HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 14, 2018

RFP Calendar

HMA News

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This Week

In Focus

Section 1332 State Innovation Waivers

This week, our *In Focus*, written by HMA Principals Nora Leibowitz and Donna Laverdiere, reviews Section 1332 State Innovation Waivers.

What Are Section 1332 Waivers and How Can They Be Used?

Section 1332 of the Affordable Care Act allows states to apply for State Innovation Waivers to pursue innovative ways of offering high-quality, affordable health coverage to state residents. This authority allows states to seek waivers of provisions related to these elements of the Affordable Care Act:

- The individual mandate (Internal Revenue Code Section 4980H)
- The employer mandate (Internal Revenue Code Section 5000A)
- Marketplaces and Qualified Health Plans (ACA Title I, Subtitle D, Parts I and II)
- Benefits and subsidies (ACA Section 1402; Internal Revenue Code Section 36B)

This broad authority is tempered by the requirement that the state show the proposal will provide access to coverage that: is available to at least as many state residents; is at least as affordable; and provides at least as comprehensive coverage as would have been provided without a waiver. In addition, the program implemented under a Section 1332 Waiver cannot increase the federal deficit. Waiver applications must follow requirements set forth in regulation, and they require federal approval, including an assessment of the state's ability to meet requirements.

What Can't Be Done with Section 1332 Waivers?

Reducing Overall Coverage or Financial Assistance. Under the current Section 1332 authority, a state may not reduce the benefits package or financial support for eligible residents. While some states have investigated changes to eligibility or covered services, at present this must be done within the requirements that coverage be as affordable and comprehensive with a waiver as without.

Changes to a State's Medicaid Program. To make changes to Medicaid, a state must use a State Plan Amendment or a Medicaid waiver. Many states have used Social Security Act Section 1115 waivers to implement significant changes to their Medicaid programs, including waiving some Medicaid requirements and using Medicaid funds in ways not otherwise allowed.

A state seeking to make health system changes that affect both Medicaid and commercial markets may develop a companion Medicaid 1115 Waiver that works with the 1332 Waiver. The dual waivers can be used to support health care reform designed to align eligibility and enrollment practices, purchasing, and/or cost containment.

ACA Section 1332 State Innovation Waiver	SSA Section 1115 Medicaid Demonstration Waiver
Used to make changes to state commercial individual and/or small group market • State agency is applicant (applicant agency is determined by state) • Waive mandates, change benefits, plan offerings, subsidies • Can be large-scale change to commercial market(s) or more narrow efforts (e.g., market stabilization)	*Used to make changes to state Medicaid program* • State Medicaid agency is applicant • Use to test and implement coverage approaches in Medicaid that do not otherwise meet federal program rules • May be comprehensive changes in eligibility, benefits, cost sharing, and provider payments, or more focused changes on specific services and populations.

Changes to Medicare or Other Federal Health Care Programs. States have limited control over programs that are federally administered.

What Are States Currently Doing with Section 1332 Waivers?

Reinsurance. In 2017, the first year that states could apply for a waiver under ACA Section 1332, CMS approved applications from Alaska (July), Minnesota (September) and Oregon (October). Each state has established a reinsurance program that is partially supported with federal funds.

Other Approval. Hawaii, which has had an employer mandate since the 1970s, in 2016 was given approval to waive SHOP requirements and related provisions. This situation was unique to Hawaii and is unlikely to be replicated by other states.

Other State Action. As of December 2017, 24 states have considered or passed legislation to develop a Section 1332 waiver. While a number of states submitted applications in 2017, several waivers were withdrawn by states during the year. In January 2017, California pulled its waiver, which would have allowed undocumented state residents to buy coverage in the state Marketplace, Covered California. Oklahoma's reinsurance waiver was not approved by its September implementation deadline and was withdrawn. The state has signaled that it will resubmit an application, possibly on a larger scale than the initial reinsurance proposal. Iowa withdrew its application when it became clear CMS had significant concerns about the proposal. Massachusetts and Vermont applications were both deemed incomplete and not further reviewed by CMS, though Massachusetts has signaled it may pursue further reforms for the 2019 coverage year. Idaho has a draft Section 1332 Waiver application out for public comment that it plans to submit in conjunction with an 1115 Waiver.

What Has Changed or May Change Soon?

Executive Order. On his first day in office, President Trump signed an executive order pledging his administration to provide states with more flexibility and control in health care. This included agencies committing to using their authority and discretion to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

Agency Support. The President's statement was followed in March 2017 by a letter to the governors from then-HHS Secretary Price, indicating support for reinsurance-focused waivers and the use of 1115 and Section 1332 Waivers to align Medicaid and private coverage rules.

Congressional Action and Proposals. While the rules regarding Section 1332 Waivers have not changed in the past year, the tax overhaul passed at the end of 2017 included a provision that eliminated the penalty associated with the individual coverage mandate. While the individual mandate penalty does not end until the 2019 tax year, it would be hard to imagine a state applying to waive this provision given the time it takes to develop and get approval of a waiver.

In addition, several Congressional health reform proposals discussed last year would have affected the applications and impact of waivers.

- **American Health Care Act (House).** Would have added new waiver authority to eliminate Essential Health Benefits, allow premiums to vary based on the health of the insured, and allow states to set age bands. States would have been able to eliminate the employer responsibility payment, establish reinsurance without a waiver, and provide tax credits in and outside of Marketplaces.
- **Better Care Reconciliation Act (Senate).** Proposed elimination of guardrails requiring the Section 1332 Waiver program provide as much coverage and coverage that is as affordable, to as many people as without the waiver. Would have eased Section 1332 Waiver approval, promoted expedited review, and lengthened the waiver period.
- **Lower Premiums Through Reinsurance Act (Collins-Nelson).** Would add $4.5 billion for reinsurance programs established by a Section 1332 Waiver, and would expedite approval for such proposals.
- **Bipartisan Health Care Stabilization Act (Alexander-Murray).** Would ease 1332 application and expedite approval process. Would relax affordability language and allow other federal program costs to be included in federal deficit impact calculation.

A combination of policies from the Collins-Nelson and Alexander-Murray bills may re-emerge based on deals made during the passage of the tax reform package at the end of 2017.

What Does This Mean for the Future of 1332 Waivers?

The Trump Administration has consistently messaged a desire to work with states seeking to innovate, and there is no reason to think this will change. While state interest in big changes has been limited to date, a number of states have indicated at least preliminary interest in market stabilization activities. If Congress or the Administration can make good on attempts to offer funding to support this work, it is likely that more states will jump into the 1332 Waiver waters. In the meantime, states should take seriously the administration's statements that it will support state-based reform, and, if they think such changes would benefit state residents, use the authority in Section 1332 Waivers to design change that fits their residents' needs. States like Idaho are now promoting programs that propose to combine changes in Medicaid and the individual market to improve affordability and access to quality care across programs. It remains to be seen how the Administration will react to such proposals under current guidance.

To watch the HMA Information Services webinar on 1332 Waivers, please click here.

HMA Medicaid Roundup

California

California Assembly Passes Bill Allowing Regulators to Reject Certain Health Care Mergers. *KPBS* reported on February 5, 2018, that the California Assembly has passed a bill that would give state regulators the authority to reject health care mergers likely to lessen competition. The bill increases the authority of the state Department of Managed Health Care to approve or reject mergers based on whether the deals improve health care quality and reduce health disparities. Insurance companies say the bill is too broad and imposes an unreasonably high standard on proposed deals. Read More

Florida

Florida Receives Bids from 8 Medicaid Dental Plans. The Florida Agency for Health Care Administration announced on February 9, 2018, that eight dental plans submitted bids in response to the state's Prepaid Dental Health Plan request for proposals: Managed Care of North America, United Healthcare of Florida, Liberty Dental Plan of Florida, Delta Dental Insurance Company, Argus Dental & Vision, Evolve Dental of Florida, DentaQuest of Florida, and SKYGEN of Florida.

Idaho

House Passes Legislation to Restore Medicaid Dental Benefits. *AP News* reported on February 13, 2018, that the Idaho House narrowly approved legislation to restore non-emergency dental benefits to more than 30,000 additional Medicaid recipients. Lawmakers restored benefits to children and individuals with major disabilities in 2013. Read More

Illinois

UnityPoint Health Terminates Network Contract with Molina in Illinois. The *Journal Star* reported on February 13, 2018, that UnityPoint Health terminated its provider network contract with Molina Healthcare in Illinois, effective January 1. The hospital will honor previously scheduled appointments in-network coverage through the end of February. Read More

Illinois Hospitals Threatened by Proposed Assessment Overhaul. The *Chicago Tribune* reported on February 13, 2018, that South Shore Hospital and Roseland Community Hospital would likely face closure or be forced to reduce services as a result of a proposed overhaul of the Illinois hospital assessment, hospital executives say. The Illinois House Appropriations-Human Services Committee held a hearing on February 13 to discuss the proposal, which seeks to better align assessment funding with hospitals serving the most patients. Read More

Iowa

Iowa Considers Reducing Medicaid Managed Care Oversight. The *Omaha World-Herald* reported on February 12, 2018, that Iowa lawmakers in the House Human Resources Committee are considering legislation that would reduce oversight of the state's privatized Medicaid program. The legislation, which has been pushed by the state Department of Human Services, would reduce the frequency of performance reporting, remove consumer protection metrics, and eliminate a requirement that the agency report expected savings from managed care. Read More

Senator Introduces Medicaid Work Requirements Bill. The *Des Moines Register* reported on February 7, 2018, that Iowa Senator Tom Greene (R-Burlington) introduced a bill that would require able-bodied, adult Medicaid recipients to be employed, seeking work, or enrolled in school or job training for at least 20 hours per week. Applicants would also be required to undergo drug screening and wait 180 days after their applications are approved before receiving coverage. Read More

Kentucky

Kentucky Plans Mobile-Device Friendly Website to Track Medicaid Work Requirements. *ABC News* reported on February 9, 2018, that Kentucky hopes to track Medicaid recipient compliance with work requirements through a website that individuals can log onto using their mobile phones. Kentucky said that the state has already tested the technology on individuals who receive food stamps. Kentucky was the first state to receive federal approval for Medicaid work requirements, which will be implemented this summer. Read More

Maryland

Maryland Recovers $81 Million from Computer Sciences Corp. Over Medicaid Claims System. *The Baltimore Sun* reported on February 9, 2018, that Maryland recovered $81 million in a settlement with Computer Sciences Corp. (CSC) over a disputed project to rebuild the state's Medicaid computer system, including claims processing. CSC is now part of DXC Technology. Maryland had originally sought $500 million in damages after terminating CSC's contract in 2015, citing complaints about the company's work. Read More

Michigan

Michigan Autism Therapy Provider Faces Whistleblower Claims. The *Detroit Free Press* reported on February 11, 2018, that former senior executives of Centria Healthcare have accused the company of Medicaid billing fraud and other violations. Centria is Michigan's largest autism therapy provider. The allegations came to light in a series of lawsuits and countersuits, including litigation filed under the Michigan Whistleblower's Protection Act. The company denies the claims and has countersued for defamation. Read More

Michigan Mental Health Providers Say Medicaid Shortchanged Them. *Crain's Detroit Business* reported on February 11, 2018, that Michigan mental health providers are claiming that the state Medicaid program shortchanged them by approximately $100 million over the past two years. The dispute centers on whether the state's 10 regional prepaid inpatient health plans are receiving the correct payment rates for aged, blind and disabled members. Read More

Mississippi

House Passes Bill to Rebid Medicaid Managed Care Program. *The Clarion Ledger* reported on February 8, 2018, that the Mississippi House passed a bill that would require the state to rebid its Medicaid managed care program. Mississippi Governor Phil Bryant indicated that he supports the House bill. An earlier version of the House bill would have enrolled 10 percent of the state's Medicaid beneficiaries in Mississippi True, a provider-led plan. Mississippi True wasn't among the winners of the state's June award of three-year Medicaid managed care contracts, which went to Centene/Magnolia Health, UnitedHealthcare and Molina Healthcare. Read More

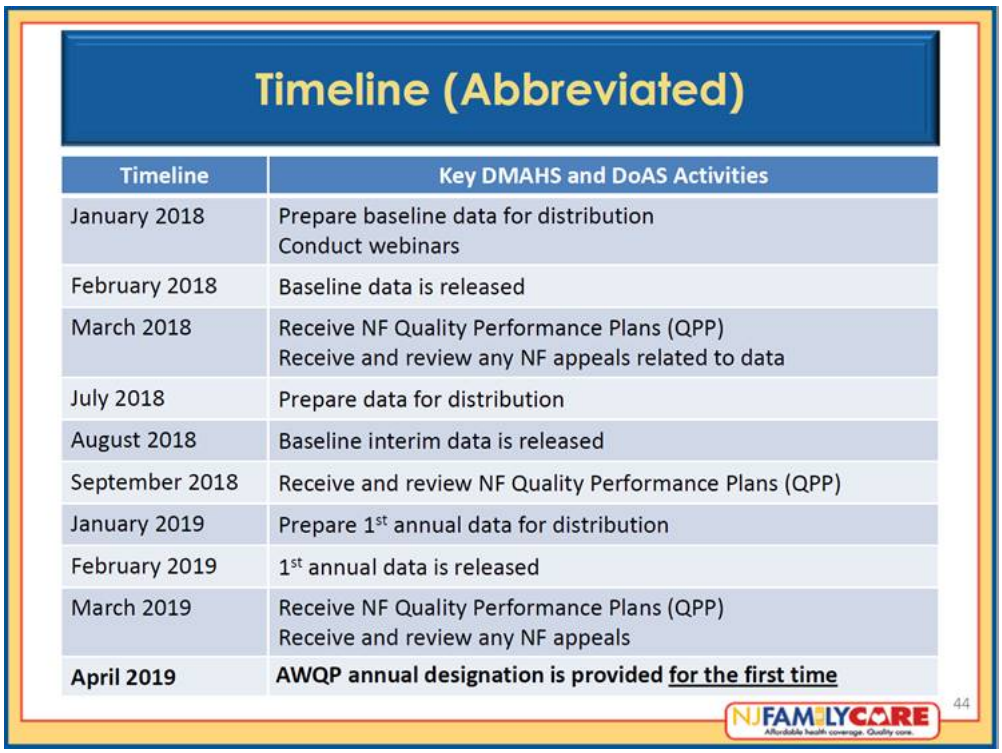
Missouri

Hospitals Win Lawsuit Over DSH Allotment Rule. *Modern Healthcare* reported on February 13, 2018, that the Missouri Hospital Association has won a lawsuit against the Centers for Medicare & Medicaid Services (CMS) over a rule that deducts Medicare and commercial insurance reimbursements from total disproportionate-share hospital (DSH) allotments. U.S. District Judge Brian Wimes ruled that the agency exceeded its authority. Missouri hospitals would have had to pay back $96 million for 2011 and 2012 alone. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Nursing Facility Quality Improvement Initiative Timeline Released. The New Jersey Division of Aging Services shared the timeline for the rollout of a nursing facility quality improvement initiative under its Managed Long Term Services and Supports (MLTSS) program. This initiative will convert the MLTSS Any Willing Provider requirement into an Any Willing Quality Provider (AWQP) initiative of which there are 302 Medicaid certified nursing facilities involved.



Timeline (Abbreviated)

Timeline	Key DMAHS and DoAS Activities
January 2018	Prepare baseline data for distribution Conduct webinars
February 2018	Baseline data is released
March 2018	Receive NF Quality Performance Plans (QPP) Receive and review any NF appeals related to data
July 2018	Prepare data for distribution
August 2018	Baseline interim data is released
September 2018	Receive and review NF Quality Performance Plans (QPP)
January 2019	Prepare 1st annual data for distribution
February 2019	1st annual data is released
March 2019	Receive NF Quality Performance Plans (QPP) Receive and review any NF appeals
April 2019	**AWQP annual designation is provided for the first time**

New Jersey DMAHS Shares Information on Medicaid Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. The New Jersey Division of Medical Assistance and Health Services (DMAHS) shared information on the OUD/SUD program under its 1115(a) demonstration waiver at the most recent quarterly MAAC meeting. The program responds to the steady increase of deaths related to SUD, primarily opiates, and on the recommendation of the September 2017 New Jersey Governor's Task Force Report on Drug Abuse Control. The OUD/SUD program will:

- Expand Medicaid benefit package to include withdrawal management services in residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD), as well as short-term and long-term rehabilitation services, peer services, and case management services for individuals with SUD
- Provide and monitor evidence-based services for individuals with SUD
- Monitor the effectiveness and efficiencies of services expanded and covered in the waiver

The following table lists the SUD benefits and Medicaid and expenditure authorities:

Sud Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (individual services covered)	
Outpatient Services	State plan (individual services covered)	
Intensive Outpatient Services	State plan (individual services covered)	
Partial Care Services	State plan (individual services covered)	
Residential Treatment	State plan (individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan (individual services covered)	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs
Targeted Case Management	State plan	Services provided to individuals in IMDs

Source: CMS Special Terms and Conditions, NJ FamilyCare 1115 Demonstration, 11-W-00279/2

OUD/SUD services will be phased in over 12 months contingent on CMS approval beginning July 2018.

New Jersey Provides MLTSS Update. As of December 2017, the New Jersey Division of Medical Assistance and Health Services reported that 40,500 individuals were enrolled in MLTSS. The MLTSS enrollment is further broken down by service setting:

Service Setting	Number of Enrollees
MLTSS HCBS	21,604
MLTSS Assisted Living	3,094
MLTSS Nursing Facility	15,522
MLTSS Specialty Care NF	280

An additional 12,037 enrollees continue to receive long term care in nursing facilities under Medicaid fee for service and are exempt from managed care enrollment. There are 972 Medicaid enrollees in the PACE program.

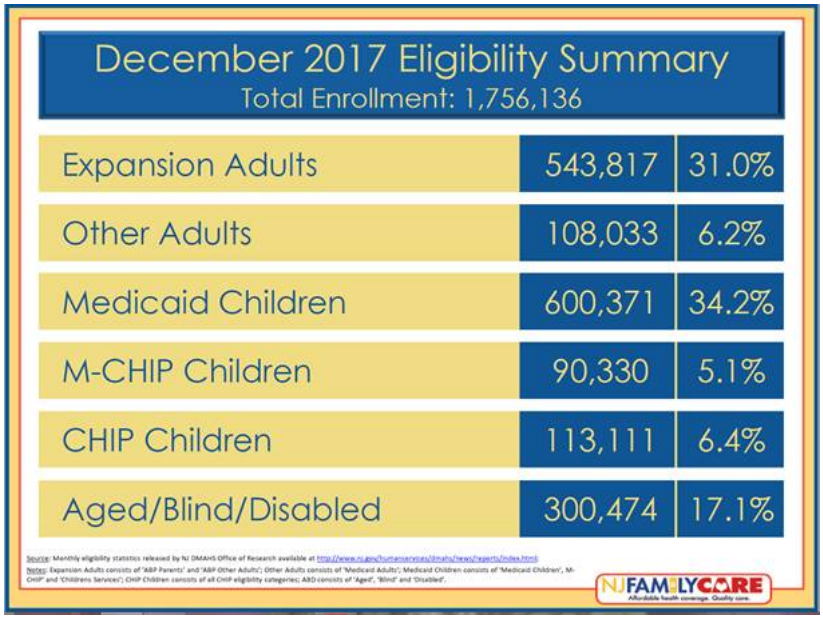
Since the implementation of MLTSS in July 2014, the state has experienced a shift in the balance of long term care provided in institutional settings from 70.5% to 52% in December 2017. However, rebalancing to shift more long-term care into community-based settings has varied across counties; 13 out of 21 counties exceeded the statewide average in the use of Medicaid-related nursing facility admissions related to custodial care: Atlantic (53%), Burlington (56%), Cumberland (57%), Essex (60%), Hunterdon (64%), Mercer (53%), Monmouth (58%), Morris (59%), Ocean (63%), Salem (64%), Sussex (76%), Union (55%) and Warren (77%).

New Jersey Medicaid to Develop Transparency Data Analytics Dashboards. New Jersey's Medicaid administration is developing a series of data analytics dashboards to provide the public with timely, in-depth demographic and performance metrics. This initiative is receiving guidance from the CMS Data Analytics Medicaid Innovator Accelerator Program. A data analytics team is researching other state dashboards, cataloging the types of information requests they receive, and meeting with Medicaid business units and the Medicaid Director to define the new dashboards. The dashboards will become available beginning in the spring of 2018 (eligibility dashboard) and in the summer of 2018 for additional dashboards. These will be accessible on the Division of Medical Assistance and Health Services (DMAHS) website.

Medicaid Officials Provide FamilyCare Enrollment Update. New Jersey Medicaid officials gave an update on the Medicaid program (called NJ FamilyCare) at the January 24, 2018, quarterly Medical Assistance Advisory Council (MAAC) meeting.

- NJ FamilyCare enrollment is 1,756,136
- 20 percent of state residents are enrolled in NJ FamilyCare
- 94 percent of the enrollees are in one of the five Medicaid MCOs
- Combined state and federal funding is $15 billion

Eligibility is further broken down as follows:



New Mexico

Senate Votes to Commission Study of Medicaid Buy-In Option. *SFGate/Associated Press* reported on February 7, 2018, that the New Mexico Senate voted 33-8 to commission a year-long study on a Medicaid buy-in coverage option for individuals who don't qualify for Medicaid. The program would redirect federal subsidies from the Exchange marketplace to a new category for Medicaid. About 10 percent of New Mexico residents are uninsured. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Releases Health Home Supportive Housing Program RFA. The New York State Department of Health (DOH) announced the release of the Health Home Supportive Housing Program (HHSHP) Request for Applications (RFA). DOH is seeking applications from community based organizations to provide rental subsidies and non-medical services to homeless Medicaid members participating in New York State's Health Home Program. The rental subsidies and services provided under the Health Home Supportive Housing Program are intended to be a means to provide affordable and stable housing and services, to thereby improve access to health services and the health status of Health Home members who are high-cost, high-utilizers of Medicaid services. The total anticipated amount available for this procurement is up to $500,000 annually, for up to 16 awards. The contracts will run from 10/1/2018-9/30/2023. Read More

Governor Signs Medical Malpractice Legislation. ***The Daily News*** reported on January 29, 2018, that New York Governor Cuomo has signed legislation known as Lavern's Law, which changes the amount of time individuals can file a medical malpractice claim. The legislation was the last piece of legislation from last year's legislative session. Currently malpractice claims involving cancer must be filed within a window that begins when the mistake occurs. The bill changes the timing to the date the patient discovers the error, and then allows a 2 ½ year filing window. Read More

Senate Opposes Governor Cuomo's Proposed Health Insurance Tax. *The NY Torch* reported on February 6, 2018, that New York Governor Andrew Cuomo has proposed a 14 percent tax on health insurance plans, as a way of recouping the money they will receive as part of the federal corporate tax cut. The Senate has passed legislation, S.7587, that would instead require that the Department of Financial Services factor in the tax savings as they review and approve insurance rates. The Senate intend that the federal tax savings be returned to consumers, rather than being directed to the state treasury. Read More

New York Health Systems Continue to Grow. Montefiore Health Systems has completed its acquisition of St. Luke's Cornwall Hospital, making it the 11th hospital under the Montefiore system. In addition, Montefiore Health System consists of a primary and specialty care network of more than 180 locations; an extended care facility; the Montefiore School of Nursing, and the Albert Einstein College of Medicine. Read More

Northwell Health announced an agreement with Western Connecticut Health Network (WCHN) to jointly explore developing new clinical programs and services, collaborate in providing population health services, and leverage the expertise of each other's health systems. WCHN operates three hospitals, Danbury Hospital, New Milford Hospital and Norwalk Hospital, and employs nearly 6,300 employees, including about 1,900 clinical staff. Northwell Health is the state's largest health care provider, with 23 hospitals, about 650 outpatient facilities and nearly 15,000 affiliated physicians. Read More

New York Delays Implementation of Children's Medicaid Transformation. The New York Children's Medicaid System Transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new Home and Community Based Services to the Medicaid benefit. Implementation had been scheduled for January 2018; it has been delayed for two years. In a presentation to the Coalition for Behavioral Health, NY Medicaid Director Jason Helgerson indicated that the delay would allow NY to address shortfalls in federal resources, ensure that the Medicaid Global Cap is balanced, and to provide more time for providers and health plans to complete readiness activities. The Transformation is intended to:

- Move the various and disparate authorizations for home and community based services (HCBS) now provided under six separate Section 1915(c) waivers to New York State's 1115 Medicaid Redesign Team Waiver (1115 Waiver);
- Unify and provide care management for high needs children with chronic conditions under the Health Home program;
- Create six new Medicaid State Plan services for children and expand eligibility criteria for aligned children's HCBS from including only children that meet Level of Care (LOC) criteria (i.e., at risk of institutional level of care) to also include children that meet Level of Need (LON) criteria. Read More

OneCity Health Performing Provider System Launches Innovation Fund. OneCity Health Performing Provider System, the NY Health + Hospitals performing provider system participating in NY's Delivery System Reform Incentive Program, has established a $5 million fund to support efforts of its community partners. Applications are being accepted for potential funding to design and implement programs to reduce avoidable hospitalizations, improve community health outcomes, and address social determinants of health, like housing and food security. OneCity plans to award 10 grants, which can range from $250,000 to $1M per selected applicant. Applications are due March 2. Read More

Pennsylvania

Pennsylvania Governor Releases 2018-19 Proposed Budget. Pennsylvania Governor Tom Wolf announced his 2018-19 budget, which totaled $32.9 billion. Twenty-one percent of that proposal is for medical assistance and long-term care. The budget focuses on four healthcare priorities: improving behavioral health treatment for opioid disorders, providing more services to more people with intellectual disabilities and autism, enhancing care for seniors and people with disabilities through Medicaid, and unifying the Department of Health and the Department of Human Services into a single streamlined entity.

- Draw down $26.5 million in federal funding from the second year of the 21st Century Cures Act. The Department of Drug and Alcohol Programs will use these funds to supplement existing efforts and focus primarily on expanding access to treatment services with a heavy emphasis on Medication Assisted Treatment (MAT).
- Include $4.5 million to provide training to service providers and serve families affected by opioid use disorder through evidence-based home visiting models.
- Provide a $74 million increase for services for individuals with intellectual disabilities and autism. Within this total, the budget targets $16 million to enroll 965 individuals with an intellectual disability or autism in waivers to provide supports and services so that they can remain in their home and community.
- Commit to consolidating the Department of Health and the Department of Human Services into one, unified department.

Read More

Puerto Rico

Puerto Rico Releases Medicaid Managed Care RFP. The Puerto Rico Health Insurance Administration (PRHIA) has issued a request for proposal (RFP) for its Medicaid managed care program. The RFP, which had been delayed mainly because of the recovery from Hurricane Maria, will implement changes under what the administration calls the "New Model of the P.R. Government Health Plan." Proposals are due April 6, 2018.

Virginia

House Passes Medicaid Work Requirements. *The Washington Post* reported on February 13, 2018, that the Virginia House passed a bill to implement Medicaid work requirements. The bill, sponsored by Delegate Jason Miyares (R-Virginia Beach), now goes to the Senate, which has its own limited Medicaid expansion bill up for debate. Republican lawmakers in Virginia have said the work requirements are required before they would consider a full Medicaid expansion. Read More

Virginia Awards NEMT Contract to LogistiCare. *EIN News* reported on February 13, 2018, that Virginia has awarded its Medicaid fee-for-service, non-emergency medical transportation contract to incumbent LogistiCare. The contract is effective for three years with three one-year options. Read More

Senate Committee Clears Limited Medicaid Expansion Bill, Broader Debate Continues. *The Richmond Times-Dispatch* reported on February 12, 2018, that the Virginia Senate Finance Committee has cleared legislation that would establish a limited Medicaid expansion to 20,000 individuals suffering from addiction, mental illness, or chronic physical disorders. The limited expansion, which would be funded through a new hospital tax, would cover inpatient and emergency room care. The bill would also fund services for 2,300 individuals with intellectual and developmental disabilities under three Medicaid waiver programs. The Virginia House also passed a bill to discuss a full Medicaid expansion with work requirements. Read More

Washington

Lawmakers Battle Over Contracting Process for Home Health Care Workers. *The Seattle Times* reported on February 8, 2018, that Democrats and Republicans in the Washington Senate are battling over legislation that could increase the number of dues-paying, unionized home health care workers. The bill would allow the state Department of Social and Health Services to contract its entire home care business to a private company, which could then contract with the Service Employees International Union. Currently, the state contracts with individual home health providers, who are permitted to opt-out of paying union dues. The state is attempting to redo the contracting process to devote more resources to care rather than contracting issues. Read More

National

CMS Is Developing Medicaid Scorecard. The *Washington Examiner* reported on February 13, 2018, that the Centers for Medicare & Medicaid Services is developing a scorecard to evaluate state Medicaid programs. The scorecard would use state-reported data to determine whether state Medicaid programs improved health outcomes, evaluate the impact of policies aimed at treatment and prevention, and potentially determine the impact of work requirements and other types of initiatives. The document could be released later this year. Read More

White House Budget to Include $17 Billion to Combat Opioid Epidemic. *The Hill* reported on February 11, 2018, that the White House budget proposal for fiscal 2019 is expected to include $17 billion to help combat the nation's opioid epidemic. The Department of Health and Human Services alone will receive $3 billion in 2018 and $10 billion in 2019 for prevention, treatment, recovery, and mental health services. Read More

Federal Budget Deal Includes Medicare Part D Donut Hole Provision. *Modern Healthcare* reported on February 9, 2018, that the Bipartisan Budget Act recently passed by Congress includes a Medicare Part D donut hole provision that increases the discount drug manufacturers have to give beneficiaries from 50 percent to 70 percent. The provision is expected to help make prescription drug coverage more affordable for seniors. Read More

Budget Deal Further Extends CHIP Funding. *Modern Healthcare* reported on February 9, 2018, that a budget deal passed by Congress and signed by President Trump extends funding for the Children's Health Insurance Program (CHIP) funding for an additional four years, bringing reauthorization to 10 years total. Other healthcare-related provisions include extending community health center funding by two years, allocating $6 billion for the opioid epidemic, ending the Medicare Independent Payment Advisory Board, and closing the Medicare Part D drug coverage gap ahead of originally scheduled. Read More

White House Budget Aims to Reduce Drug Prices. *The Daily Caller* reported on February 8, 2018, that the White House budget for fiscal 2019 includes proposals aimed at lowering prescription drug prices for Medicaid and Medicare. For example, the Trump administration will ask Congress to allow a small group of states to attempt to negotiate lower Medicaid drug prices with manufacturers than offered by current rebate programs. Another initiative would clarify the definition of generic, over-the-counter drugs to avoid the type of rebate misclassifications that cost Medicaid $1 billion from 2012 to 2016. Read More

ACA Exchange Enrollment Falls 3.7 Percent. *Kaiser Health News* reported on February 7, 2018, that enrollment in the Affordable Care Act (ACA) Exchanges fell 3.7 percent to 11.8 million for 2018. Enrollment on the the federal Exchange fell 5.3 percent while state Exchange enrollment rose 0.2 percent. Open enrollment for this year had a shorter timeframe than prior years and reduced federal funding for marketing. Read More

Industry News

Molina Posts 4Q17 Net Loss of $262 Million. *Modern Healthcare* reported on February 12, 2018, that Molina Healthcare posted a net loss of $262 million in the fourth quarter of 2017. Results include $356 million in impairment losses, restructuring and separation costs, and loss on debt extinguishment. The end of federal Exchange plan cost-sharing reductions subsidies also impacted results. Read More

Atrium Health to Merge with Navicent Health. *Modern Healthcare* reported on February 8, 2018, that Atrium Health, which recently changed its name from Carolinas HealthCare System, will merge with Georgia-based Navicent Health. Atrium is the largest hospital chain in North Carolina. It is seeking to expand out of state. Atrium is also looking to acquire UNC Health Care. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
February 27, 2018	Iowa	Contract Awards	600,000
February 2018	Washington FIMC (Most Remaining Counties)	RFP Release	~1,400,000
March 2018	Alabama ICN (MLTSS)	RFP Release	25,000
March 1, 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 or May 2018	Alabama ICN (MLTSS)	Contract Award	25,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 6, 2018	Texas STAR and CHIP	RFP Release	3,342,530
April 6, 2018	Puerto Rico	Proposals Due	~1,300,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
July 2018	Texas STAR and CHIP	Proposals Due	3,342,530
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
September 26, 2018	Texas STAR and CHIP	Evaluation Period Ends	3,342,530
October 2018	Alabama ICN (MLTSS)	Implementation	25,000
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 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
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 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	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

Upcoming Webinar - Innovations in Medicaid Managed Long-Term Services and Supports: How Health Plans are Providing Support to Family Caregivers (February 28, 1 – 2 EST). Join Health Management Associates and the AARP Public Policy Institute as we discuss the findings of the new report on Emerging Innovations in Managed Long-Term Services and Supports (LTSS) for Family Caregivers. The report shows that health plans are increasingly recognizing and supporting family caregivers for individuals with LTSS needs. The webinar will also feature the real-world experiences of Anthem Inc., a health plan that is helping family caregivers in LTSS settings. The emerging innovations report is part of the joint Long-Term Services and Supports State Scorecard series and supported by The Commonwealth Fund, The SCAN Foundation, and the AARP Foundation. Read More

HMA WELCOMES…

Leslie Brooks – Senior Consultant

Leslie joins HMA most recently from Care Integration Partners where she served as population health manager. In this role, Leslie developed, implemented, and managed a clinical registry that facilitated measurement-based care and supported the collection and tracking of physical and behavioral health outcome measures for the Behavioral Health Integration and Complex Care Initiative (BHICCI). She informed the health plan's population health strategy, with an emphasis on data integration and the use of population health tools. Leslie participated in case rate and return on investment work groups to develop sustainable funding mechanisms and create the infrastructure to understand and monitor the return on investment. She provided training and technical assistance for data analysts, clinical teams, and healthcare organization leaders on registry functionality, including how to integrate it into clinical workflows, and its unique role in population health management.

Prior to Care Integration Partners, Leslie served as new programs integration analyst at Community Health Plan of Washington. In this role, Leslie provided program management for Care of Mental, Physical, and Substance Use Syndromes (COMPASS), a three-year, $1.5 million-dollar CMMI grant for integrated complex care. She administered the Mental Health Integration Program (MHIP), executed contracts, managed budgets, oversaw registry configuration and report development, participated in program implementation and evaluation, collaborated with members of the national consortium, and achieved timely completion of grant deliverables. Leslie served as system administrator of a web-based patient registry, where she led strategic development of the system to ensure effective support for new programs and reporting needs within critical timeframes. Leslie participated in the design of new Washington state Medicaid programs, including Health Homes, Enrollees with Special Health Care Needs, and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Leslie earned a bachelor's degree in English literature from the University of Washington.

Betty Rider – Senior Consultant

Betty Rider joins HMA from Health Dialog where she most recently served as manager of market development. In this role, Betty developed and implemented successful market assessment driven strategic plans and business development initiatives to expand the product portfolio into new markets. These markets included Patient-Centered Medical Home (PCMH), physician group practices, hospitals and health systems, national and regional health plans, large employers, and state and federal government healthcare systems. Betty served as an internal subject matter expert related to federal government projects focused on health policy, development of PCMH initiatives, and healthcare delivery systems within the Department of Veterans Affairs and Military Medicine.

Prior to this, Betty served as client services executive at Health Dialog. In this role, Betty delivered against contractual requirements for analytics, health and wellness, and disease management services. She provided direction and management of client-specific program elements and developed a training session on proposal management and development. Additionally, she developed preliminary market assessments related to potential expansion of various markets.

Betty earned a master's degree in counseling psychology from Eastern Kentucky University. She earned both a master's degree in healthcare administration and a bachelor's degree in social science (economics, sociology and history) from Trinity University. Betty is a certified Life Fellow through the American College of Healthcare Executives (ACHE).

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.

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

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