HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

TEXAS RECEIVES 1115 WAIVER RENEWAL

This week, our *In Focus* section reviews Texas' 1115 Medicaid waiver renewal. After more than a year of negotiations, on December 21st the Texas Health and Human Services Commission (HHSC) received CMS approval to extend the state's 1115 waiver.[1] The Texas Healthcare Transformation and Quality Improvement Program waiver was initially approved by CMS as a five-year demonstration waiver that began December 2011 and ended September 2016

[1] See announcement and related documents at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthcare-transformation-ca.pdf

and included $29 billion in funding. The waiver authorized the expansion of Medicaid managed care while preserving federal hospital funding historically received as supplemental payments. The waiver created two new funding pools: the Uncompensated Care (UC) payment pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

In May 2016, Texas received a 15-month extension that continued the waiver through December 2017, during which time HHSC and CMS continued negotiations on a longer-term agreement. As a condition of the extension, HHSC was required to contract with an independent entity to evaluate the roles of Texas' UC Pool and DSRIP program in the overall Medicaid system for paying hospitals. The study was conducted by Health Management Associates and submitted to CMS in August 2016.[2]

The new extension continues the waiver for an additional five-year period beginning October 2017 through September 2022. As with the initial waiver, the renewal includes three primary components:

- Continuation of the statewide managed care program, which now covers more than 90 percent of all Medicaid enrollees and includes all 254 Texas counties;
- Modification and continuation of the DSRIP program through September 30, 2021; and
- UC funding to support hospitals and other providers for costs associated with treatment of indigent or low-income patients.

The State also received approval for other payment programs using the available Budget Neutrality provision under the waiver. This includes the Network Access Improvement Program (NAIP), the Quality Incentive Payment Program (QIPP), and the Uniform Hospital Rate Increase Program (UHRIP).

The waiver includes multiple provisions and deadlines the State must meet in order to receive full funding, which is described in more detail below.

FINANCING PROVISIONS AND REQUIREMENTS

The terms of the renewal include over $11 billion in DSRIP program funding and at least an estimated $13 billion for UC payments. The DSRIP program is allotted $3.1 billion in Demonstration Year (DY) 7 and DY 8, decreasing to $2.91 billion in DY 9, $2.49 billion in DY 10, and $0 in DY 11.

Funding for UC is more complicated due to the waiver Special Terms and Conditions (STCs) that require the State to change the way UC costs and payments are calculated. Under the first two years (DY 7 and 8), UC funding will continue under the current methodology with approximately $3.102 billion available in each year. The STCs require the State to develop a new

[2] *Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool*, August 26, 2016. Conducted by Health Management Associates on behalf of Texas Health and Human Services Commission. Available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/DY5/UC-Study-Report-091316-FINAL-corrected.pdf

methodology for calculating costs and payments, which will determine the UC pool amount. The actual amount of funding will be determined after Texas has submitted and CMS has approved the new protocol and cost data. If the State fails to meet the STC requirements, CMS will temporarily set the payment to a reduced default amount of $2.3 bill for DY 9-11.

Demonstration Year	UC Funding	DSRIP Funding
DY 7: October 2017-September 2018	$3,101,776,278	$3,100,000,000
DY 8: October 2018 – September 2019	$3,1010,776,278	$3,100,000,000
DY 9: October 2019 – September 2020	$2,334,323,270*	$2,910,000,000
DY 10: October 2020 – September 2021	$2,334,323,270*	$2,490,000,000
DY 11: October 2021 – September 2022	$2,334,323,270*	$0
Waiver Extension Total (DY 7-DY 11)	$13,206,522,366	$11,600,000,000
Cumulative Total (DY 1 – DY 11)	$33,888,622,386	$26,118,000,000

DSRIP Program Provisions

Texas was the second state to receive authorization for the DSRIP program and is the largest funded program in the country to date. The program provides financial incentives that encourage hospitals and other providers to achieve measurable improvements in quality of care and overall population health through innovative, collaborative programs and care strategies. More than 250 providers participate in the program, including public and private hospitals, community mental health centers, local health departments, and physician groups affiliated with an academic science center. The program includes more than 1,450 DSRIP projects that must meet pre-approved metrics, milestones and performance goals to qualify for payments. Current projects are approved based on a lengthy Program Funding and Mechanics (PFM) protocol document developed by HHSC and approved by CMS.

As part of the waiver extension proposal, HHSC submitted a revised PFM that incorporated significant changes to the DSRIP program to ensure projects continue to demonstrate progress and reflect plans for long-term sustainability when DSRIP funding is no longer available. The December 21st approval required HHSC to continue working with CMS to finalize the PFM and other documents by January 20, 2018 to ensure the documents clearly demonstrate how the state will meet the following STC requirements:

- Strengthen the measurement set used to measure and report progress on specific projects
- Define and incorporate an attribution model for determining which individuals are included in the denominator used to measure project participation and performance

- Assure the distribution of incentive funds is in proportion to the value of the activities associated with project bundles, and distribute funding within a project bundle proportionately across all required measures
- Include a suitable and accountable performance measurement and payment methodology for incentive payments for providers that have high and/or maximized performance baselines
- Require providers to link core activities to selected project measure bundles and outcome measures.

On January 19th, HHSC announced that CMS had approved the revised documents, including the PFM and the Measure Bundles Protocol. [3] In its approval letter, CMS noted that Texas "has improved its measure bundles to focus more on outcome measures, added a robust and comprehensive attribution methodology, refined the process by which providers may distribute funding across measure bundles, included a suitable and accountable performance and payment methodology for providers with high or maximized performance baselines, and enhanced how providers will specify, link and report core activities to outcome." [4]

The STCs also require HHSC to submit a draft transition plan to CMS no later than October 1, 2019, describing how the State will continue its delivery system reform efforts when DSRIP funding is no longer available and meet mutually agreeable milestones to demonstrate ongoing progress. The transition plan must be finalized by the end of March 2020. In its January 19th approval letter, CMS proposed to meet with the state no later than June 30, 2018 to outline goals and expectations for the transition plan.

Uncompensated Care Pool and Payment Provisions

The most significant financing changes under the waiver will affect the uncompensated care payments for charity care. UC funding initially increases from $3.1 billion to $3.102 billion for the first two years of the waiver (DY7-8) with no changes required in the methodology or distribution of UC funding. However, beginning in DY 9, UC pool payments will be re-sized based on hospital charity care provided to individuals who are uninsured as reported on the Worksheet S-10 of the Medicare hospital cost report (Form CMS-2552-10). Under the current UC protocol, Texas calculates uncompensated care based on the cost of all services to Medicaid and uninsured patients minus all payments received. UC pool payments are cost-based and currently include the difference between what Medicaid pays for a service and what Medicare would pay for the same service, i.e., the state's "shortfall".

To calculate payments, Texas uses the "UC Claiming Protocol and Application," a data tool created by HHSC under the initial waiver. The UC application allows a broader definition of charity care than what is included in the Form S-10. As noted in the 2016 Texas Uncompensated Care study

[3] Documents have not yet been publicly posted at the time of publication, but will be available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthcare-transformation-ca.pdf

[4] Letter of approval to Stephanie Muth, Texas Medicaid Associate Commissioner of Medicaid and CHIP, from CMS Director of System Reform and Demonstrations, dated January 19, 2018.

submitted to CMS, the S-10 data defines charity care based on the principles of the Healthcare Financial Management Association and does not include bad debt or Medicaid shortfall, costs that are currently allowed under Texas' UC protocol. The report also notes that charity care is typically reported when a strict set of pre-defined conditions are met and bad debt is used as the default for other unreimbursed patient charges. Bad debt may often meet the requirements for charity care, but are not reported as such on the S-10 due to technical reporting requirements.

As a result of these changes, the amount of the UC funding pool is likely to be reduced beginning DY 9 and in subsequent years. The STCs confirm that UC payments will no longer include amounts for the Medicaid shortfall as CMS prefers that reimbursement rates be adequate to cover Medicaid costs. The STCs also require HHSC to develop a new UC Payment Protocol which must take effect no later than September 1, 2019 (see timeline below for more details regarding development of protocol). HHSC announced at a public meeting they will continue to work closely with providers to ensure the protocol reflects actual costs to the greatest extent possible while meeting CMS requirements.

Beginning October 2019 and through the end of the waiver (DY 9-11), the UC pool size will be based on hospitals' 2017 charity care costs as reported on the S-10. HHSC emphasized the importance of accurate reporting and will work with providers to ensure they accurately report their charity care consistent with Medicare cost reporting principles. For providers and hospitals not required to complete the S-10 (mainly children's, cancer, and rehabilitation hospitals, and Institutions of Mental Disease), an alternative methodology based on CMS-approved cost reports will be used to determine charity costs.

Timeline for Key UC and DSRIP Program Activities

The waiver STCs include specific deadlines for both UC and DSRIP program activities and identifies penalties that may be imposed if the state fails to meet the specified deadlines. HHSC Commissioner Charles Smith acknowledged that some dates are aggressive but is confident the state will be able to comply and is committed to working with providers to ensure there are no disruptions in payments or program activities. The tables below summarize key deadlines and applicable penalties if the state fails to meet CMS requirements related to the UC and DSRIP programs:

Uncompensated Care Modifications and Implementation Deadlines

Timeframe	STC Deliverable Requirements/HHSC Activity	Applicable Penalties for Non-Compliance[5]
February 2, 2018	HHSC begins drafting UC reimbursement protocol	
February 12, 2018	HHSC shares draft UC reimbursement protocol with stakeholders	

[5] Penalty reductions in UC expenditures are cumulative.

February 14 – March 21, 2018	HHSC reviews and finalizes draft UC protocol	
March 30, 2018	HHSC must submit the draft UC funding and reimbursement protocol to CMS	Failure to meet timeline will result in permanent reduction of UC expenditure by 20% for DY 7
July 1, 2018	Expected CMS approval of UC protocol	
July 31, 2018	Upon receipt of CMS approval of UC Payment Protocol, HHSC must begin the necessary administrative rulemaking process by publishing notice of the proposed rulemaking and public hearing in the Texas Register	Failure to meet timeline will result in permanent reduction of UC expenditure by 20% for DY 7
January 30, 2019	HHSC must publish final administrative rules to implement the required UC pool distribution methodology, for an effective date of no later than September 30, 2019	Failure to meet timeline will result in an additional 20 percent reduction of allowable UC expenditures for DY 8
May 1, 2019	HHSC must submit draft revised UC application tools for all provider types to CMS for review and approval	An additional 20 percent reduction of allowable UC expenditures for DY 8 if deadline is not met
August 31, 2019	CMS must approve the revised UC tools for all provider types	An additional 20 percent reduction of allowable UC expenditures for DY 8 if deadline is not met
September 1, 2019	CMS finalizes the uncompensated charity care UC pool limit for DY 9-11	
September 30, 2019	Final effective date for Texas Administrative Code Rules on UC pool distribution methodology	
October 1, 2019	Implementation of new UC pool distribution methodology	An additional 20 percent reduction of allowable UC expenditures for DY 9 if deadline is not met

DSRIP Program Modifications and Deadlines

Timeframe	STC Deliverable Requirements/HHSC Activity	Applicable Penalties for Non-Compliance
January 20, 2018	HHSC will work with Texas DSRIP providers and CMS to finalize updates to the DSRIP RHP Planning Protocol and the Program Funding and Mechanics (PFM) Protocol. (Note: Protocols were approved by CMS January 19th).	Federal funds will not be available until protocols are approved by CMS
October 1, 2019	HHSC must submit a draft transition plan to CMS that includes how the state intends to sustain delivery system reform after DSRIP funding is discontinued, and/or how the state plans to phase out DSRIP funded activities	Failure to submit the sustainability plan will result in a deferral of 10 percent of federal funds beginning in the next quarter and in all subsequent quarters until the requirement is met.
March 31, 2020	Final DSRIP Transition Plan must be approved by CMS	
October 1, 2021	Federal Funds for DSRIP are discontinued	

Approval of IGT Financing Methodology

Also of note, the waiver renewal appears to allow the state to continue its current method of financing Intergovernmental Transfer (IGT) payments. Under both the UC and DSRIP pools, public IGT funds paid by public hospitals or other governmental entities are used to draw down matching funds under the waiver. While CMS has previously expressed some concerns specifically regarding the use of burden alleviation as currently allowed, CMS appears to allow this method of finance, at least for the time being. STC 46 states "CMS may review at any time, the sources of the non-federal share of funding for the demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed with the time frames set by CMS."

In a public meeting on January 11th, HHSC Commissioner Charles Smith reiterated that the deadlines imposed by CMS are aggressive and will require public engagement. HHSC will be creating workgroups to engage stakeholders in the various initiatives and will continue to provide updates on the website.

Link to Texas Medicaid 1115 Waiver Renewal Approval

HMA Medicaid Roundup

Arizona

Governor to Propose Limits on Opioid Dosages. *Modern Healthcare* reported on January 19, 2018, that Arizona Governor Doug Ducey will propose legislation that would allow doctors to prescribe no more than an initial five-day supply of opioids and limit the maximum dosage for most chronic pain patients. The plan would also include $10 million in funding for substance use disorder treatment for the uninsured. Read More

Alabama

Governor Hopes to Implement Medicaid Work Requirements. *AL.com* reported on January 17, 2018, that Alabama Governor Kay Ivey has directed her administration to develop a plan for implementing Medicaid work requirements. Medicaid commissioner Stephanie Azar has been tasked with formulating the policy, which would apply to able-bodied Medicaid recipients, with exemptions for children, the elderly, and people with disabilities. The plan would also increase copays for able-bodied Medicaid recipients. Read More

Alaska

Senators Criticize Further Increases in Medicaid Spending. *Alaska Public Media* reported on January 18, 2018, that Republican senators on the Alaska Senate Finance Committee criticized continued increases in the state's Medicaid costs. The state has added a total of $100 million to cover Medicaid costs after the state budget passed. State budget director Pat Pitney said higher-than-expected enrollment drove the increases. Read More

Colorado

Medicaid Waiting List for Adults with Severe Developmental Disabilities Grows. *The Denver Post* reported on January 18, 2018, that the Colorado Medicaid waiting list for adults with developmental disabilities continues to grow, according to a legislative briefing. Since 2015, the list of adults in need of services has grown 40 percent to 2,915. Coverage for adults on the list needing "comprehensive" services would cost about $200 million annually, said Medicaid Director Gretchen Hammer. Read More

Connecticut

Hospitals Say Proposed Medicaid Rate Increases Are Insufficient. *The CT Mirror* reported on January 17, 2018, that Connecticut hospitals are appealing proposed state Medicaid rates, arguing that the level of increase is insufficient. The dispute threatens state efforts to secure federal approval of a new hospital tax arrangement, according to Budget Director Ben Barnes, who argues that hospitals are reneging on an agreement with state lawmakers. Under the proposal, the state would increase taxes on hospitals from $556 million to $900 million annually in exchange for paying hospitals $200 million more per year in Medicaid funds. Read More

Florida

House Panel Approves Pharmacy Cost Transparency Bill. *Health News Florida* reported on January 18, 2018, that the Florida House Health Innovation Subcommittee approved legislation that would increase drug cost transparency. The legislation would require pharmacists to inform patients about the cost of drugs and whether retail prices are lower than health plan cost-sharing requirements. The bill would also require pharmacy benefit managers to register with the Florida Office of Insurance Regulation, amend insurance laws to specify what is and isn't allowed in a health plan contract with a PBM, and prohibit PBMs from limiting the ability of pharmacists to fill prescriptions with generics. The bill now heads to the House Appropriations Committee. Read More

Illinois

Illinois Hasn't Calculated Medicaid MLR Minimums Since 2012, Audit Says. *Crain's Chicago Business* reported on January 23, 2018, that Illinois has not calculated whether Medicaid managed care plans have met minimum medical loss ratio requirements since 2012, according to a report from the state auditor general. The audit also says that the Illinois Department of Healthcare and Family Services was unable to provide auditors with the data necessary to determine actual claims paid, claims denials, and administrative costs incurred by Medicaid plans. Read More

Iowa

Iowa Stands Behind Medicaid Managed Care Program, Official Says. The *Des Moines Register* reported on January 17, 2018, that Iowa will continue its Medicaid managed care program despite snags, according to Jerry Foxhoven, director of the state Department of Human Services. Foxhoven said the state is making progress in reducing payment delays and will look into recent complaints about claim denials. Read More

Proposal Would Exempt Disabled, Elderly from Medicaid Managed Care. The *Des Moines Register* reported on January 17, 2018, that legislation proposed by Iowa State Senators Amanda Ragan (D-Mason City) and Liz Mathis (D-Hiawatha) would exempt tens of thousands of elderly and disabled individuals from Medicaid managed care. The Iowa Health Care Association and the Iowa Association of Community Providers back the bill, but Republican lawmakers are expected to oppose it. Read More

Kansas

KanCare 2.0 May Be in Jeopardy, Says Lawmaker. *KCUR 89.3* reported on January 22, 2018, that Kansas House Health Committee Chair Daniel Hawkins (R-Wichita) said the state's proposed KanCare 2.0 Medicaid managed care waiver renewal may be in jeopardy. Kansas lawmakers have introduced legislation to block KanCare 2.0, which includes work requirements and a lifetime cap on benefits. Hawkins added that other lawmakers are wary of extending KanCare given problems with the original program, including payment delays, an applications backlog, and concerns over care for individuals with disabilities. Read More

Louisiana

Governor Proposes Medicaid Funding Cuts. *The Times-Picayune* reported on January 22, 2018, that Louisiana may remove 46,000 elderly and disabled individuals from Medicaid as part of a series of health care-related budget cuts proposed by Governor John Bel Edwards for fiscal 2019. The proposal would cut $657 million in state health care funding and as much as $2.4 billion including federal matching funds. The proposal would also cut funding to safety net hospitals and eliminate mental health services for adults who don't otherwise qualify for Medicaid. Edwards and leadership in the legislature agree that tax increases are likely to avoid the health care cuts included in Edwards' budget plan. Read More

Health Secretary Opposes Medicaid Work Requirements. In an opinion piece published on January 22, 2018, in The Advocate, Louisiana Medicaid Director Rebekah Gee wrote that she does not agree with a proposal from state Senator Sharon Hewitt (R-Slidell) to impose Medicaid work requirements. Gee noted that nearly 70 percent of the state's 1.6 Medicaid recipients are children, elderly or disabled. Among "nonworking" Medicaid recipients, about 80 percent are family caregivers, students, or too disabled or sick to work. Read More

Michigan

Detroit Medical Center to Cut Jobs, Focus on Quality. The *Detroit Free Press* reported on January 22, 2018, that the Detroit Medical Center (DMC) will cut jobs and focus on efforts to reduce readmissions and improve patient satisfaction as part of a system-wide reorganization. DMC is owned by Tenet Healthcare and includes Detroit Receiving Hospital, Sinai-Grace, Children's Hospital, and Harper Hutzel. Read More

Mississippi

Medicaid Reauthorization Bill to Cut Provider Reimbursement by 5 Percent. *The Clarion Ledger* reported on January 20, 2018, that proposed legislation to reauthorize the Mississippi Division of Medicaid for three years would cut provider reimbursement rates by 5 percent. The proposal, drafted by State Senate Medicaid Committee Chairman Brice Wiggins (R-Pascagoula), would impact providers virtually across the board, including physicians, hospitals, nursing facilities, intermediate care facilities, psychiatric residential treatment facilities, and pharmacies. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

NJ Senators Introduce Five New Health Care Bills. Five new health care bills were introduced in the New Jersey State Senate this week. We highlight the bills below:

- S891 – Establishes an Office of State Dental Director and a New Jersey Oral Health Commission
- S961 – Requires all Medicaid managed care organizations to permit all pharmacies in state to dispense for all covered medications
- S964 – Establishes Behavioral Health Services Task Force
- S975 – Establishes a three-year Medicaid demonstration project to pay for certain drugs according to an outcome-based system
- S1028 – Establishes Office of Health Transformation to coordinate certain strategic planning for State health care programs.

New Mexico

New Mexico Awards Centennial Care MCO Contracts. New Mexico has awarded contracts for the state's Centennial Care Medicaid managed care program to Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan and Centene/Western Sky Community Care. Molina Healthcare, UnitedHealth Group, Presbyterian Health Plan, and Health Care Service Corp./Blue Cross Blue Shield of New Mexico were the incumbents. Molina was the largest Medicaid plan in the state, covering nearly 34 percent of program enrollees as of November 2017. Contracts will begin January 1, 2019. Centennial Care integrates long-term care, physical, and behavioral health services for approximately 675,000 individuals.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York ACA Marketplace Enrollment Exceeds 2017 Levels. The New York State of Health, New York's health insurance marketplace, announced that 243,600 individuals have enrolled in health insurance on the State's health insurance exchange, exceeding levels at the end of open enrollment in 2017. This number reflects an increase of nearly 15,000 since December. Approximately 54,700 individuals are new enrollees, while 188,900 were reenrolling in coverage. Enrollment in the Essential Plan reached 726,300, an increase of 10,000 since last reported in December. Enrollment is expected to steadily increase in the final two weeks of open enrollment, which closes January 31.

New York DOH Releases VBP Guidance for MLTC Plans. The New York State Department of Health has released Value Based Payment (VBP) guidance documents for Medicaid Advantage Plus (MAP) Plans, Fully Integrated Duals Advantage (FIDA) Plans, and Program for All-Inclusive Care for the Elderly (PACE) Plans to make stakeholders aware that these plans are required to submit VBP contracts to cover all provider types by March 31, 2018. Penalties for failing to meet VBP requirements that are applicable to mainstream managed care plans will also apply to MAP, FIDA, and PACE Plans beginning January 2018. The 2018 Medicaid VBP target is 10% of plan spending in arrangements that have shared savings with no downside risk. Read More

Stakeholders Respond to Governor's Health Budget Proposal. Following the release of New York Governor Cuomo's Executive Budget Proposal, several stakeholder groups have expressed both concern and support for the Governor's health-related proposals.

• Eric Linzer, the Health Plan Association's incoming President said in a press release that proposals to 'recoup' federal tax savings of health plans and apply an assessment on conversions, acquisitions, or related transactions in which not-for-profit health insurers convert to corporations organized for profit would do "nothing to address the underlying factors driving health care costs and make New York a less attractive place to do business." One such conversion is Centene's proposed acquisition of Fidelis Care for $3.75 billion. According to Crain's Health Pulse, the Archdiocese of New York had planned to use an estimated $3.5 billion to create a health care foundation and the "foundation was instrumental to the archdiocese's decision to sell the health plan."

• Physician groups have expressed concern over the proposal to authorize the establishment of retail practices that would provide treatment and referral for common health care complaints. According to New York Daily News, the proposal "has raised …that corporate-owned medical practices would be more concerned about profits than the patient's best interest."

• The hospital industry expressed support for the Governor's efforts to respond to federal budget cuts. The Greater New York Hospital Association has stated its intent to request additional funding to ensure the final budget meets the needs of safety net providers.

New York to Continue Medicaid Coverage for DACA Recipients. Governor Andrew Cuomo announced on January 23, 2018, that recipients of Deferred Action for Childhood Arrivals (DACA) will remain eligible for state-funded Medicaid, regardless of any federal changes to or termination of the program. There are approximately 42,000 DACA recipients in New York. Under New York Law, DACA recipients are considered People Residing Under Color of Law (PRUCOL) and are eligible for state-funded Medicaid or CHIP. Read More

North Carolina

North Carolina Releases List of Respondents for Medicaid Managed Care Operations and Actuarial RFIs. North Carolina Department of Health and Human Services released the list of respondents for both the Medicaid Managed Care Program Operations and Medicaid Managed Care Program Actuarial RFIs. A request for proposal is expected to be released as early as spring 2018. The respondents are:

Managed Care Operations

1. 3M
2. Active Health
3. Aetna
4. Alliance
5. AmeriHealth
6. Automated Health Systems
7. Blue Cross Blue Shield
8. Carolina Complete Health
9. Carolinas Center for Medical Excellence
10. Chapmans dba Southern Health Care Network
11. Gateway Health
12. Maximus
13. Meridian Health
14. Molina Healthcare
15. NC Academy of Family Physicians
16. NC Association of Health Plans
17. NC Community Health Center Association
18. NC Hospital Association
19. NC Justice Center
20. NC PACE Association
21. NC Pediatric Society
22. NC Provider Owned Plans
23. NC Substance Use Disorder Federation
24. Nuna
25. Optima Health
26. Partners Behavioral Health Management
27. Reinvestment Partners
28. Trillium Health Resources
29. United Health Care
30. UPMC For You
31. Vaya Health
32. Virginia Premier

33. WellCare
34. Zero-to-Three

Managed Care Actuarial

1. 3M
2. Aetna
3. AmeriHealth
4. Blue Cross Blue Shield
5. Carolina Complete Health
6. Gateway Health
7. Molina Healthcare
8. NC Academy of Family Physicians
9. NC Association of Local Health Directors
10. NC Community Health Center Association
11. NC Hospital Association
12. NC Pediatric Society
13. NC Provider Owned Plans
14. Optima Health
15. United Health Care
16. UPMC For You
17. Virginia Premier
18. WellCare

Aetna had already announced that it plans to bid on the Medicaid managed care procurement.

Ohio

Ohio Considers Medicaid Work Requirements. *WKSU 89.7* reported on January 22, 2018, that Ohio may impose work requirements on able-bodied Medicaid recipients. Ohio's Republican-controlled legislature passed a budget last year that requires the state to request permission from federal regulators to impose work requirements; however, the state has yet to submit a federal waiver request. According to budget director Tim Keen, the number of people who would lose coverage because of work requirements is small. Read More

Oregon

Voters Approve Tax on Hospitals, Insurers to Fund Medicaid Expansion. *CBS News* reported on January 24, 2018, that Oregon voters approved taxes on hospitals and health plans to continue to fund the state's Medicaid expansion. The taxes, which were approved in a ballot measure, are expected to generate $210 million to $320 million over two years by imposing a 0.7 percent tax on some hospitals and a 1.5 percent tax on gross health insurance premiums and on managed care organizations. Unions and large, self-insured employers are exempt. Read More

Rhode Island

Budget Proposal Seeks Medicaid Cuts, Targets Health Plan Profits. The *Providence Journal* reported on January 18, 2018, that a budget proposal from Rhode Island Governor Gina Raimondo includes nearly $166 million in Medicaid cuts. The budget would also institute member copays and eliminate the state's 1.5 percent "guaranteed" profit margin for managed care organizations. Copays would range from $2.50 for generic prescription drugs to $8 for non-emergency visits. Read More

Tennessee

Republicans Show Little Support for Medicaid Expansion. *The Tennessean* reported on January 21, 2018, that Republican lawmakers in Tennessee show little support for Medicaid expansion, despite the willingness of Democrats to include work requirements and co-pays. Governor Bill Haslam also has no plans to bring back Insure Tennessee, a Medicaid expansion plan introduced in 2015 that failed in the state Senate. Read More

Virginia

Hospital Gets Reprieve in Battle Over Medicaid Expansion. *The Washington Post* reported on January 23, 2018, that Senate Democrats in Virginia voted to pass an emergency bill that would reopen Pioneer Community Hospital in Stuart. As previously reported, Democrats blocked the initiative last week after Senator Bill Stanley (R-Franklin) resisted calls to expand Medicaid in the state. Virginia Governor Ralph Northam, a Democrat, urged lawmakers not to use the hospital as leverage to expand Medicaid. Read More

National

Senate Democrats Question Legality of Medicaid Work Requirements in Letter to HHS. The *Associated Press* reported on January 18, 2018, that Senate Democrats submitted a letter to Acting U.S. Health & Human Service Secretary Eric Hargan questioning the legality of Medicaid work requirements. The letter was drafted by Senator Ron Wyden (D-OR) and signed by 29 senators. It states that restrictions on Medicaid eligibility like work requirements, drug testing, and time limits "contradict the plain text and purpose" of the Medicaid statute. Read More

CHIP Reauthorized for Six Years. *Kaiser Health News* reported on January 22, 2018, that President Trump signed legislation reauthorizing the Children's Health Insurance Program (CHIP) for six years as part of a measure to provide stop-gap funding to end the government shutdown. Funding for CHIP had expired in October 2017. The legislation also delays taxes on medical device manufacturers, health insurers, and high-cost "Cadillac" health plans. Read More

States Still Struggling With Hepatitis C Treatment Costs for Inmates. *Kaiser Health News* reported on January 23, 2018, that states continue to struggle with the cost of providing Hepatitis C drugs to inmates. Civil liberties groups in at least eight states are suing for access to the drugs, which can cost $84,000 per treatment. In Missouri, for example, the cost of treating 2,500 Missouri inmates with Harvoni (Gilead Sciences) would likely exceed the state's entire budget for inmate health, according to the American Civil Liberties Union's own projection. Read More

Work Requirements May Open Door to Medicaid Expansion in Conservative States. *ABC News* reported on January 24, 2018, that federal approval of Medicaid work requirements is prompting Republican lawmakers in some conservative states to revisit Medicaid expansion. In Utah, for example, Representative Robert Spendlove (R-Sandy) is drafting legislation to partially expand Medicaid. Kansas Representative Susan Concannon (R-Beloit), who supports expansion, said work requirements "gives us a chance." Read More

CMS Deputy Administrator Brian Neale to Resign. *The Hill* reported on January 23, 2018, that Brian Neale, deputy administrator of the Centers for Medicare & Medicaid Services, will resign next month. He oversees Medicaid and the Children's Health Insurance Program. Read More

Senate Approves Azar as HHS Secretary. *Modern Healthcare* reported on January 24, 2018, that the U.S. Senate has approved Alex Azar as Secretary of the Department of Health and Human Services. Azar, who replaces Tom Price, was previously an executive at drug maker Eli Lilly & Co. During a Senate confirmation hearing, Azar vowed to address concerns over drug prices. Read More

Kentucky Medicaid Recipients File Lawsuit Challenging Work Requirements. The Trump administration has been hit with a federal class action lawsuit challenging the imposition of Medicaid work requirements in Kentucky. The lawsuit, which was filed in U.S. District Court in Washington on behalf of a group of Kentucky Medicaid recipients, argues that work requirements, premiums, cost sharing, lockouts, and benefit cuts are not "consistent with the objectives of the Medicaid Act." The National Health Law Program and the Kentucky Equal Justice Center represent the plaintiffs. Read More

Industry News

None to report

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
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
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 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
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
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
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	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, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Texas STAR+PLUS Statewide	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA NEWS

What Do You Want for Your Care? In 2016, HMA partnered with the Scan Foundation and the Alliance for Health Policy to identify the essential attributes of high-quality healthcare for individuals with complex needs. Next Avenue recently produced this animated video about these essential attributes: https://vimeo.com/248927109

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; Raleigh, North Carolina; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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