach an agreement by the end of the year. Read More

Kansas

Providers, Beneficiaries Express Concerns About KanCare Renewal. *KCUR 89.3* reported on November 21, 2017, that state officials are struggling to reassure Medicaid providers and beneficiaries that the state's proposed

renewal of its KanCare Medicaid managed care program will successfully address administrative and access problems that have plagued the program since it was implemented in 2013. The concerns expressed about KanCare 2.0 at a recent public hearing included administrative burdens; decreased services, especially for individuals with developmental and physical disabilities; work requirements; and a lifetime cap on services for certain beneficiaries. Read More

Kansas Disputes Federal Allegations that it Overstated CHIP Enrollment. *The News & Observer* reported on November 18, 2017, that Kansas is disputing allegations by the U.S. Department of Health and Human Services (HHS) Office of Inspector General that the state overstated its Children's Health Insurance Program enrollment when seeking bonus payments to offset Medicaid costs between 2009 and 2013. HHS is recommending that the state refund the money. Kansas says it followed federal guidelines and did nothing wrong. Read More

Kentucky

Kentucky Moves Closer to Winning CMS Approval of Medicaid Waiver, State Official Says. *Harlan Daily Enterprise* reported on November 16, 2017, that Kentucky is getting closer to receiving federal approval for a waiver to implement the state's Kentucky HEALTH Medicaid program, according to Department for Medicaid Services commissioner Steve Miller. The waiver was submitted 16 months ago, with the program originally scheduled to be fully implemented July 1, 2018. Click here to access our *In Focus* article about the Kentucky HEALTH waiver proposal. Read More

Louisiana

Governor to Sign Emergency Medicaid Managed Care Contract Extensions. *U.S. News* reported on November 21, 2017, that Louisiana Governor John Bel Edwards intends to use emergency powers to extend contracts with the state's five Medicaid managed care plans for 23 months, bypassing the state legislature. The decision was made after Louisiana House Republicans voted twice to block the contract renewals. Current contracts expire on January 31, 2017. Read More

Health Officials Say Medicaid Drug Payments Follow Industry Standards. *The Times-Picayune* reported on November 28, 2017, that Louisiana health officials told a legislative study group that the state follows industry standards when making prescription drug payments to Medicaid managed care plans. The state also caps administrative fees. Lawmakers are concerned that Medicaid plans are marking up the cost of drugs to boost profits. The study group was created by lawmakers hoping to save money on Medicaid, which accounts for nearly half the state budget. Read More

Massachusetts

State Seeks Waiver to Negotiate Medicaid Drug Rebates, Exclude Certain Medications. *Kaiser Health News* reported on November 21, 2017, that Massachusetts is seeking a federal Section 1115 waiver that would allow the

state to negotiate Medicaid drug rebates instead of relying on a set percentage of a drug's list price. The state is also seeking the ability to drop coverage for drugs with limited efficacy; Medicaid currently covers most medications. The state hopes to receive an answer on the waiver request by the end of the year. Read More

Mississippi

State Seeks Job Training Requirement for Some Medicaid Recipients. The *Clarion Ledger* reported on November 16, 2017, that Mississippi is seeking a federal waiver to allow the state to require job training for some able-bodied adults who receive Medicaid. Individuals with mental illness and full-time caregivers would be exempt. The Mississippi Division of Medicaid estimates the requirement would affect approximately 15,000 to 20,000 low-income parents or caregiver relatives. Read More

Missouri

State to Cover Hepatitis C Cure for All Medicaid Beneficiaries Following Lawsuit. The *St. Louis Post-Dispatch* reported on November 22, 2017, that Missouri will cover medications that cure Hepatitis C for all Medicaid beneficiaries, reversing a prior decision to restrict coverage to the sickest patients. The decision follows a federal lawsuit filed against the Missouri Department of Health on behalf of three Medicaid members suffering from the virus. The lawsuit was dropped after the state reversed course. The new policy is expected to impact 13,000 Medicaid recipients. Read More

New Hampshire

Commission Recommends Continuing Medicaid Expansion, But Shifting to Managed Care. *The Miami Herald* reported on November 15, 2017, that a New Hampshire commission has recommended that the state extend its Medicaid expansion program for five years and transition the program to managed care in 2019. Medicaid expansion coverage in New Hampshire is currently received through the Affordable Care Act Exchange. The program, which covers 43,000 individuals, is set to expire in December 2018. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Rebecca)

New Jersey to Expand Substance Abuse Treatment for Pregnant Women and New Moms. *NJ Spotlight* reported on November 17, 2017, that New Jersey will award $5 million in contracts to several nonprofit organizations to expand their substance abuse treatment and medical care for pregnant women and new moms. As part of the contracts, the nonprofit organizations will be responsible for delivering residential treatment, preventing relapses, offering medication-assisted treatment and wraparound care, connecting healthcare providers, and providing assistance with housing, transportation, childcare, and job skills. The contracts, which runs from early December to June 2018, will be awarded to the Center for Great Expectations Inc., Capital Health System, Eva's Village Inc., Robins Nest, and Cooper Health System. Read More

HHS OIG Report Says CMS Wrongly Paid New Jersey $606 Million for Special Education Services. *Media HealthLeaders* reported on November 29, 2017, that the Center for Medicare & Medicaid Services (CMS) wrongly paid New Jersey over $606 million in school-based Medicaid services, according to the U.S. Health and Human Services (HHS) Office of Inspector General (OIG). An audit report found that the overpayments were a result of the state misreporting of time studies to indicate that activities were related to Medicaid services and incorrectly incorporating payment rates to school employee's pension fund and salaries for employees that did not provide health-related services. The report recommends that the state pay $300.5 million in unallowable costs for special-education services and work with CMS to determine the permissible amount of $306.2 million reimbursed using payment rates. The New Jersey Department of Human Services contested the findings of the report. Read More

State to Add 811 Psychiatric Beds Over Next Two Years. *New Jersey Business* reported on November 17, 2017, that New Jersey has approved the addition of 811 adult acute care psychiatric beds at 26 facilities over the next two years, a 40% increase in the number of adult acute psychiatric beds in the state. The beds are approved for 19 existing general hospitals, three existing psychiatric hospitals, and four psychiatric hospitals to be developed. Read More

Governor-elect Phil Murphy Announces Remaining Members of Health Care Transition Team. *Return on Information* reported on November 20, 2017, that New Jersey Governor-elect Phil Murphy released a list of the remaining individuals that will be joining the rest of his Health Care Transition Team.

New York

Medicaid Spending Over Projections. New York's Medicaid spending rose slightly above projections in August. Spending was $25 million or 0.3 percent over projections, resulting in total expenditures of $9.010 billion. Spending on managed long-term care was $35 million over projections due to higher-than-expected enrollment; fee-for-service long-term care spending was $19 million over projections due to more individuals receiving personal care than had been projected. Growth in long-term care spending was identified as a source of concern in last year's budget. Several proposals were introduced to constrain spending, including banning marketing by the plans (which was recently implemented), restricting enrollment to people who are eligible to be placed in a nursing home, and reducing the bonuses plans can receive for meeting certain quality measures. New York's Medicaid global spending cap limits spending to the ten-year average of the Medical Care Consumer Price Index, which is 3.2 percent for the current fiscal year. Read More

Two Medicaid Managed Care Plans Report 2016 Operating Losses. *Crain's HealthPulse* reported on November 22, 2017, that Fidelis Care, with 1,215,000 members, lost $102 million. Fidelis had $5.7 million in total Medicaid revenue. Cost per member per month rose at twice the rate of the increase in the capitation payment, with hospital, medical and pharmacy costs growing 10 percent between 2015 and 2016. Centene recently announced its planned acquisition of Fidelis. Read More *Crain's HealthPulse* also reported on November 28, 2017, that HealthFirst, with 917,000 members, lost $35 million. Healthfirst saw spending increased in several areas, including specialty care

and outpatient mental health, and noted that while prescription drug spending had leveled off in 2016, it remains "a potentially destabilizing force" for all Medicaid managed care plans in the state. The two plans account for almost half of New York's Medicaid managed care enrollment. Read More

New York Submits Children's Health Transformation Plan to CMS. New York State has submitted its Final Draft Transition Plan for the Children's Medicaid System Transformation to CMS. The document is subject to CMS approval. The Department of Health will be hosting a webinar to review the document on December 4, 2017, 12:30 – 2:00 pm. To register for the webinar, click here. Read More

State Senate Health Priorities. *City & State NY* reported on November 20, 2017, the priorities of Kemp Hannon, Chair of the State Senate Committee on Health, for the coming legislative session. They note that health care legislation in Albany during the 2018 session will be largely affected by decisions made in Washington. New York's health care system will be rattled by potential changes to the Affordable Care Act, which the state embraced, implementing many of its provisions. New York will also be hit by cuts in federal funding for disproportionate share hospital payments, where additional aid is given to public hospitals to cover their expenses for uninsured patients, and cuts to the Child Health Insurance Program (CHIP). Hannon feels it is unlikely that the state Senate will have to create legislation to compensate for the loss of CHIP and other federally funded programs, saying that it is more likely that lawmakers will come up with a solution in Washington.

Hannon mentioned several other priorities for the state Senate Health Committee next year: work of the state Senate Task Force on Lyme and Tick-Borne Diseases and the Task Force on Heroin and Opioid Addiction. Hannon said the Senate will strive to pass legislation on the opioid crisis. Despite strong support for a safe staffing bill that would mandate nurse-to-patient ratios by state Senate Labor Committee chairwoman Marisol Alcantara, Senator Hannon did not indicate it was a priority for the Health Committee. Read More

Department of Health Division of LTC to Hold Meeting on Future of Integrated Care. The New York Department of Health's Division of Long Term Care, together with the Centers for Medicare & Medicaid Services, will be convening the fifth meeting for the stakeholder series on the future of integrated care in New York State. These sessions are designed to facilitate the conversation on what is envisioned for the State's integrated care programs after 2019. Topics to be covered in this session include: 1) Geographic Scope, 2) Consolidation of Existing Programs, 3) Platform for Integrating with Medicare, and 4) Considerations for Transition.

The meeting will take place Friday, December 8 from 11:30 am-2:00 pm. Stakeholders are invited to either attend in person at 290 Broadway, 30th floor rooms 1-2, in New York City, or via webinar/conference call. To attend in person RSVP no later than December 4th with the first and last names of attendees to futureofintegratedcare@health.ny.gov. Read More

NYC Health + Hospitals' Accountable Care Organization Generates Four Years of Shared Savings. NYC Health + Hospitals, New York City's public health care system, announced that its accountable care organization (ACO), under the national Medicare program, had achieved shared savings for the fourth consecutive year, the only program in the state to achieve such shared savings success. The ACO saved the Medicare program $3.59 million for 2016

and returned $1.58 million in shared savings to the public health system. Through enhanced care coordination, the health system was able to prevent unnecessary emergency department visits, avoidable hospitalizations, and other high-cost care for the more than 10,000 Medicare fee-for-service patients who are followed through the program. NYC Health + Hospitals' ACO recorded a quality score of 90 percent. The score reflects a composite of 34 different quality metrics, covering such concerns as 30-day all-cause hospital readmissions and measures reflecting patients' control of such conditions as hypertension and diabetes. As a result of its success in the Medicare Shared Savings Program, NYC Health + Hospitals is expanding its value-based payment focus beyond Medicare. It has submitted an application to the New York State Department of Health to become a State All Payer ACO, which would change the payment structure for coordinated care for Medicaid fee-for-service patients and privately insured patients as well. Read More

State University of New York Academic Medical Centers Face Challenges. *Politico NY Health* reported on November 15, 2017, that the academic medical centers operated by the State University of New York (SUNY) may need to reduce their reliance on government financing. The three centers, in Brooklyn, Stony Brook, and Syracuse, will be impacted by changes in health care financing from Washington. The three facilities rely on Disproportionate Share Hospital dollars. They also receive funding through the 340B drug discount program and are at risk should Congress undermine the Affordable Care Act as part of the tax overhaul. Politico cites a report to the SUNY Board of Trustees that suggests the hospitals should consider limiting the number of services offered to achieve financial stability. "Curtailing certain items like primary care that other providers in the surrounding area offer would potentially allow SUNY to focus on more-specialized services that are less accessible in the region and produce more medical students experienced in such specialties." It also notes that specialty care can offer better margins to providers. Read More

Long Island Health Network Loses Member. *Crain's HealthPulse* reported on November 27, 2017, that the Long Island Health Network, a network of hospitals that came together to improve negotiating power with providers, as well as work collectively on quality initiatives, is losing a member. The 455-bed South Nassau Communities Hospital is withdrawing from the coalition at the end of the month and will be joining the Mount Sinai Health System. According to Crain's, South Nassau "didn't believe LIHN was the right vehicle to help it prepare for value-based contracts with insurers in which it will be accountable for patients' health outcomes." It is the second hospital to withdraw this year, as Winthrop-University Hospital (591 beds) left the coalition in March to join the NYU Langone Health system. Eight hospitals, including six that make up Catholic Health Services, remain in the network. Read More

North Carolina

North Carolina Proposes Medicaid Premiums, Work Requirements in Waiver Amendment. *Modern Healthcare* reported on November 27, 2017, that North Carolina submitted a Medicaid waiver amendment that will impose premiums and work requirements on Medicaid members. In addition, to get more doctors to participate in the Medicaid network, the state would start a

loan repayment and incentive program aimed at general surgeons, OB-GYNS, psychiatrists, psychologists and midlevel behavioral health providers. The Section 1115 waiver application would shift the state's fee-for-service Medicaid program to managed care by 2019. Approximately 1.5 million individuals would be enrolled in Medicaid managed care. Read More

State Takes Over Daily Operations of Cardinal Innovations, Removes Board of Directors. The *Winston-Salem Journal* reported on November 28, 2017, that the North Carolina Department of Health and Human Services (DHHS) has temporarily taken over the daily operations of Cardinal Innovations Healthcare Solutions, the state's largest behavioral health managed care organization. The move represents the strongest action taken by the state in response to a previously reported state audit report over executive compensation. DHHS also removed the company's board of directors. A new board will be selected by DHHS and county commissioners. DHHS will also develop a corrective action plan for the company and hire additional management. Read More

North Carolina Disputes It Made $63 Million in Medicaid Claims Processing Errors. *The News & Observer* reported on November 16, 2017, that North Carolina disputes findings by the U.S. Department of Health and Human Services (HHS) that the state made $63 million in Medicaid claims processing errors from 2011-13. HHS believes that the state should pay back the federal government's share, which amounts to $41 million. Read More

Three Behavioral Medicaid LME/MCOs Announce Coalition. Vaya Health announced on November 15, 2017, that it is partnering with two other North Carolina Local Management Entities/Managed Care Organizations (LME/MCOs) for Medicaid behavioral health in order to leverage resources and expertise as the state undergoes its Medicaid reform plan. The coalition formed by Vaya Health, Alliance Behavioral Healthcare, and Trillium Health Resources, will "seek to have a stronger voice in preserving the role of the public behavioral healthcare system in Medicaid Transformation." Read More

Oregon

Medicaid Claims Payment Error Hits $152 Million, Report Says. *Oregon Live* reported on November 20, 2017, that the Oregon Health Authority may have made a total of $152 million in incorrect Medicaid payments, double what was previously reported. The newly uncovered errors involve Medicaid payments for ineligible individuals, unauthorized immigrants, the deceased, residential mental health facilities, bariatric surgeries, and abortions. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania House Votes Unanimously to Reauthorize CHIP. *Lancaster Online* reported on November 22, 2017, that the Pennsylvania House of Representatives unanimously passed a bill to reauthorize the Children's Health Insurance Program, which covers 177,000 Pennsylvanian children. The bill reauthorized the program through 2019 and currently awaits a vote in the Senate. The routine bill became controversial this year because the Senate

inserted language that would have prohibited CHIP from covering transgender kids' transition surgeries. The House deleted that provision in the version sent to the Senate. The deadline for reauthorization is the end of the year. Read More

Puerto Rico

Senate Democrats Propose Lifting Medicaid Spending Caps on Puerto Rico, Virgin Islands. *The Hill* reported on November 28, 2017, that Senator Bernie Sanders (I-VT) introduced legislation that would lift federal Medicaid spending caps on Puerto Rico and the U.S. Virgin Islands. Federal funding for Medicaid in Puerto Rico is capped at $300 million annually, which amounts to a federal match of less than 20 percent. Puerto Rico is also subject to a 55 percent limit on the federal matching rate up to the cap. The bill is co-sponsored by Senators Richard Blumenthal (D-CT), Kirsten Gillibrand (D-NY), Kamala Harris (D-CA), and Ed Markey (D-MA). Read More

South Carolina

Prescription Drug Monitoring Program Reduces Opioid Use by Nearly 30 Percent. *U.S. News* reported on November 27, 2017, that South Carolina's prescription drug monitoring program reduced the number of opioid prescriptions written for Medicaid beneficiaries by 29 percent, according to a study by the University of South Carolina. The program requires that all doctors check a database created by the state's Department of Health and Environmental Control before prescribing opioids. Read More

Medicaid Managed Care Plan Offers GED Vouchers. *The Post and Courier* reported on November 27, 2017, that Select Health has begun offering General Equivalency Diploma (GED) vouchers to its Medicaid managed care members in South Carolina. The vouchers cover the cost of one GED test and a retake. Several hundred members have taken advantage of the program, and 18 have received their GED. Select Health, a subsidiary of AmeriHealth Caritas, is the largest Medicaid managed care plan in the state. Read More

Utah

Utah Enrolls 100 Homeless, Others in Limited Medicaid Expansion. *KSL.com* reported on November 27, 2017, that Utah has enrolled about 100 individuals, including the chronically homeless and individuals referred by substance abuse or mental health programs, into the state's limited Medicaid expansion. The limited expansion is aimed at 4,000 to 6,000 homeless and needy individuals. Voters in Utah will decide in November 2018 whether to fully expand Medicaid to about 90,000 individuals. Read More

Wisconsin

State Requests 5-Year Extension of 1115 Medicaid Reform Waiver. The Wisconsin Department of Health Services (DHS) announced on November 20, 2017, that it is requesting a five-year extension for the BadgerCare Reform Demonstration waiver, expiring December 31, 2018. The Section 1115 waiver

provides Medicaid coverage to childless adults at 100 percent of the federal poverty level or below. DHS is accepting public comments from November 24 – December 24, 2017. Two public information sessions will also be held on December 5th and December 7th. If approved, the waiver extension will start January 1, 2019. Read More

National

CMS Hopes to Reduce Medicaid DME Spending through Data Collection Effort. *Modern Healthcare* reported on November 27, 2017, that the Center for Medicare & Medicaid Services (CMS) will look to curb Medicaid spending on durable medical equipment (DME) by requiring states to report DME reimbursement rates. The information will be used to determine whether states are paying a higher rate than Medicare for DME. The initiative is expected to save CMS approximately $26 billion over the next decade. Read More

State Officials Prepare for CHIP Funding to End. *The Washington Post* reported on November 23, 2017, that state officials in nearly a dozen states, where Children's Health Insurance Program (CHIP) funding is running low, are preparing to notify families that children may lose coverage. The Centers for Medicare and Medicaid Services (CMS) provided approximately $542 million to keep states' programs running a bit longer and issued guidance detailing their options if the funding was completely depleted. Arizona, California, Minnesota, Ohio, Oregon and the District of Columbia are expected to run out of CHIP funding by the end of December or early January. The Senate Finance Committee is working to find a bipartisan solution to extend funding for CHIP. Read More

ACA Exchange Enrollment Slows in Third Week. *Reuters* reported on November 22, 2017, that sign-ups for healthcare coverage via Healthcare.gov slowed in the third week of open enrollment. Approximately 800,000 people enrolled, down 75,000 from the previous week. Still, new customers increased to 220,323 from 208,397. The Congressional Budget Office estimates that 11 million individuals will enroll for 2018 coverage. Open enrollment ends December 15. Read More

Senator Murkowski Supports Repeal of Individual Mandate. *Politico* reported on November 21, 2017, that Senator Lisa Murkowski (R-AK) supports repeal of the Affordable Care Act (ACA) individual mandate, according to an opinion piece she wrote for the *Daily News-Miner*. A spokesperson for Murkowski noted, however, that the Senator's comments do not necessarily mean she will support the proposed Senate tax bill, which includes language that would repeal the mandate. Murkowski, who voted against prior Republican repeal and replace efforts, also wrote that she strongly supports bipartisan legislation to stabilize the ACA Exchanges, as proposed by Senators Patty Murray (D-WA) and Lamar Alexander (R-TN). Read More

Bipartisan Murray-Alexander ACA Stabilization Bill Is Back in Play. *The Hill* reported on November 20, 2017, that previously proposed bipartisan legislation designed to help stabilize the Affordable Care Act (ACA) Exchanges could be included in a year-end federal funding package, according to Senator Lamar Alexander (R-TN). The ACA fix, sponsored by Alexander and Patty

Murray (D-WA), would reinstate Exchange cost sharing subsidies while while allowing states more flexibility to modify certain ACA rules. Read More

HHS Office of Inspector General to Review Medicaid Payments for Telehealth Services. *Healthcare-Informatics* reported on November 21, 2017, that the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) will review Medicaid payments for telehealth services to ensure they are in compliance with Medicaid requirements. Findings are scheduled to be released in 2019. OIG stated that Medicaid claims for telehealth services have been increasing significantly. Read More

New Nursing Home Regulations Are Under Fire from Lawmakers. *Cleveland.com* reported on November 26, 2017, that lawmakers in Congress are pushing back against recent revisions to nursing home regulations, the first reworking of industry standards in more than 25 years. A group of 146 U.S. Senators and Representatives (all but two of whom are Republicans) argue in a letter to the Trump administration that the new rules are overly burdensome. Patient advocates had pushed for the revisions to address staffing and care quality at nursing homes, among other issues. Nursing homes must comply with the Nursing Home Reform Law to receive federal Medicaid and Medicare funds. Read More

CMS Provides $600 Million Stopgap CHIP Funding to 14 States. *CQ* reported on November 16, 2017, that the Centers for Medicare & Medicaid Services (CMS) will distribute $600 million in stopgap funding for the Children's Health Insurance Programs in 14 states and territories. Arizona, California, Massachusetts, Minnesota, Oregon, Pennsylvania, Utah, Washington, and Washington, DC are included. Read More

Study Says Lowering Medicaid Fees to Providers Can Compromise Access to Care. *Reuters* reported on November 16, 2017, that Medicaid provider reimbursement levels and access to care are directly related, according to a study in JAMA Internal Medicine. Every $10 increase in Medicaid fees paid to providers led to a 1.7% increase in the proportion of Medicaid members who could secure an appointment. The same was true for declines in fees. The findings are based on 12,000 calls made by individuals posing as patients in Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas. Read More

Industry News

Horizon BCBS-NJ CEO Robert Marino to Retire; Kevin Conlin to Replace. *Return on Information* reported on November 16, 2017, that Robert Marino, chief executive of Horizon Blue Cross Blue Shield of New Jersey, will retire at the end of 2017. Horizon chief operating officer Kevin Conlin will succeed him. Read More

Trinity Health to Merge Its MI Facilities into One Statewide System. *Crain's Detroit Business* reported on November 15, 2017, that Trinity Health will merge its St. Joseph Mercy Health System and Mercy Health to form one statewide system in Michigan. Rob Casalou, president and chief executive of St. Joseph Mercy, will be leading the combined organization, which will include 10 hospitals, nine outpatient health centers, 12 urgent care centers, and 35 specialty facilities. Read More

Former WellCare General Counsel Sentenced to Prison for Medicaid Fraud. *Nasdaq/Reuters* reported on November 22, 2017, that Thaddeus Bereday, former general counsel of WellCare Health Plans, Inc., was sentenced to six months in prison, after pleading guilty to making a false statement concerning a Florida Medicaid fraud scheme involving false reporting of mental health services expenditures. Read More

Centene Names Cynthia Brinkley President, COO. Centene announced on November 16, 2017, that it has named Cynthia Brinkley president and chief operating officer; she was previously executive vice president of global corporate development. Jesse Hunter was named executive vice president of mergers and acquisitions and chief strategy officer; he was previously executive vice president of products. Mark Brooks was named chief information officer; he was previously CIO of Health Net. Kevin Counihan was named senior vice president of products. Michael Neidorff will remain Chairman and chief executive officer. Read More

LHC Group, Almost Family Announce Merger. Publicly traded home care providers LHC Group Inc. and Almost Family Inc. announced on November 16, 2017, a definitive agreement to merge in an all-stock transaction valued at approximately $860 million. The combined entity would provide home health services in 36 states and generate annual revenues of $1.8 billion. The transaction is expected to be completed in the first half of 2018. Keith Myers, current chairman and chief executive of LHC Group, will be named chairman and chief executive of the combined company.

Preferred Care Partners Files for Bankruptcy Protection. *Dallas News* reported on November 15, 2017, that nursing home chain Preferred Care Partners has filed for Chapter 11 bankruptcy protection. Preferred Care has a $28 million payout on a personal injury claim and 160 pending lawsuits. Preferred Care

operates more than 110 skilled-nursing, assisted-living, and independent-living facilities in 12 states. Read More

UnitedHealth/Optum to Launch Venture Capital Fund. *Modern Healthcare* reported on November 28, 2017, that the Optum division of UnitedHealth will branch into venture capital through a $250 million fund called Optum Ventures. Optum Ventures plans to invest in start-up companies focusing on healthcare access, delivery systems, and payment systems. Optum has already made initial investments in data and analytics platforms Apervita and Shyft Analytics, and artificial intelligence companies Buoy Health and Mindstrong Health. Other insurers, including Humana and Cambia Health Solutions, have also pushed into venture capital. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
November/December 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
January 1, 2018	Delaware	Implementation	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices (Delay Likely)	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 5, 2018	Iowa	Proposals Due	600,000
January 10, 2018	Texas STAR+PLUS Statewide (Delay Possible)	Proposals Due	530,000
January 25, 2018	Arizona	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	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 (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
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	Implementation	1,600,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000

COMPANY ANNOUNCEMENTS

AbsoluteCARE Opens New Ambulatory ICU in Greenbelt, MD to Cover Most Complex Chronically Ill Patients. Read More

HMA NEWS

Medicaid Innovation Accelerator Program National Webinar Scheduled for December 13. The Centers for Medicare & Medicaid Services' Medicaid Innovation Accelerator Program (IAP) Reducing Substance Use Disorder (SUD) program area is holding a national learning webinar on December 13 from 2:30 to 4:00 PM ET. This webinar, titled "Emergency Department Treatment and Follow-Up Strategies for Opioid Use Disorder," will highlight successful strategies being used to treat opioid use disorders in hospital emergency departments, including effective approaches for initiating treatment, facilitating referrals, and ensuring follow-up care. During this learning opportunity, participants will learn about these innovative approaches, hear about lessons learned, and have an opportunity to pose questions to the speakers regarding their programs, including the Project ASSERT and Faster Paths to Treatment programs at the Boston Medical Center and Project ASSERT at the Yale-New Haven Hospital. *HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates. To participate in this webinar, register here.*

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