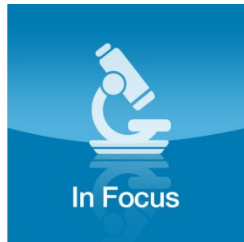
HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 21, 2018



RFP Calendar

HMA News

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THIS WEEK

- IN FOCUS: HCBC SETTINGS RULE ISSUE BRIEFS
- FLORIDA GOVERNOR SCOTT SIGNS OPIOID BILL
- MICHIGAN AWARDS BEHAVIORAL CARVE-IN CONTRACTS
- MONTANA MEDICAID EXPANSION BOOSTS ECONOMY, REPORT SAYS
- NEW YORK SENATE, HOUSE RESPOND TO GOVERNOR'S EXECUTIVE BUDGET PROPOSAL
- NEW YORK NAMES FRESCATORE MEDICAID DIRECTOR
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- MACPAC CALLS FOR STREAMLINING MEDICAID MANAGED CARE AUTHORITY
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- HMA WELCOMES: JEN BURNETT (HARRISBURG); MARCEY ALTER (ATLANTA)

IN FOCUS

HCBS SETTINGS RULE ISSUE BRIEFS

This week's *In Focus* section highlights four briefs written by Health Management Associates (HMA) in collaboration with the National Council on Assisted Living that address key areas of compliance with the Centers for Medicare & Medicaid Services (CMS) home and community-based services (HCBS) settings final rule. The briefs are intended to inform states and Assisted Living (AL) communities on common challenges facing AL communities, the strategies for compliance available, and the steps states have taken to address them in their approved statewide transition plans. To create the briefs, HMA analyzed the regulations, CMS guidance, and the statewide transition plans that had received final approval from CMS at the time of writing. State plans reviewed were: Arkansas, District of Columbia, Delaware, Kentucky, Oklahoma, Tennessee, and Washington.

In 2014, CMS issued a final rule defining the settings in which home and community-based services could be delivered under Medicaid waiver or other HCBS programs. For the first time, CMS defined the characteristics and beneficiary experiences it expected in community-based settings. Until then, HCBS had been defined as services provided in locations other than those classified as institutions, like nursing facilities. The rules require that Medicaid HCBS settings are integrated in and facilitate full access to the community; are selected by the individual as part of a person-centered planning process; ensure the rights to privacy, dignity and respect, and freedom from coercion or restraint; optimize individual initiative, autonomy, and independence in making life choices; and facilitate choice. Provider owned or controlled residential settings (like assisted living) have additional requirements regarding privacy, freedom to control schedules, and ability to receive visitors.

These changes were applauded by disability and aging advocates. However, they constituted a notable change in the delivery of Medicaid HCBS and CMS allowed a significant implementation period, which has recently been extended to 2022.

The briefs cover four topics of particular challenge or concern to the Assisted Living industry, including meeting choice and privacy requirements as provider-owned residential settings, legacy co-location of AL communities in the same building as nursing facilities (and state regulations that may encourage such co-location), the challenges faced by AL communities when state regulations contradict the federal rules, and issues specific to serving individuals with Alzheimer's and other dementias.

Ensuring Individual Choice and Privacy describes the choice and privacy provisions of the rules and steps states and AL communities have taken to ensure these critical components of the rule. The brief describes how states have monitored and documented choice and privacy in AL communities, including the meaningful choice of the AL from a set of options (including a non-disability-specific option); how AL communities can document the choices offered to and made by residents, such as through availability of private dining and roommate choice; and the privacy elements of AL community policies and practices, including private communications and protection of personal and medical information.

Community Integration Options and Resident Choice Are Key in Assessment of Co-Located Assisted Living Communities and Inpatient Facilities addresses the specific issue of AL communities located in the same building as inpatient facilities, including nursing homes. These settings may demonstrate compliance with the rule by differentiating the purpose, design, and programmatic features of the setting; demonstrating the degree of physical, programmatic, and financial disconnect between the settings; and demonstrating how the resident's experience complies with the rule, including through valid consumer experience surveys.

Resolving Differences Between State Assisted Living Licensure Requirements and HCBS Settings Rule provides information for AL communities in states whose state requirements may not match or comply with the Settings rule. Differences include regulations regarding staffing, which may require or encourage co-mingling and cross training of AL and nursing facility staff; discharge, which require discharge of an individual who has reached a higher level of care; and regulations that require controlled egress or other limitations for people with dementia. To date, CMS has approved transition plans that do not change state regulatory language that is counter to the rule, but the plans promise future changes or clarification in provider manuals and other official communications.

An Effective Person-Centered Planning Process is Key for Memory Care Units describes the crucial importance of a person-centered planning process to ensure that individuals with dementia receive high quality services. This includes the meaningful choice of setting (including one with controlled egress), ensuring that any modifications to the protections of the rule are based on a person-centered process and respond to a specific individual need, and how best practices in dementia care can assist with compliance with the rule and improve overall care.

The briefs represent actions and strategies identified in states with final approved statewide transition plans as of November of 2017. Information and strategies will continue to evolve as more states finalize their plans and move toward full compliance with the HCBC Settings Rule in 2022.

Links

An Effective Person-Centered Planning Process Is Key for Memory Care Units

Community Integration Options and Resident Choice Are Key in Assessment of Co-Located Assisted Living Communities and Inpatient Facilities

Ensuring Individual Choice and Privacy

Resolving Differences Between State Assisted Living Licensure Requirements and HCBS Settings Rule

HMA MEDICAID ROUNDUP

Florida

Florida Governor Scott Signs Opioid Bill. *Health News Florida* reported on March 19, 2018, that Florida Governor Rick Scott signed legislation aimed at fighting the opioid crisis. The new law limits prescriptions for treatment of acute pain to a three-day supply in most cases. Cancer patients, the terminally ill, palliative care patients, and those who suffer from major trauma are exempt. The law also requires doctors to check a statewide database, known as the prescription drug monitoring program, before prescribing or dispensing controlled substances to patients who may be visiting multiple doctors or pharmacies to get drugs. Read More

Florida Announces Public Notice, Comment Period for Medicaid 1115 MMA Waiver Amendment. The Agency for Health Care Administration (Agency) announced on March 20, 2018, that they will conduct a 30-day public notice and comment period from March 21, 2018 through April 19, 2018. The Agency is seeking federal authority to amend Florida Medicaid's 1115 Managed Medical Assistance Waiver (Project Number 11-W-00206/4) to:

- Modify the Low Income Pool Special Terms and Conditions to add:
  - Regional Perinatal Intensive Care Centers as an eligible hospital ownership subgroup effective State Fiscal Year (SFY) 2017-18.
  - Community behavioral health providers as a participating provider group effective SFY 2018-19.
- Eliminate the three-month Medicaid retroactive eligibility period for non-pregnant recipients aged 21 years and older (adults) effective July 1, 2018. Eligibility will continue to begin the first day of the month in which a non-pregnant adult applies for Florida Medicaid.

The Agency has scheduled two public meetings to solicit input on the proposed waiver amendment. The meetings will be held in: 1) Tampa, Florida on March 28, 2018 from 3:30 – 5:00 pm; and 2) Tallahassee, Florida on April 3, 2018 from 10:00 – 11:00 am. Read More

Idaho

Idaho to Modify Proposed Health Insurance Rules that Skirt Key ACA Provisions. *CQ Health* reported on March 16, 2018, that Idaho will modify a series of proposed insurance guidelines aimed at weakening key provisions of the Affordable Care Act, including rules concerning pre-existing conditions, essential health benefits, and annual coverage limits. The move comes after the Centers for Medicare & Medicaid Services rejected the state's initial proposal for failing to comply with the health law. Read More

Louisiana

Louisiana to Notify 60,000 Medicaid Recipients of Potential Loss of LTC Benefits. *NOLA.com/The Times-Picayune* reported on March 15, 2018, that the Louisiana Department of Health will notify approximately 60,000 elderly or disabled individuals that they could lose Medicaid long-term care benefits beginning July 2018 because of a state budget standstill. About 46,000 Medicaid recipients who qualify for nursing home services but have some personal income as well as 14,000 recipients who receive in-home personal care assistance will receive warnings of the cuts in May. Restoration of the services would cost $286 million in state funding. Read More

Maryland

House Considers Pilot Medicaid Dental Program. *The Baltimore Sun* reported on March 20, 2018, that the Maryland House is considering a bill to establish a pilot program to cover certain critical dental procedures for adult Medicaid recipients. The bill is a scaled-back version of an earlier, more comprehensive Medicaid dental coverage proposal. The scaled-back version has already passed in the state Senate. Read More

Maryland All-Payer Hospital Model Reduces Admissions, Lowers Costs. *Kaiser Health News* reported on March 19, 2018, that Maryland has seen reductions in hospital admissions and enjoyed cost savings in the first three years since advancing its All-Payer Hospital Model, a new state report shows. The study found that hospitals are successfully keeping per capita hospital revenue growth below a 3.58 percent annual target. The five-year initiative launch in 2014 holds hospitals accountable for the total cost of hospital care, effectively penalizing them for not finding less expensive outpatient alternatives. Read More

Michigan

Michigan Awards Behavioral Carve-In Contracts. The Michigan Department of Health and Human Services (MDHHS) announced on March 9, 2018, that it has awarded contracts for three regional pilot projects to fully financially integrate Medicaid physical and behavioral health benefits. The pilots will contract with the state and each Medicaid managed care organization in the relevant geographic area. The recommended awards are to:

- Pilot #1: Muskegon County CMH (dba HealthWest) and West Michigan Community Mental Health
- Pilot #2: Genesee Health System
- Pilot #3: Saginaw County Community Mental Health Authority

Implementation is expected to begin October 2018.

Minnesota

Minnesota Lawmakers Propose Medicaid Work Requirements. *Star Tribune* reported on March 18, 2018, that Minnesota state Senator Mark Johnson (R-East Grand Forks) along with other Republican lawmakers have proposed Medicaid work requirements. The legislation would affect approximately 125,000 individuals. Under the proposal, Medicaid recipients would be required to work, look for work, train, or be engaged in community or public service for 80 hours a month. They must also accept any suitable employment offer. Opponents of the legislation argue that the increase in administrative costs would erase potential savings and the policy would limit health care access for affected members. Read More

Montana

Montana Medicaid Expansion Boosts Economy, Report Says. The *Sidney Herald* reported on March 17, 2018, that Medicaid expansion has boosted the Montana economy, resulting in gains in jobs, personal income, workforce participation, and federal health care funds, according to a study by the Bureau of Business and Economic Research. The study also found that expansion helped reduce medical debt, prevents bankruptcies, and reduce crime. The analysis was funded by the Montana Health Care Foundation and Headwaters Community Foundation. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

NJAMHAA Annual Conference Planned. On April 10-11, 2018, the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) will hold its annual conference, *Creating Balance Through Integrated Care*, at Pine Manor in Edison, New Jersey. In addition to a selection of workshops the meeting will feature Matthew D'Oria, Medicaid 2.0 Chief Transformation Officer of the New Jersey Health Care Quality Institute who will moderate a panel discussion of health plans and providers on *The Future of Integrated Care in Medicaid*. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Senate, House Respond to Governor's Executive Budget Proposal. The New York Governor introduced his Executive Budget for fiscal year 2019 in January. The two houses of the state legislature presented their budget proposals last week. Budget negotiations have begun, with the goal of passing the budget by March 29th, prior to the holiday break. The new state fiscal year begins April 1.

The Executive Budget proposal for FY 2019 included a series of new revenue streams to mitigate against potential losses in federal Medicaid funding. The legislature has accepted some of these proposals and rejected others.

Healthcare Shortfall Fund: The FY 2019 Executive Budget creates a new fund of $1 billion to be held in reserve against federal health care spending cuts, ensuring the continued availability of funding for health. The Financial Plan includes $500 million annually over four years from conversions, acquisitions, or related transactions in which not-for-profit health insurers convert to corporations organized for profit.

The Assembly creates a $1 billion "Healthcare Stabilization Account." The Assembly proposes to use all the charitable assets that the state might receive from the sale or transfer of control of a health insurer, which would be paid for through the proceeds from sales or conversions of nonprofit insurers to for-profit insurers. 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 Senate adopts the Governor's proposal to create a $1 billion shortfall fund without mention of where or how anticipated funds would be retrieved. The Senate included in its budget memo that they are "open to discussions to explore ways to provide security should there be a shortfall in future healthcare funding due to a loss of federal funds."

Excise Tax on Vapor Products and Opioid Epidemic Surcharge: The budget calls for a 10 cent per fluid milliliter excise tax on vapor products at the distributor level and proposes a 2 cent per milligram surcharge on opioids that would be charged to manufacturers to raise $170 million. The opioid surcharge directs all proceeds to the Opioid Prevention, Treatment and Recovery Fund to support on-going efforts to respond to the epidemic.

The Assembly bill increases the proposed opioid surcharge from two cents per morphine milligram to two and a half cents per morphine milligram, which would generate an additional $31.75 million. The additional revenue would be used to expand opiate addiction treatment, prevention and recovery programs, school-based substance use programming, workforce recruitment and retention, substance abuse programming in local jails and alternatives-to-incarceration programs. The Assembly accepts the Executive proposal to tax vaping products but increases the tax rate from 10 to 40 cents per fluid milliliter.

The Senate denies both the Executive proposal to impose an excise tax on vapor products and on opioids. The Senate also increases the state's support

for opioid use disorder-related services to $265 million, as compared with the executive proposal of $228 million, offering a slate of new policies to address the opioid epidemic. The Senate also seeks to prohibit Medicaid reimbursement for opioids if a patient has been treated with opioids for pain that has lasted for more than three months, unless their medical record contains a written treatment plan.

Healthcare Insurance Windfall Profit Fee: The budget includes a plan to 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. The new surcharge is meant to recapture some of the estimated $14 billion in annual revenue that New York will lose under the new federal tax law. The money will go directly into the state's Health Care Reform Act (HCRA) pools.

Both houses of the legislature have omitted the Healthcare Insurance Windfall Profit Fee.

Other Budget Proposals

Pharmaceutical Pricing Efficiencies: In last year's budget NY passed legislation that set a spending limit on pharmaceuticals, and provided the state with enhanced authority to negotiate additional rebates with manufacturers to maintain spending within the spending limit. Manufacturers that don't reach rebate agreements are subject to Drug Utilization Review (DUR) Board referral for a value-based review and recommendations for targeted supplemental rebates. The budget proposal extends the pharmacy drug cap within the Medicaid program for an additional year.

The Assembly supports the proposal; the Senate extends the Medicaid Drug Cap, but removes it from the Global Cap and establishes it as a stand-alone item, to increase transparency in drug spending.

Retail Practices: The budget authorizes the establishment of retail practices that would provide treatment and referral for common health care complaints in a retail setting such as a pharmacy, grocery store, or shopping mall. Retail practices would be required to offer extended hours, walk-in availability, and a sliding fee scale.

The Assembly rejects the proposal.

The Senate redefines retail clinics as limited services clinics, and requires that they demonstrate a commitment to practice in underserved communities. While the executive proposal defines the scope of practice, staffing requirements, and operational and physical plant standards, the Senate would have the Commissioner of Health promulgate such regulations.

Health Home Incentives: The budget proposes an initiative that would provide incentive payments to Health Home members for participating in wellness programs, and for avoiding unnecessary hospitalizations and unnecessary use of the Emergency Department. The Budget also establishes penalties for managed care plans and health homes that fail to enroll a targeted number of high-risk enrollees into the Health Homes program.

The Assembly tweaks the executive proposal on health home member incentive payments by specifying that payments shall not penalize an enrollee who uses hospital or emergency department services. The Assembly supports

the proposal to develop enrollment targets for managed care plans, and to establish penalties for failing to meet those targets.

The Senate rejects the proposal to allow for incentive payments to health home members. They also deny the proposal to create health home enrollment targets.

Statewide Health Care Facility Transformation Program: The third phase of the program includes $450 million to health care providers that fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community. A minimum of $60 million of this total amount is available for community-based health care providers, which are defined as diagnostic and treatment centers, mental health and alcohol and substance abuse treatment clinics, primary care providers and home care providers. The objective of the Statewide Health Care Facility Transformation Program is to support capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including merger, consolidation, acquisition or other activities intended for a number of functions: to create financially sustainable systems of care, to preserve or expand essential health care services, to modernize obsolete facilities, to foster participation in value-based payment, to increase the quality of care in residential facilities, and to improve health information technology infrastructure.

The Assembly supports the proposal, increasing funding to $525 million, with at least $75 million for community based providers.

The Senate supports the proposal, increasing funding to $500 million, with at least $70 million for community based providers, $20 million for Assisted Living Programs, $60 million for residential healthcare facilities, and $25 million for home care providers.

Children's Medicaid System Transformation: The executive budget does not include funding for the Children's Medicaid System Transformation. The plan, which has been under development for seven years, would simplify the delivery system for high needs children currently served under several different waiver programs, expand care management, and add new Home and Community Based Services to the Medicaid benefit. The administration has announced its plan to delay the implementation for two years due to budget constraints.

The Assembly includes $15 million to allow for the implementation of the transformation agenda; the Senate includes $7.5 million.

Certified Registered Nurse Anesthetists: The executive budget includes a proposal to recognize Certified Registered Nurse Anesthetists (CRNA) as Advanced Practice Nurses. Current law requires that a nurse anesthetist be under the supervision of a physician when practicing. The proposal would allow CRNAs to practice in collaboration with a physician, without the requirement of a written practice agreement.

Both the Assembly and the Senate reject the proposal.

Managed Long-Term Care: The governor's budget includes several proposals aimed at limiting the growth in the cost of managed long-term care, which is now the fastest-growing component of the Medicaid proposals. The executive budget proposes increasing the acuity score to become eligible for home and

community-based services. It also proposes disenrolling Medicaid beneficiaries from a managed long-term care plan if they become permanent residents of a nursing facility, which is defined as a stay of six months. This is meant to eliminate duplicative care management services provided by both the nursing facility and the managed long-term care plan.

The Assembly rejects the proposed change in eligibility for managed long-term care services. The Assembly 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 additional savings. Finally, the Assembly includes a proposal to establish a high-needs rate cell for individuals requiring live-in personal care, more than 12 hours/day of home based services, and for other high-needs individuals.

The Senate rejects the proposed change in eligibility for managed long-term care services. The Senate 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. Finally, the Senate includes a proposal to establish separate rate cells to reflect the costs of care for specific high-need and/or high-cost enrollees.

Executive Budget:
https://www.budget.ny.gov/pubs/archive/fy19/exec/fy19bills.html

Assembly Budget:
http://assembly.state.ny.us/leg/?bn=a9507

Senate Budget:
https://www.nysenate.gov/legislation/bills/2017/S7507/amendment/B

New York Names Donna Frescatore Medicaid Director. *Politico* reported on March 15, 2018, that Donna Frescatore will replace Jason Helgerson as New York's Medicaid director. A new Medicaid director will be named in 2019. Frescatore will continue to lead the state's online insurance exchange, NY State of Health. She will be taking over the Medicaid program during the middle of New York's $8 billion delivery system reform incentive payment program. Read More

New York Issues RFA for Community-Based Organizations Participating in DSRIP. The New York State Department of Health has re-issued a Request for Applications (RFA) to support strategic planning activities for Community Based Organizations under a one-year grant to facilitate their engagement in DSRIP and VBP activities in the Rest of State Region. This RFA is designed to provide funding to one CBO consortium comprised of non-Medicaid billing Community Based Organizations, with an operating budget of less than $5 million, who address the social determinants of health. CBOs are seen as essential for Performing Provider Systems be able to have an impact on the social determinants of health. The state is concerned that smaller CBOs can be challenged in their ability to engage and contract with the lead organizations running the Performing Provider Systems (PPS in DSRIP). The grant is meant to assist a CBO Consortium in planning activities to identify business requirements and formulate strategies for short-term needs as well as longer term plans that the CBO Consortium may envision for sustainability in system

transformation. The Department intends to make one award, with a maximum funding amount of $2,500,000 with an anticipated start date of October 2018. Applications are due May 4, 2018.

The original RFA, which was released in May 2016, identified three regions across the state. The award for the New York City region is the Arthur Ashe Institute for Urban Health, which began work in March 2017. The award for the Long Island – Mid-Hudson region was made to the Health and Welfare Council of Long Island, which is beginning start-up activities. The Rest of State region grant had been awarded to S2AY Rural Health Network, Inc., but was never finalized. No explanation was given as to why that grant was never made, or why the RFA has been re-issued. HMA is providing consulting support to both the Arthur Ashe Institute and the Health and Welfare Council of Long Island. Anticipated Contract Term: 10/1/2018-09/30/2019 Read More

New York DSRIP Whiteboard Video Posted for Year 4. New York Medicaid director Jason Helgerson released a WhiteBoard video describing the focus for the fourth year of the DSRIP program, which begins on April 1, 2018. He describes Year 4 as the time to begin focusing on the legacy of the performing provider systems once DSRIP ends, in March 2020. The theme for Year 4 is Start a Movement! (#StartAMovementNY). Helgerson believes DSRIP has created an opportunity to change the culture of health care. He envisions communities coming together to improve the health and well-being of their most vulnerable members. Goals for Year 4 include a focus on performance rather than process, the move to Value Based Payment, and planning for the future to maintain PPS infrastructure. Click here to watch the video.

New York Releases DSRIP Workforce Impact Analysis Report. At the start of DSRIP, New York Performing Provider Systems (PPS) made workforce spending commitments to support DSRIP goals and priorities of $415 million over five years. At the half-way point of the program, PPSs have spent $247.5 million on workforce initiatives including:

- Recruiting for high need and emerging titles, particularly nurse-aides, care managers, and home care workers;
- Developing workforce pipelines in collaboration with high schools and institutions of higher learning;
- Creating new college credit–bearing and certificate programs for emerging workforce titles, as well as scholarship funds for these students;
- Providing training in DSRIP initiatives, and other DSRIP priorities such as VBP and cultural competency;
- Creating incentives and bonuses to improve workforce retention and recruitment in underserved areas;
- Building change management competencies to help facilitate organizational readiness for an integrated delivery system and support systems for trainers including adoption and sustainability of training solutions. Read More

North Dakota

North Dakota Launches Mobile Health Application by New Ocean Health Solutions. *Business Wire* reported on March 7, 2018, that New Ocean Health Solutions plans to offer its free mobile-first health and well-being solution, Wellness Advantage, to Medicaid recipients nationwide. North Dakota will be the first state to partner with New Ocean and launch The Voyage, a new mobile application created by New Ocean. The application features comprehensive content and tools to promote healthy lifestyles and health management for those with chronic conditions. Read More

Ohio

Ohio Medicaid Pharmacy Supervisor Joins PBM. *The Columbus Dispatch* reported on March 16, 2018, that Margaret Scott, most recently a supervising pharmacologist for the Ohio Department of Medicaid pharmacy program, has joined CVS as a clinical advisor. CVS acts as pharmacy benefit management vendor for Medicaid managed care plans in the state. Ohio legislators have been calling for more transparency into CVS' billing practices. Read More

Ohio Medicaid Work Requirement Proposal Raises Concerns Over Increased Cost to Counties. *Crain's Cleveland Business* reported on March 13, 2018, that the Center for Community Solutions estimated Ohio's proposal to add work and community engagement activities to Medicaid eligibility requirements will increase county government administrative costs by $380 million over a five-year period. The increased costs are attributed to new case management services for more than 200,000 enrollees. Read More

Oklahoma

House Approves Bill to Privatize Medicaid Eligibility Verification. *Tulsa World* reported on March 14, 2018, that the Oklahoma House approved a bill requiring the state Health Care Authority to privatize Medicaid eligibility verification. The legislation, which was carried over from the 2017 session, now moves to Governor Mary Fallin's desk. Read More

Pennsylvania

Pennsylvania Unveils Overdose Information Network for Law Enforcement and State Officials. On March 19, 2018, Pennsylvania law enforcement and human services officials unveiled the Pennsylvania Overdose Information Network (ODIN). ODIN is a centralized repository to track overdoses, naloxone administrations, and investigative drug information that may be used by police, public safety, and healthcare professionals to better track and share all types of information related to opioid abuse in their communities. This information will be used to help health officials judge where best to use resources and help law enforcement apprehend drug traffickers. Read More

Pennsylvania Unveils Opioid Data Dashboard. On March 14, 2018, Pennsylvania Governor Tom Wolf announced an opioid data dashboard that will focus on data sets around prevention, rescue and treatment, showing data at the county level. According to Acting Department of Health Secretary and Physician General Dr. Rachel Levine, "Through this data, we can see where prevention is needed, where rescue can be improved and where treatment is necessary to help those communities that have been affected the most by the opioid epidemic." Read More

South Dakota

South Dakota Sues Three Opioid Drugmakers for Violating Medicaid Fraud Laws. *Reuters* reported on March 14, 2018, that South Dakota is suing three opioid manufacturers, including Endo International Plc's Purdue Pharama unit and Johnson & Johnson's Janssen unit, for violating Medicaid fraud laws and state deceptive trade laws. South Dakota claims that the drugmakers deceptively marketed prescription opioids and spread false information about opioids' risks and benefits. In 2017, nearly 596,000 prescriptions for a total of 39.3 million doses were filled in the state. South Dakota is the 16th state to sue opioid manufacturers. Read More

Tennessee

Tennessee House Passes Medicaid Work Requirement Bill. *The Times Free Press* reported on March 19, 2018, that the Tennessee House passed a Medicaid work requirements bill sponsored by House Speaker Beth Harwell (R-Nashville). The bill directs TennCare, the state's Medicaid program, to apply for a federal waiver from the Centers for Medicare & Medicaid Services to implement work requirements. A companion Senate bill is also ready for floor consideration. Read More

Virginia

Virginia Medicaid Expansion to Take Center Stage During Special Session on Budget. *Kaiser Health News* reported on March 16, 2018, that Medicaid expansion is expected to be a key issue as the Virginia legislature goes into a special session on the state budget next month. Virginia Governor Ralph Northam has told state budget negotiators to include Medicaid expansion in spending plans or he would add expansion as a budget amendment. The special session to discuss the budget begins April 11. Read More

National

Exchange Stabilization Efforts Stall in House. *Modern Healthcare* reported on March 19, 2018, that efforts to stabilize the Affordable Care Act Exchanges have stalled in the House, with lawmakers dropping measures to fund reinsurance and cost-sharing reduction (CSR) payments from a spending bill. The measure would have authorized a three-year, $30 billion reinsurance fund as well as three years of CSR payments. Read More

MACPAC Calls for Streamlining Medicaid Managed Care Authority. *CQ* reported on March 15, 2018, that the Medicaid and CHIP Payment and Access Commission (MACPAC) is calling on Congress to streamline the process for implementing Medicaid managed care for states. MACPAC is recommending that states be allowed to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority without a waiver and that 1915(b) waiver approval and renewal periods be extended from two to five years. The Medicaid Health Plans of America is supporting the recommendations. Read More

'Money Follows the Person' Community Care Program to Run Out of Reserve Funding. *CQ News* reported on March 20, 2018, that the national community care program, Money Follows the Person, is exhausting its remaining funding. The program has been running on reserve funds since it officially expired in 2016. Attempts to reauthorized the program have to date been unsuccessful. Money Follows the Person moves the elderly and disabled out of nursing homes and back into communities. Read More

PBMs Save Medicaid $6 Billion in 2016, Report Says. A report released by UnitedHealth Group in March 2018 concluded that pharmacy benefit management organizations (PBMs) saved Medicaid programs $6 billion in 2016, with savings potentially reaching an additional $8.5 billion in 2019. According to the report, savings came from PBM efforts to drive use of lowest costs drugs, including generics; development of preferred pharmacy networks; prevention of fraud, waste, and abuse; and promotion of evidence-based, clinically effective utilization. Read More

Labs Worry Additional States will Cut Medicaid Rates. *CQ Health* reported on March 16, 2018, that medical labs are worried other states will follow moves by Missouri and Nevada earlier this year and reduce Medicaid payment rates for laboratory services. Lab industry representatives say that further cuts could results in reduced lab hours and closures, especially in rural and underserved areas that see a high volume of Medicaid patients. The cuts come at a particularly bad time given recent reductions in Medicare payments to labs. Read More

Senate Joins House in Push for 340B Drug Discount Transparency. *Modern Healthcare* reported on March 15, 2018, that the Senate Health, Education, Labor & Pensions Commitee leadership indicated in a hearing that they will support the House in its push for hospitals to be transparent about where they direct 340B drug discounts. The House is currently working on a set of bills that include new reporting requirements and an assessment on hospitals participating in the program. Read More

Prisoners Struggle with Access to Hepatitis C Drugs. *The New York Times* reported on March 15, 2018, that prisoners continue to struggle with access to costly Hepatitis C drugs. Prisoners have filed lawsuits in at least nine states to provide the medication. Most recently, Massachusetts settled a lawsuit by agreeing to provide medication to all prisoners with advanced stages of Hepatitis C. In November, Florida ordered a state prison to provide medication to all prisoners with severe liver damage by the end of 2018 and to all prisoners with significant damage in 2019. Before the ruling, the state had treated only 13 inmates out of the 5,000 who were diagnosed. Drugmakers continue to defend the high prices of Hepatitis C drugs, saying that the funds are needed for innovation. Read More

Industry News

Highmark Health Reports Exchange Plan Profits in 2017. *Modern Healthcare* reported on March 19, 2018, that Pittsburgh-based Highmark Health reported a profit from its Affordable Care Act Exchange plan business in 2017, driven by improved premium pricing, reduced payment rates to certain providers, narrow networks, and improved care management. Highmark previously lost approximately $1 billion from its Exchange business between 2014 and 2016. Highmark has 91,600 individual plan members both on and off the Exchange. Read More

EmblemHealth Sued for Defrauding Taxpayers. *WNYC* reported on March 16, 2018, that EmblemHealth is being sued for defrauding taxpayers of over $1 billion. The lawsuit unsealed in New York Supreme Court last month alleges that Group Health Incorporated (GHI), along with parent company EmblemHealth and their partner, Empire Blue Cross Blue Shield, engaged in a long-running scheme that provided inadequate healthcare to city employees and retirees. EmblemHealth was formed as the result of a merger between GHI and Health Insurance Plan of Greater New York (HIP) in 2005. EmblemHealth is made up of GHI, which has roughly 1.5 million members, and HIP, which has about 624,000 members. The GHI-Empire plan covers 600,000 people, representing 75 percent of city workers, retirees and families. While GHI does not participate in Medicaid managed care, HIP provides coverage to 140,000 Medicaid beneficiaries.

EmblemHealth has been struggling for several years. Their bonds were downgraded in June 2015. In March 2016, *A.M. Best* reported that it had placed the plan under review with negative implications for their financial strength ratings of B+ (Good) and the issuer credit ratings of "bbb-" of EmblemHealth subsidiaries. The "under review" status reflects a material decline in capital at HIP at year-end 2015, which was attributable to continued underwriting losses and an unrealized capital loss. The plan reported a $3 million underwriting loss through the first quarter of 2017, which was a significant improvement over its performance in 2016, when it reported a $29 million loss for the same period. Karen Ignani, former President and CEO of America's Health Insurance Plans (AHIP) was brought in as President and CEO in September 2015, but has not yet found a strategy to stabilize the finances of the plan. 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 - The State of the States: Key Data on State Medicaid Long-Term Services and Supports Programs on March 22, 1–2 EDT. Read More

Upcoming Webinar - Technology Refresh: Assessing, Updating Health Insurance Exchange Platforms to Improve Marketplace Functionality and Enhance the User Experience on April 11, 1-2 EDT. Read More

HMA WELCOMES

Jen Burnett – Principal

Jen Burnett joined HMA most recently from Commonwealth of Pennsylvania where she served as deputy secretary, Office of Long Term Living (OLTL), DHS.

In this role, Jen was responsible for oversight of a $6 billion dollar a year budget, overseeing ongoing operations and management of the long-term care system. This included day-to-day management of the payments and Medicaid policy for nursing homes, including all revenue generating activities related to nursing homes, and the corresponding payments. Additional program tasks included oversight and management of five home and community-based 1915c Waivers, and the LIFE (Program of All-inclusive Care for the Elderly) program. While managing the day-to-day operations of the legacy fee-for-service long-term care system, Jen was responsible for launching the PA Managed Long-term Services and Supports program known as Community HealthChoices. This included managing a significant stakeholder engagement process to develop the program, including the request for proposal, as well as supervising the development of operational procedures for the new system, managing the actuarial soundness process, overseeing readiness review, and supporting the information system readiness team. In addition, Jen was responsible for developing and conducting a nationally-recognized ongoing stakeholder engagement process by implementing a third Thursday webinar, an advisory committee that included 50 percent people with disabilities and seniors, and other activities to assure significant stakeholder input.

Additional roles Jen has held include chief of staff at the OLTL, Commonwealth of Pennsylvania, policy manager at the Governor's Office, Commonwealth of Pennsylvania, independent consultant at Burnett Communications, director of training and development at the Pennsylvania Coalition of Citizens with Disabilities, outreach and education director at the Statewide Independent Living Council, and many others.

Jen earned her bachelor's degree in social work from The Pennsylvania State University.

Marcey Alter - Senior Consultant

Marcey Alter joined HMA from Georgia Department of Community Health/Division of Medicaid where she most recently served as assistant chief of Medicaid, policy and provider services. In this role, Marcey developed and led the roll out of a benefit coverage plan for Autism Services, developed a strategic plan for compliance with the Home and Community-Based Settings Rule including significant stakeholder engagement in implementation planning; refined Telemedicine Policy to expand opportunities for access to healthcare including and school-based medical and behavioral health. Marcey strategically applied new federal regulations to operations and incorporated them into governing policies. She responded to evolving needs for benefit enhancement through vendor contract development, negotiation, and amendments, provider contract agreement improvements, education, and outreach. Marcey oversaw 50+ staff members and managed daily operations of

70+ Medicaid programs and development, refinement, and promulgation of associated policy. Marcey served on a Medicaid management team in broad visioning, strategic planning, and project implementation.

Prior to assistant chief of Medicaid, Marcey was deputy director, Medicaid aging and special populations at Georgia Department of Community Health. In this role, she expanded access to home and community-based services (HCBS) through a $67 million federal balancing incentive payment program grant. She implemented operations to support the ACA Concurrent Hospice Care Rule, and she successfully identified and implemented pathways to reduce provider administrative burden. Marcey managed and directed all Medicaid long-term services and supports (LTSS) for aging and disabled populations. She established a statewide response to new federal rules governing quality improvement of LTSS programs through stakeholder engagement and led reporting out to federal oversight representatives. She was part of a leadership team that developed benefit enhancements, including through innovative systems change initiatives, request for proposal development, and evaluation.

Additional roles Marcey has held include project director at Wright and Associates/Consortium on Innovative Practices, contracts manager at Georgia Department of Human Resources/Division of Mental Health, Developmental Disabilities, and Addictive Diseases, project specialist at Medicaid Systems Design and Revenue Maximization Section, and project development director at Georgia Council on Developmental Disabilities.

Marcey earned her Master of Health Administration and her Master of Business Administration from Georgia State University. She earned her bachelor's degree in management marketing from Tulane University.

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; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
http://healthmanagement.com/about-us/

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