

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... March 14, 2018



[RFP Calendar](#)

[HMA News](#)

Edited by:
Greg Nersessian, CFA
[Email](#)

Annie Melia
[Email](#)

Alona Nenko
[Email](#)

Nicky Meyyazhagan
[Email](#)

THIS WEEK

- [IN FOCUS: SNP PROVISIONS OF THE BIPARTISAN BUDGET ACT OF 2018](#)
- [FLORIDA, NEW JERSEY FY 2019 BUDGETS INCLUDE KEY HEALTHCARE PROVISIONS](#)
- [CMS DENIES IDAHO PLAN TO SKIRT ACA REQUIREMENTS](#)
- [ILLINOIS PASSES HOSPITAL ASSESSMENT PLAN](#)
- [IOWA ANNOUNCES MEDICAID MANAGED CARE RFP RESPONDENTS](#)
- [MINNESOTA RELEASES SPECIAL NEEDS BASICARE RFP](#)
- [NEBRASKA MEDICAID EXPANSION ADVOCATES LAUNCH BALLOT INITIATIVE](#)
- [NEW YORK FQHCS PLAN MERGER](#)
- [TEXAS AWARDS CHIP RURAL AND HIDALGO SERVICE AREAS CONTRACTS](#)
- [CENTENE ANNOUNCES INVESTMENT IN PBM RXADVANCE](#)
- [CIGNA TO ACQUIRE EXPRESS SCRIPTS](#)

IN FOCUS

SNP PROVISIONS OF THE BIPARTISAN BUDGET ACT OF 2018

This week's *In Focus* section reviews the recent Bipartisan Budget Act of 2018 (the Act), which adopts policies aimed at improving care for Medicare beneficiaries with chronic conditions, including individuals dually enrolled in Medicare and Medicaid (dual eligible individuals). The Act provides new authority to the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office or MMCO), which serves dual eligible individuals, and will help accelerate its goals of providing full access to seamless, high quality health care and a system that is as cost-effective as possible.¹ **The Act also**

¹ [Link to CMS Medicare-Medicaid Coordination Office Web Site](#)

includes several provisions that have an impact on Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs). These provisions and their implications for D-SNPs and Medicare-Medicaid integration strategies follow.

Background: Dual eligible individuals are a complex, high-cost population

There are currently more than 11 million individuals covered by both Medicare and Medicaid.² They have significant health and social service needs, multiple chronic conditions, and high costs. Nationally, in 2012, people dually eligible for these programs represented on average only 15 percent of the Medicaid population and 20 percent of the Medicare population, but accounted for 33 percent of total Medicaid spending and 34 percent of total Medicare spending.³ As a result, there continues to be significant state and federal interest in integrated Medicare-Medicaid managed care models which can improve quality and reduce spending by coordinating care, providing a better care experience, and aligning finances across programs.

Integrated managed care models⁴ include the capitated Financial Alignment Initiative (FAI); Medicaid managed long-term services and supports (MLTSS) (with requirements for Medicare and Medicaid integration through required state Medicaid agency contracts (SMACs) with D-SNPs (MLTSS+D-SNP)); and D-SNP designation as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP).

Ten states are currently engaged in capitated FAIs,⁵ and there is increasing interest among states in pursuing integration through D-SNPs. Eleven states are advancing integrated MLTSS+D-SNP and/or FIDE SNP models.⁶ Some MLTSS+D-SNP integrated managed care models are established (e.g. Arizona and Minnesota) while others have been implemented more recently (e.g. Tennessee and Virginia). FIDE SNPs are active in eight states.⁷ We are observing an increasing number of state Medicaid agencies requiring their MLTSS plans or comprehensive Medicaid managed care (MMC) plans offer a D-SNP plan.

² Medicare-Medicaid Coordination Office, Medicare-Medicaid Dual Enrollment from 2006 through 2016. Available at: [MMCO Enrollment Trend Report](#).

³ *Beneficiaries Dually Eligible for Medicare and Medicaid, Data Book*, jointly produced by Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), January 2018.

⁴ Another capitated model, called the Programs of All-Inclusive Care for the Elderly (PACE), is a Medicare and Medicaid program that provides integrated, coordinated care for dual eligible individuals in select geographies who need a nursing home level of care.

⁵ California, Illinois, Massachusetts, Michigan, New York (2 FAIs), Ohio, Rhode Island, South Carolina, Texas, Virginia [CMS Capitated FAI Web Link](#)

⁶ J. Verdier, *The State of Integration: Next Phase and Opportunities for Working with States*, SNP Alliance 13th Annual Leadership Forum Washington, DC, November 2, 2017. States identified: Arizona, California, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Tennessee, Texas, Wisconsin.

⁷ Arizona, California, Idaho, Massachusetts, Minnesota, New Jersey, New York and Wisconsin. Centers for Medicare & Medicaid Services, Special Needs Plan Comprehensive Report (February 2018), available at: [CMS Special Needs Plan Comprehensive Report February 2018](#).

11 States Currently Require MLTSS/**MMC Contractors to Offer D-SNPs:**

Arizona	Pennsylvania
Hawaii	Tennessee
Massachusetts	Texas
Minnesota	Virginia
New Mexico	Wisconsin
New Jersey	

Bipartisan Budget Act of 2018: Key changes are expected to have an impact on D-SNPs and Medicare-Medicaid integration strategies

Permanent SNP reauthorization. The Act permanently authorizes Medicare Advantage (MA) SNPs, which include D-SNPs, Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs). Reauthorization provides stability to the SNP market and continuity of care for the beneficiaries enrolled in SNP plans. As of February 2018, there were approximately 2.1 million beneficiaries enrolled in D-SNPs, 348,000 enrolled in C-SNPs, and 73,000 enrolled in I-SNPs.⁸

Strengthened Authority for the Medicare-Medicaid Coordination Office regarding increased integration of D-SNPs. The MMCO, initially created by the Affordable Care Act (ACA) to support more integrated benefits and improve coordination for dual eligible individuals, now has expanded authority to:

- Operate as the dedicated point of contact for state Medicaid programs to address misalignments that arise with the integration of D-SNPs.
- Establish a uniform process for disseminating to state Medicaid agencies information under the law's title impacting contracts between Medicaid agencies and D-SNPs.
- Provide resources for states interested in using D-SNPs as a model for integration (e.g., model contract and other tools).
- Develop rules and guidance to unify grievances and appeals procedures for services and items provided by D-SNPs.
- Develop rules and guidance related to the integration or alignment of Medicare and Medicaid policy and oversight for D-SNPs.
- In implementing these provisions, the Act requires the MMCO to obtain stakeholder input, such as feedback from plans, beneficiaries, providers, and other organizations.

⁸ Ibid.

Improved integration and coordination for D-SNPs. Beginning in 2021, D-SNPs must meet new requirements for integration or be subject to an enrollment freeze. D-SNPs must meet *one or more of the following three options*:

- Be a FIDE SNP *or* provide LTSS and/or behavioral health services under a capitated contract with the state Medicaid agency.
- Coordinate LTSS and/or behavioral health according to a new set of contract requirements that will be established by MMCO (e.g., provide notification to the state Medicaid agency of hospitalizations and ED visits).
- Assume clinical and financial responsibility for all Medicare and Medicaid benefits if the D-SNP is offered by the parent organization of the Medicaid plan providing LTSS and/or behavioral health services.

Unified grievances and appeals for services and items provided by D-SNPs. MMCO must establish uniform grievances and appeals procedures, to the extent feasible, for D-SNPs by April 1, 2020. They are to align procedures such as single notifications, unified timeframes, and simplified reporting. Unified procedures must be used by D-SNPs with contracts with state Medicaid agencies for 2021 and subsequent years.

Plan level Star ratings. The Act gives CMS the authority to calculate Star ratings at the plan level, instead of the contract level, for SNPs. This change has the potential to increase plan reporting burden and positively or negatively impact a plan's Star rating.

Before exercising its new authority, CMS must consider such things as validity of measurement and impact on plans that serve a disproportionate number of dual eligible individuals. The change, if adopted, would only apply to SNPs. However, the Act also directs CMS to examine the feasibility of calculating Stars at the plan level for all MA plan types.

Expanded supplemental benefits. Starting in 2020, all MA plans, including D-SNPs, will be able to provide supplemental benefits to chronically ill enrollees that "have a reasonable expectation of improving or maintaining the health or overall function." Similar proposals that would expand the scope of supplemental benefits so long as they "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization," were included in February's CY 2019 Advance Notice and Draft Call Letter and would take effect in 2019.

Expanded telehealth benefits. All MA plans, including D-SNPs, may start covering telehealth services that do not meet the strict requirements of the Medicare fee-for-service program. These services can be included in the bid amount and will no longer have to be provided as a supplemental benefit, starting in 2020. Look for draft guidance outlining what services are covered and other requirements, such as provider qualifications and coordination of care, as early as November of this year.

MedPAC/MACPAC and GAO studies related to D-SNPs. The Act directs the Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC) to evaluate how D-SNPs perform among each other and other comparison groups such as the FAI and MA plans that are not D-SNPs, by March 15, 2022. A separate report by the

Government Accountability Office (GAO) will evaluate state-level integration between D-SNPs and state Medicaid agencies and make recommendations for legislative or administrative action.

Implications: Greater alignment across programs and interest in D-SNPs as a platform to integrate care

As a result of permanent SNP authorization and the expanded scope of the MMCO, we are likely to see new investments in more coordinated care by plans, and enhanced interest by state Medicaid agencies in using the MLTSS+D-SNP model as a pathway to improve care for dual eligible individuals. The Act's focus on integration and alignment across Medicare and Medicaid is likely to benefit dual eligible individuals, states and health plans by advancing efforts to reduce system complexity and support seamless, quality care.

While the Act strengthens the MMCO's authority to develop regulations and guidance, as well as provide tools and supports to promote integration through D-SNPs, authority remains with the states to pursue a Medicare-Medicaid model of integration based upon state and local resources, unique features of the health care delivery system, and state Medicaid agency goals. States retain flexibility in determining their preferred model of integration, and the type of contracting arrangement they may pursue with D-SNPs.

We expect to see more uniform integration and alignment procedures for D-SNPs at the federal level, which is likely to reduce administrative burden for plans that operate in multiple states. Additionally, all MA plans, including D-SNPs, will be better equipped to address social determinants and help members maintain or improve function with the new flexibility the Act provides in offering more expansive supplemental benefits.

We also hope to see stakeholders, including states, health plans, beneficiaries and the federal government, engaging in a dialogue about how to further Medicare-Medicaid program integration and alignment through D-SNPs.

The MMCO has already issued a call for stakeholder input to inform its work developing a unified D-SNP grievance and appeals process and new integration standards for D-SNPs. It will accept comments on any related issue, but is particularly interested in feedback on topics such as:

D-SNP Integration Standards

- New integration standards CMS should consider for D-SNPs that coordinate but do not cover Medicaid LTSS and behavioral health services. The Act provided three examples: 1) notifying state of hospitalizations, emergency room visits, and hospital or nursing home discharges; 2) PCP assignment; and 3) data sharing to support coordination of items and services. CMS is looking for feedback on these specific examples, as well as other activities CMS should consider.
- The circumstances when CMS should determine that a parent organization has "clinical and financial responsibility."
- Roles CMS and the states should play in determining whether D-SNPs meet integration standards.

- CMS considerations for partial carve-outs of Medicaid services when applying integration standards.
- Issues related to the timing, process, or criteria for FIDE SNP determination the CMS should consider in implementing the provisions of the Act.

Grievances and Appeals

- Opportunities to limit administrative burden for plans and providers, and opportunities to improve the beneficiary experience.
- Differences between plan-level Medicare and Medicaid grievances and appeals processes, and an identification of which processes are more protective of the beneficiary.
- Challenges and options for developing unified Medicare-Medicaid grievances and appeals processes for D-SNPs that have adopted different forms of Medicaid integration (e.g., some D-SNPs coordinate with Medicaid but do not cover Medicaid benefits; other D-SNPs are only permitted to enroll individuals who are also enrolled in a Medicaid managed care plan operated by the D-SNP's parent organization.)
- Challenges and considerations for D-SNPs that operate under a contract that includes additional Medicare Advantage products (e.g., impact on reporting requirements).
- State-specific legal provisions, including statutes, regulations, and consent decrees, that CMS should consider that may complicate its unification work.
- Operational and business needs of states, plans, providers and other entities that may necessitate categorizing grievances as either "Medicare" or "Medicaid".
- Examples of well-crafted, unified notices that could be used in the future.

Comments in response to the letter from MMCO are due April 12, 2018. They should be submitted to MMCOCapsmodel@cms.hhs.gov, with "Comments on Section 50311" in the subject line. A link to the Request for Stakeholder Input is available [here](#).

HMA

HMA has experts in Medicare Advantage, D-SNP, dual eligible individuals, LTSS and behavioral health. Our consultants support health plans and states with Medicare-Medicaid integration strategies and operations, as well as clinical integration. We can help your organization develop a Medicare and Medicaid integration strategy, or re-evaluate your existing strategy, as well as identify new opportunities provided by the Act. We can also help you formulate a message to the MMCO as it moves forward with the Act's directive to align policies and procedures, and enhance Medicare-Medicaid integration, for D-SNPs.

For further information, please contact: Sarah Barth at sbarth@healthmanagement.com or Aimee Lashbrook at alashbrook@healthmanagement.com.



HMA MEDICAID ROUNDUP

Arkansas

Arkansas House Approves One-Year Extension of Medicaid Expansion with Work Requirements. *WREG-Memphis/Associated Press* reported on March 8, 2018, that the Arkansas House voted to keep the state's Medicaid expansion in place for another year after the Trump Administration approved Arkansas' request for work requirements. The bill now heads to Governor Asa Hutchinson's desk. [Read More](#)

Connecticut

Connecticut Lawmakers Consider Work Requirement Bill for Medicaid and SNAP Recipients. *The CT Mirror* reported on March 12, 2018, that Republican lawmakers in Connecticut have introduced a bill to implement work requirements for adult recipients of Medicaid and prohibit the state from removing work requirements in the Supplemental Nutrition Assistance Program (SNAP). A public meeting on the bill will be held later this week. In order to implement work requirements in Medicaid, the state would be required to submit a waiver application to the federal government. Approximately 800,000 residents are enrolled in Medicaid and about 200,000 households are enrolled in food stamps in the state. [Read More](#)

Florida

Florida 2018 Legislative Session Concludes. The Florida Legislature ended its 2018 session on Sunday March 11, 2018 by adopting a \$88.7 billion budget for State Fiscal Year 2018-19. Of the total budget, \$32.4 billion is general revenue funds. The budget represents a 7.6 percent increase over the current year budget, or about \$6.3 billion more while setting aside \$3.3 billion in reserves. The budget vote occurred during an hour-long procedural formality, with the House voting 93-12 and the Senate, 31-5, to endorse the spending plan which goes into effect July 1, 2018. The votes concluded an annual session that ran two days into overtime after lawmakers failed to agree on a budget in time to observe a constitutionally required 72-hour "cooling-off" period before an expected Friday vote on the budget.

The budget includes \$28.3 billion for Medicaid programs, \$9.9 billion in transportation projects, a \$1.5 billion boost in emergency response spending, \$400 million for the Marjory Stoneman Douglas School Safety Act, \$100 million for the Florida Forever land conservation program and an additional \$54.5 million to fight opioid abuse. The budget also includes a \$171 million package of one-time and recurring tax cuts.

The delay on budget negotiations between the House and Senate related to a disagreement over how to fund hospitals. The Senate's proposal called for cutting \$318 million in automatic rate enhancements to 28 hospitals that treat Medicaid patients and, instead, using these funds to increase the base rate paid to all 200-plus Florida hospitals when they treat a Medicaid patient. The House, however, wanted to retain the existing Medicaid hospital reimbursement system. The House prevailed in maintaining the current hospital reimbursement methodology in regard to enhancements. There was proviso language to require the Medicaid agency to recalculate the Enhanced Ambulatory Patient Grouping (EAPG) parameters and to adjust the outpatient rates effective April 1, 2018 for the remainder of the State Fiscal Year 2017-18. The House also agreed to the Senate proposal to allocate almost \$130 million, of which \$50 million is general revenue, for nursing home rate enhancements. Finally, the House agreed to the Senate proposal to increase the personal needs allowance for residents in institutional settings from \$105 to \$130 per month.

Medicaid Budget Highlights FY 2018-19

General Medicaid Issues

- Medicaid Price Level and Workload Adjustment – \$898.9M total funds (TF); \$414.8M general revenue (GR) – Fully funds the increase in Medicaid caseloads and price level adjustments for an estimated 4.0 million Medicaid beneficiaries. (Includes an average rate increase in the MCO capitation payment of 3.75% for MMA and 1.5% for LTC managed care rates.)
- Florida KidCare Enrollment – \$42.2M total; \$3.3M GR – Fully funds the increase in the KidCare program to serve an estimated 212,462 children.
- Florida Medicaid Management Information System (FMMIS) Re-procurement – \$24.5M TF – Provides nonrecurring funding for the Medicaid Enterprise System Procurement project. (The funding is for the second year of this six-year project.)
- Claims Data Analytics Solution (APCD) – \$925,000 TF – Provides funding (\$625,000 nonrecurring) to competitively procure a comprehensive health care claims data analytics service to enhance analysis and transparency of health care claims data.
- Prepaid Dental Health Program – \$700,000 TF – Provides nonrecurring funding to implement a statewide Medicaid Prepaid Dental Health program for children and adults.
- Medicaid School Faculty Physician Supplemental Payments – \$277.3M TF – Provides funding 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.
- Low Income Pool \$1.5B – Provides funding to continue the charity care program that covers the costs of uncompensated care for uninsured individuals.
- Graduate Medical Education Programs
 - GME Primary Care Shortage – \$5.0M TF

- GME Physician Specialists Shortage – \$10M TF
- GME Statutory Teaching Hospital Charity Care – \$30M TF
- Cancer Center Medicaid Prospective Payment Exemption – \$81.5M TF – Provides funding to implement cost based reimbursement for inpatient and outpatient services for qualifying Florida cancer hospitals that meet specified the criteria.

Medicaid Rate Increases

- Delivery Epidural Services Fee Increase- \$1.3M Total; \$0.5M GR – Provides funding for a fee increase for delivery epidural services.
- NICU/PICU Rate Increase – \$3.5M Total; \$1.4M GR – Provides funding for a Neonatal Intensive Care Unit (NICU) and Pediatric Intensive Care Unit (PICU) rate increase.
- Prescribed Pediatric Extended Care (PPEC) Rate Increase – \$5.1M Total; \$2.0M GR – Provides funding for a rate increase for PPEC Centers.
- ICF/DD Rate Increase – \$11.5M Total; \$4.5M GR – Provides funding for a provider rate increase for Intermediate Care Facility/Developmentally Disabled.
- Personal Needs Allowance – \$14.9M Total; \$5.8M GR – Provides funding to increase the personal needs allowance from \$105 to \$130 per month for residents in institutional settings.
- Nursing Home Reimbursement Rate Adjustment – \$128.5M Total; \$50.0M GR – Provides funding to fund nursing home rate enhancements by increasing the quality incentive pool and increased direct care reimbursement.
- Nursing Home Prospective Payment System (PPS) Transition – \$9.8M TF – Provides nonrecurring funding for a transition payment methodology to nursing home facility rates related to the implementation of the nursing home prospective payment system, effective October 1, 2018.

Medicaid Reductions

- Retroactive Eligibility Reduction – (\$98.4M Total; \$38.1M GR) – Reduces funding as a result of eliminating the Medicaid retroactive eligibility period for non-pregnant adults. Eligibility will continue to begin the first day of the month in which a non-pregnant adult applies for Medicaid. The agency shall seek federal approval to allow the state to implement this provision effective July 1, 2018.

Healthcare 2018 Legislation Highlights (Passed Bills)

- Direct Primary Care (HB 37): Allows physicians, chiropractors, nurses or primary-care group practices to sign agreements with patients that let them charge patients monthly fees in advance of providing services. Specifies that these “primary-care” agreements do not violate insurance agreements.
- Medical Marijuana (HB 6049): Repeals a provision in state law that requires black farmer applications to be members of the Black Farmers and Agriculturalists Association Florida Chapter. Currently, the state must

issue a new medical marijuana license to a black farmer who is also a member of the association.

- Health-care Ministries ([SB 660](#)): Would increase enrollment in health-care sharing ministries, which have been exempt from Florida's insurance code, and limits participation to people who share the same religious beliefs. Broadens current law to include people with the same set of ethical or religious beliefs.
- Controlled Substances – Opioids ([HB 21](#)): Limits opioid prescriptions to three-day supplies for treatment of acute pain, though seven-day supplies would be allowed for medical reasons. The restrictions do not apply to patients suffering pain from cancer, terminal illness, palliative care or serious traumatic injuries. Appropriates \$53 million on treatment and prevention. Requires practitioners to consult the state's prescription drug monitoring program before prescribing or dispensing. Authorizes the health department to share information with other states.
- Prescription Drug Pricing ([HB 351](#)): Requires pharmacists to advise people about the costs of prescriptions and whether a patient's cost sharing obligation exceeds the retail price of a drug in the absence of prescription drug coverage.
- Trauma Centers ([HB 1165](#)): Revises rules and regulations, and recognizes trauma centers at some HCA Healthcare facilities across Florida, while aiming to fend off litigation over the issue. Reduces the number of trauma service areas to 18 and sets a new cap for the number of trauma centers at 35.
- Assisted Living Facilities ([SB 7028](#)): Requires assisted living facilities to have backup power sources, ratifying a rule issued by Governor Rick Scott after Hurricane Irma. The power source must ensure that it can control indoor temperatures for 96 hours after an outage and sets the ambient temperature at 81 degrees. The rule would cost the state's 3,000 assisted living facilities about \$243 million to comply over the next five years.
- Nursing Homes ([HB 7099](#)): Requires nursing homes to have backup power sources, ratifying a rule issued by Governor Rick Scott after Hurricane Irma. The power source must ensure that it can control indoor temperatures for 96 hours after an outage and sets the ambient temperature at 81 degrees. The rule will increase costs by more than \$121 million over the next five years.

Florida Announces Public Notice, Comment Period for Medicaid PDHP 1115 MMA Waiver Amendment. The Florida Agency for Health Care Administration (Agency) announced on March 9, 2018, that they will conduct a 30-day public notice and comment period from March 9, 2018 through April 7, 2018 prior to the submission of the proposed amendment to Florida Medicaid's 1115 MMA Waiver (Project Number 11-W-00206/4). The proposed amendment will enable the State to operate a Statewide Medicaid Prepaid Dental Health Program (PDHP) as an "Additional Program" under Section XIII of the Special Terms and Conditions (STCs). The PDHP will provide Florida Medicaid State Plan dental services to recipients through dental managed care organizations. The PDHP is expected to be implemented by January 1, 2019. The public meeting will be held in Tallahassee, FL – March 20, 2018, 2:00 pm – 4:00 pm; and in Tampa, FL – March 28, 2018, 3:30 pm – 5:00 pm. [Read More](#)

Lawmakers Agree on Hospital Automatic Rate Enhancements, Ending Budget Impasse. *Health News Florida* reported on March 7, 2018, that Florida lawmakers agreed on continuing the current Medicaid reimbursement formula for hospitals and increasing nursing home funding by \$40 million, ending a budget impasse. Previously, the Senate proposed redistributing \$318 million in Medicaid “automatic rate enhancements” paid to hospitals with large Medicaid caseloads and using the funding to increase rates for all hospitals. Lobbyists say the budget deal will maintain access to care in safety net hospitals. [Read More](#)

Idaho

Senate Passes Bill Restoring Medicaid Non-Emergency Dental Coverage. *The Coeur d’Alene Press* reported on March 12, 2018, that the Idaho Senate passed a bill that restores Medicaid non-emergency dental coverage. The coverage was cut in 2011 during the recession. The bill, HB 465, already passed the House and now moves to Governor Butch Otter. It is expected to cost \$38 a year per patient. [Read More](#)

Idaho Plan to Allow Individual Health Coverage that Skirts ACA Requirements Denied by CMS. *Modern Healthcare* reported on March 8, 2018, that Idaho’s plan to allow health insurers to sell individual policies that do not comply with key provisions of the Affordable Care Act (ACA) has been rejected by the Trump administration. The Centers for Medicare & Medicaid Services (CMS) has told the state they would be able to refashion the non-compliant health plans as short-term plans, in accordance with a recently proposed rule expanding access to short-term insurance without ACA protections. Idaho’s proposal would have allowed insurers to exclude coverage for pre-existing conditions for people who had a gap in coverage, and set a \$1 million annual cap on benefits, among other features that are prohibited by the ACA. [Read More](#)

Illinois

Governor Signs New Medicaid Hospital Assessment Plan. *The Sun Times/Associated Press* reported on March 12, 2018, that Illinois Governor Bruce Rauner signed a new Medicaid funding plan that changes the hospital assessment formula. The new formula will provide additional funding to hospitals with large amounts of Medicaid patients and comply with federal mandates that more patients be covered by managed care organizations. The plan will be sent to the Centers for Medicare & Medicaid Services for approval. [Read More](#)

Iowa

Iowa Announces Medicaid Managed Care RFP Respondents. The Iowa Department of Human Services announced on March 12, 2018, that Iowa Total Care, Inc./Centene and Trusted Health Plan (District of Columbia), Inc. submitted bids in response to the Health Link request for proposals for Medicaid managed care services. Iowa is in the process of searching for additional managed care organizations for the current program.

Minnesota

Minnesota Releases Special Needs BasicCare RFP. The Minnesota Department of Human Services released a request for proposals (RFP) on March 12, 2018, to provide coordinated health care services in 25 counties through the Special Needs BasicCare (SNBC) Program to adults with disabilities eligible for Medical Assistance (MA). Qualified responders must hold a current contract to provide Minnesota Health Care Programs Medicaid managed care services. Proposals are due May 23, 2018, with contracts set to be implemented January 1, 2019. [Read More](#)

Nebraska

Nebraska Medicaid Expansion Advocates Launch Petition Seeking November Ballot Measure. *KOLN/KGIN-TV/Associated Press* reported on March 7, 2018, that advocates for Medicaid expansion in Nebraska launched a petition drive, "Insure the Good Life", to place the issue on the November 2018 general election ballot. Nebraska lawmakers have rejected the expansion measure the past five legislative attempts. The Medicaid expansion would cover almost 90,000 adults without dependent children. [Read More](#)

New Hampshire

Senate Passes Medicaid Expansion Bill with Work Requirements. The *Associated Press* reported on March 9, 2018, that the New Hampshire Senate passed a bill to continue the state's Medicaid expansion program. The legislation, which now heads to the House, would impose work requirements on members and utilize 5 percent of liquor revenues to cover the cost of expansion. The Senate voted to reauthorize the Medicaid program for five years and transition to managed care in 2019. The current expansion program, New Hampshire Health Protection Program, covers about 50,000 individuals. [Read More](#)

New Jersey

HMA Roundup - Karen Brodsky ([Email Karen](#))

Governor Murphy's FY 2019 First Budget Address Makes Numerous Health Care Commitments. On March 13, 2018, New Jersey Governor Phil Murphy delivered his first budget address of \$37.4 billion with a projected surplus of \$743 million. Fiscal 2019 revenues are projected to grow by 5.7 percent from last year. Among the health care provisions are:

- Commitments to health care and public health:
- Close to \$4.4 billion in state funds to provide health care to almost 1.8 million residents through New Jersey's Medicaid program, NJ FamilyCare
- \$8.5 million to implement Autism Spectrum Disorder services for Medicaid-eligible children and teens to help 10,000+ families with behavioral and physical supports
- \$11 million in state and federal funds to expand family planning services under NJ FamilyCare to residents at or below 200 percent of the federal poverty level

- Enhanced Affordable Care Act (ACA) awareness measures
- \$252 million to fund the hospital Charity Care program
- \$166.6 million in state and federal funds for the Delivery System Reform Incentive Payments (DSRIP) program
- \$218 million for the Graduate Medical Education program
- \$19.8 million in state funds to support home and community-based services for adults with intellectual and developmental disabilities
- Establish the Center on Gun Violence Research and raise firearm fees
- Restore \$7.5 million to fund women's health care centers and expand access to family planning services
- Spend \$100 million to fund addiction initiatives
- \$500,000 to continue the New Jersey Prescription Monitoring Program

The New Jersey Budget in Brief for FY 2019 can be found [here](#).

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

New York Federally Qualified Health Center Networks Plan Merger. *NewsWire.com* reported on March 12, 2018, that Hudson River Health Care (HRHCare) and Brightpoint Health announced their intent to merge and create a combined healthcare organization. Health Management Associates (HMA) provided strategy and communication support. The new organization will serve over 200,000 patients in 41 Community Health Centers across urban and rural communities. The organization will provide a broad spectrum of integrated services, including primary medical care, oral health services, behavioral health care and urgent care. *Crain's HealthPulse* [reports](#) that an HRHCare spokesman indicated the two organizations would operate independently, including keeping their names and brands, for one year after regulators approve the merger. HRHCare currently serves more than 185,000 patients annually through its network of 28 healthcare centers across rural, urban and suburban areas in the Hudson Valley and Long Island. Brightpoint Health was established as a residential skilled nursing facility focusing on people living with AIDS. It currently operates 13 health centers across New York City, serving a population of 45,000 patients annually. Federal and state approval of the merger is expected by the summer. [Read More](#)

New York Assembly Releases Budget Bill. The New York Assembly released its one-house budget bill. The plan restores \$135 million in reductions to the Medicaid program. The bill supports Governor Andrew Cuomo's plan to establish a \$1 billion Healthcare Shortfall Fund, to be held in reserve against federal health care spending cuts. The fund would be financed by proceeds from years from conversions, acquisitions, or related transactions in which not-for-profit health insurers convert to corporations organized for profit. The Assembly would also require that any money raised be deposited in a discreet fund to prevent it from being used for other purposes than health care. The Assembly rejects the governor's plan to establish a Healthcare Insurance Windfall Profit Fee, which would impose a 14 percent surcharge on the net profits of private health insurers in the state. Health insurers are expected to benefit from a 40 percent decrease in the corporate tax rate under the new federal tax law, and the governor wants to recapture some of the estimated \$14 billion in annual revenue that New York will lose under the new federal tax law. The Assembly budget also includes \$15 million in funding to begin implementation of the Children's Medicaid System Transformation. The plan would simplify the delivery system for high needs children currently served under a number of different waiver programs, expand care management, and add new Home and Community Based Services to the Medicaid benefit. The governor's budget delays implementation of the plan for two years due to cost. The plan also earmarks \$525 million in capital funding for the state's health care providers, up from \$450 million in the governor's budget, with at least \$75 million for community based providers, up from \$60 million. The Assembly also supports Governor Cuomo's plan to disenroll Medicaid beneficiaries from a managed long-term care plan if they become permanent residents of a nursing facility, and would require only three months' nursing home residence, rather than the governor's proposed six-month timeframe, a change intended to generate savings. [Read More](#)

Delay of New York Children's Medicaid Transformation Being Reconsidered. *Politico NY* reported on March 9, 2018, that New York Governor Andrew Cuomo's administration will consider scrapping its plan to delay implementation of its Children's Medicaid System Transformation. According to the report, the reform is one of the top items the governor would like to restore in final budget negotiations with legislators. The plan, which has been under development for seven years, would simplify the delivery system for high needs children currently served under a number of different waiver programs, expand care management, and add new Home and Community Based Services to the Medicaid benefit. The State Plan Amendment has already been approved by CMS, and new services were scheduled to begin in July. [Read More](#)

Legislative Leaders Announce Schedule for Adopting SFY 2018-2019 Budget. New York Senate Majority Leader John J. Flanagan, Assembly Speaker Carl E. Heastie, Senate Finance Committee Chair Catharine M. Young and Assembly Ways and Means Committee Chair Helene E. Weinstein announced an agreement on a joint legislative budget schedule that sets deadlines for the adoption of an on-time state budget.

The agreed-to legislative budget schedule for 2018 is as follows:

March 14 Senate & Assembly One House Budget Actions

March 14 Joint Senate & Assembly Budget Conference Committees Commence

March 22 Joint Conference Committees End

March 27-29 Joint Legislative Budget Bills Taken Up by Senate & Assembly. [Read More](#)

New York Awards Contract for Consumer Education Campaign. *Crain's* reported on March 12, 2018, that the New York Department of Health has awarded a contract to the New York Academy of Medicine to conduct a consumer education campaign related to its Delivery System Reform Incentive Payment (DSRIP) program. The terms and conditions of the program require NY to conduct a state-wide consumer education program to help educate Medicaid and uninsured populations about the benefits of health care transformation. The 18-month contract, reported to be for \$335,000, includes designing a state-wide research strategy, conducting focus groups consisting of Medicaid and uninsured populations, testing healthcare messages, and reporting to the Department of Health with recommendations for launching a state-wide education campaign on DSRIP principles. [Read More](#)

New York Court Agrees to Hear Home Care Worker Wage Dispute. The New York Court of Appeals, the state's highest court, has agreed to hear a case regarding wages for home care workers. A state Appellate Court ruled in September that home care agencies must pay live-in home health aides 24 hours per day, and not the 13 hours that is the industry standard. As reported in *Crain's HealthPulse*, home care agencies have typically paid employees for 13 hours of work per day, assuming that they are allowed eight hours of sleep and three hours for meals. The NY Department of Labor has issued an emergency regulation that maintains the policy of allowing employers to pay home care workers for 13 hours of a 24-hour shift.

The case was brought by two home care workers who argued that New York's minimum wage law requires that workers be paid for the time an employee is required to be available for work. If the decision stands, it means that agencies must pay for an additional 11 hours of care per day, almost doubling the cost of care. It is estimated that it will increase costs for home care in New York's Medicaid program by tens of millions of dollars. [Read More](#)

Ohio

Ohio Pharmacies Accuse PBM Of Overcharging Medicaid Managed Care Plans. *The Columbus Dispatch* reported on March 13, 2018, that the Ohio Pharmacists Association alleged CVS Caremark overcharges Medicaid managed care plans for medications while often reimbursing pharmacists less than the cost of the drug. CVS denied accusations of overcharging in an attempt to drive out retail competition and reported there are strict firewalls between their retail business and their pharmacy benefit manager (PBM) business, CVS Caremark. Beginning in July, Medicaid managed care companies will be required to report to state regulators how much PBMs are paying pharmacies. [Read More](#)

Ohio Releases Home Care Waiver Program Case Management RFP. The Ohio Department of Administrative Services (for the Ohio Department of Medicaid) released on February 28, 2018, a request for proposal (RFP) for Ohio Home Care Waiver Program Case Management and Specialized Recovery Services Recovery Management. Contractors must be experienced in providing community long-term care case management services to children, adults and seniors who have disabilities, are chronically ill, and/or have medically complex conditions. The scope of work includes assisting with implementation and management of these home and community-based programs, and interfacing with individuals and providers at the local level to ensure individuals' health and welfare. Proposals are due on April 11, 2018, with contracts anticipated to begin July 1, 2018. Multiple contracts may be awarded per region. [Read More](#)

Oklahoma

Senate Approves Bill to Tighten Medicaid Income Threshold for Parents, Caretakers. *NewsOK* reported on March 13, 2018, that the Oklahoma Senate approved legislation to tighten the income threshold for Medicaid eligibility among parents and caretakers to 20 percent of the federal poverty level, down from 40 percent under current state law. The move could impact nearly 44,000 of the 107,000 parents and caretakers on Medicaid in the state. It would not affect children on Medicaid or the aged, blind or disabled. The legislation now moves to the House. [Read More](#)

Pennsylvania

Pennsylvania Considers Consequences of Potential Medicaid Work Requirements. *WTF* reported on March 8, 2018, that the Pennsylvania Department of Human Services discussed HB 59, a bill that would require able-bodied Medicaid recipients to prove they are looking for work, during a budget hearing. The bill was passed last year by the General Assembly, but vetoed by Governor Wolf. Acting Human Services Secretary Teresa Miller said implementing the requirements would be expensive – estimating the project could run up to \$600 million in the first year. Secretary Miller said the agency is studying a number of proposals. [Read More](#)

Allegheny Health Network and Highmark Health to Open Cancer Center in Pittsburgh. *Trib Live* reported on March 7, 2018, that Highmark Health and Allegheny Health Network (AHN) announced an \$80 million AHN Cancer Institute Academic Center at Allegheny General Hospital that will serve as the academic specialty base of AHN. It is expected to open in late 2019. [Read More](#)

Texas

Texas Awards CHIP Rural and Hidalgo Service Areas Contracts. The Texas Health and Human Services Commission (HHSC) announced contract awards for the state's Children's Health Insurance Program (CHIP), Rural and Hidalgo Service Areas. The six awardees are: Blue Cross and Blue Shield of Texas (Central Region), Driscoll Children's Health Plan (Hidalgo Region), Molina Healthcare of Texas, Inc. (Central, Hidalgo, Northeast, and West Regions), Superior Health Plan, Inc./Centene (West Region) and Texas Children's Health Plan, Inc (Northeast Region). Contracts are slated to begin on September 1, 2018. [Read More](#)

Utah

Lawmakers Pass Limited Medicaid Expansion Bill with Work Requirements. *The Washington Times/Associated Press* reported on March 9, 2018, that Utah legislators passed a limited Medicaid expansion bill. The legislation would cover approximately 70,000 individuals under 100% of the federal poverty level and impose a work requirement and spending cap for enrollees. [Read More](#)

Virginia

Governor to Introduce New Budget in Special Session with Medicaid Expansion. *The Richmond Times-Dispatch* reported on March 10, 2018, that Virginia Governor Ralph Northam will introduce a new budget that will include Medicaid expansion during a legislative special session. Virginia's General Assembly adjourned a 60-day session without being able to come to terms on a state budget. The special session will focus on reconciling the Senate and House budgets. [Read More](#)

National

U.S. Spent Almost 18 Percent of GDP on Health Care in 2016, Study Says. *The Hill* reported on March 13, 2018, that the United States spent twice as much on health care than ten other high-income countries in 2016, according to a study released by the Journal of the American Medical Association. The study cited high costs of prescription drugs, administrative overhead and labor as potential reasons for the U.S. spending almost 18 percent of its gross domestic product (GDP) on health care. Approximately 10 percent of U.S. citizens are uninsured, more than any other country examined in the study. [Read More](#)

ObamaCare Premiums May Rise Steeply in Next Three Years, Study Says. *The Hill* reported on March 8, 2018, that some states may see a cumulative increase ranging from 35 to 90 percent in ObamaCare premiums from 2019 to 2021, according to a study released by California's insurance marketplace. The study cited Congress' repeal of ObamaCare's individual mandate and the Trump administration's effort to expand association and short-term health plans as potential reasons for the premium increase. [Read More](#)



INDUSTRY NEWS

Centene Announces Investment in PBM RxAdvance. Centene Corporation announced on March 13, 2018, that it has made an initial investment in RxAdvance, a full-service pharmacy benefit management company (PBM). This partnership will include a customer relationship in addition to the investment in RxAdvance. [Read More](#)

Cigna to Acquire Express Scripts. Cigna announced on March 8, 2018, that it will acquire Express Scripts for \$65 billion, including the assumption of \$15 billion in debt. David M. Cordani will stay as President and CEO of Cigna. Meanwhile, Tim Wentworth will assume the role of President, Express Scripts. The transaction has been approved by both boards of directors. [Read More](#)

Amazon Provides Prime Membership Discount for Medicaid Recipients. *The New York Times* reported on March 7, 2018, that Amazon will begin offering Prime membership program discounts for adult Medicaid recipients. For Medicaid enrollees, Amazon has reduced the Prime membership fee to \$5.99 from the standard \$12.99 a month, and will include free shipping and video streaming. [Read More](#)

COMPANY ANNOUNCEMENTS

ConcertoHealth Promotes Christopher Dodd to Chief Care Transformation Officer. [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
Spring 2018	North Carolina	RFP Release	1,500,000
March 2018	Alabama ICN (MLTSS)	RFP Release	25,000
April or May 2018	Alabama ICN (MLTSS)	Contract Award	25,000
April 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 11, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Proposals Due	~1,600
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
April 24, 2018	Iowa	Contract Awards	600,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
April 12, 2018	Washington FIMC (Remaining Counties)	Proposals Due	~1,600,000
May 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
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	Puerto Rico	Implementation	~1,300,000
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	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
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 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
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	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA NEWS

Upcoming Webinar - Technology Refresh: Assessing, Updating Health Insurance Exchange Platforms to Improve Marketplace Functionality and Enhance the User Experience on March 21, 1-2 EDT. [Read More](#)

Upcoming Webinar - The State of the States: Key Data on State Medicaid Long-Term Services and Supports Programs on March 22, 1-2 EDT. [Read More](#)

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.