HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MEDICAID COMMUNITY ENGAGEMENT INITIATIVES: A COMPARISON OF THREE STATES

This week, our *In Focus* is the second in a series written by HMA Medicaid Market Solutions (MMS). MMS works with states to design and implement Section 1115 Demonstration Waivers that support individual state goals for member engagement and personal responsibility while complying with new Centers for Medicare and Medicaid Services (CMS) guidance.

A joint letter from then-Health and Human Services (HHS) Secretary Tom Price and CMS Administrator Seema Verma released March 2017[1] promoted state flexibility for Medicaid program design and implementation. This announcement prompted states to submit 1115 demonstration requests to allow new policies and requirements for targeted Medicaid beneficiaries. Many of these demonstrations have proposed aspects of "personal responsibility," including benefit packages and cost structures that align more with commercial insurance, member accounts that act more like health savings or flexible spending accounts, premium assistance to help beneficiaries access commercial health insurance, and requirements to participate in work or work-equivalent activities as a condition of eligibility.

One of the most considered and controversial state requests for 1115 demonstration waiver authority is to require targeted Medicaid populations to complete work or "work-equivalent" activities as a condition of eligibility. On January 11, 2018, CMS issued policy guidance[2] for states that wanted to require work, training, and other similar activities for their Medicaid populations. CMS called these activities "community engagement," citing the agency's longstanding support for work and other forms of community involvement as a component of sustained health and independence. The guidance laid out policy and operational guidelines for states, including restrictions on who could be required to participate and recommending alignment with existing program policies and processes.

To date, three states—Kentucky,[3] Indiana,[4] and Arkansas[5] -- have been granted approval to implement community engagement requirements as a condition of eligibility for certain Medicaid beneficiaries. While each state program goal and design aligns with the CMS guidance, there are key differences that highlight the many decision points states and stakeholders face when designing and implementing a community engagement requirement.

[1] Released March 14, 2017. Source: https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf

[2] Released January 11, 2018. Source: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

[3] Approved January 12, 2018. Source: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf

[4] Approved February 1, 2018. Source: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf

[5] Approved March 5, 2018. Source: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf

POPULATIONS THAT QUALIFY FOR COMMUNITY ENGAGEMENT

Flexibility exists for the specific populations states might require to participate in community engagement activities as a condition of eligibility; however, CMS guidance excludes certain individuals from community engagement requirements. The guidance *restricts* states from applying penalties for non-compliance with community engagement to pregnant women, children under age 19, and individuals who are elderly, medically frail, or eligible for Medicaid due to disability. The guidance also indicates that individuals enrolled in the Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) program are subject to the work requirements and exemptions for those programs; and regardless of the state's requirements, individuals on SNAP and TANF meeting work requirements would automatically be considered meeting their state's Medicaid community engagement requirements. Medicaid populations outside of these exclusions are described by CMS as "working-age, non-pregnant adult Medicaid beneficiaries who qualify for Medicaid on a basis other than a disability."

The Medicaid beneficiaries subject to community engagement requirements vary based on which Medicaid beneficiaries are included in the state's demonstration request. Kentucky, Indiana, and Arkansas are all Medicaid expansion states, and the community engagement requirements for all three states apply to the expansion adult, or newly eligible adult group. Kentucky's and Indiana's approved demonstrations also include targeted individuals outside of the Medicaid expansion population, including individuals eligible as very low-income parents and caretakers, and those that move from this group to transitional medical assistance coverage when they gain employment.

Some states have also chosen to limit their community engagement requirement with age restrictions. All three state demonstrations provide medical benefits for individuals age 19-64; but Kentucky is the only state where community engagement requirements align with this eligibility criteria. Indiana's community engagement requirements will apply to individuals age 19-59 aligning with the state's TANF requirements; and Arkansas' community engagement requirements will apply to individuals age 19-49, aligning with SNAP requirements.

CMS guidance also recognized that many individuals that fail to meet the Medicaid definition of "disabled" still face significant challenges getting and holding jobs, and acknowledged the need for exemptions from the community engagement requirements. Aligning with CMS guidance, all three states exempt medically frail individuals,[6] but each state has flexibility in how it defines and identifies this population. States may choose to take a broader view of the medically frail designation; or may develop a narrower definition for medically frail while providing exemptions under other categories, if the definition meets federal requirements. For example, both Kentucky and Indiana exempt homeless individuals from community engagement requirements; but Kentucky does so as a part of its medically frail definition whereas Indiana offers a separate exemption for homeless individuals and reserves its medically frail definition for more complex chronic diseases.

In addition to the exemptions defined by CMS (medically frail, pregnant women, children, elderly individuals, SNAP/TANF recipients complying with applicable work requirements, and disabled individuals), each state has been approved to include additional exemptions in its 1115 demonstration, detailed in Table 1.

Table 1. Community engagement exemptions, by state

Exemption Reason	Kentucky	Indiana	Arkansas
SNAP/TANF recipients complying with applicable work requirements Medically frail Pregnant women Children Elderly individuals Disabled individuals Full-time students Caregiver	✓	✓	✓
Enrolled in the state's Medicaid employer premium assistance program Homeless	✓	✓	✗
Temporary incapacitation Receiving substance use disorder treatment	✗	✓	✓
Former foster care youth up to age 26	✓	✗	✗
Incarcerated within the last six months Part-time student	✗	✓	✗
Lives in a home with his or her minor dependent child (≤ age 17) Receiving unemployment benefits	✗	✗	✓

[6] Medically frail individuals are described at 42 CFR 440.315(f) as individuals with: disabling mental disorders (including adults with serious mental illness); chronic substance use disorders; serious and complex medical conditions; a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or a disability determination based on Social Security criteria or State pan criteria (if more restrictive). Source: https://ecfr.io/Title-42/pt42.4.440#se42.4.440_1315

In addition to longer-term exemptions, Kentucky, Indiana, and Arkansas have also aligned with the SNAP/TANF policy of offering good cause exemptions to individuals who may have failed to meet requirements due to some unexpected circumstances beyond their control, such as disability,[7] hospitalization, and other serious illnesses for the beneficiary or a member of the beneficiary's household. In addition to these common good cause exemption reasons, the approved demonstrations also vary on some of the good cause exemptions they currently anticipate approving. Some examples of different good cause exemptions are highlighted in Table 2, but all three states with approved community engagement waivers have authority to add good cause exemptions as appropriate.

Table 2. Good cause exemption reasons, by state

Good cause exemption reason	Kentucky	Indiana	Arkansas
Disability Hospitalization, or other serious illness Victim of domestic violence	✓	✓	✓
Natural disaster Family emergency or other life-changing event (e.g. divorce or domestic violence) Birth, institutionalization, or death	✓	✗	✓
Change in insurance coverage Eviction or homelessness	✓	✗	✗

PARTICIPATION REQUIREMENTS, ELIGIBLE ACTIVITIES, AND CONSEQUENCES FOR NON-COMPLIANCE

The level of participation required, the types of activities that will meet the requirement, and the consequences for failing to comply with the requirements vary between the demonstrations approved to date. Currently, all approved community engagement demonstrations will require beneficiaries to complete at least 80 hours of qualified activities per month.

The types of activities beneficiaries can complete to meet their community engagement requirement are generally similar from state to state, including employment (subsidized, unsubsidized, or self-employment), job search, job skills training, vocational education and training, community service, and education (such as high school, GED, college or graduate education, or English as a second language, or other education related to employment). Qualified activities are detailed in Table 3. Non-exempt beneficiaries may complete a combination of these activities to meet their community engagement requirements.

[7] Someone with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act may not qualify as disabled under other federal definitions that would exempt the person from community engagement requirements in the three waivers approved to date.

Table 3. Qualified activities, by state

Qualified Activity	Kentucky	Indiana	Arkansas
Employment (subsidized, unsubsidized, or self-employment) Vocational education and training Job search Community service Job skills training Education	✓	✓	✓
Community work experience Caregiving for a non-dependent relative or other person with a disabling medical condition	✓	✓	✗
Other education Participate in partner initiatives	✗	✓	✓
Participate in substance use disorder treatment	✓	✗	✗

States will need to consider the consequences for beneficiaries who do not meet the community engagement requirement. Kentucky, Indiana, and Arkansas were all approved to withhold benefits for non-exempt beneficiaries who do not meet the state's community engagement requirement. However, the frequency with which the states check compliance, the number of months non-exempt beneficiaries must meet the requirements, opportunities to avoid the penalty, the length of time these beneficiaries could be without coverage and beneficiary options to regain access to their benefits vary significantly across the states. This variation is detailed in Table 4.

Table 4. Non-compliance policies, by state

Non-compliance	Kentucky	Indiana	Arkansas
State checks compliance	Monthly	Annually	Monthly
Months of non-compliance before a penalty	2 months	5 months	3 months
Penalty effective date	After the end of the month following the missed month	Start of the next calendar year	After the end of the 3rd missed month
Options to get benefits back			
Good cause exemption *Eligible for a different Medicaid eligibility category*	✓	✓	✓
Complete one month of qualified activities	✓	✓	✗
Take a state-approved health literacy course	✓	✗	✗

IMPLEMENTATION AND ROLL-OUT

Just as there is a great deal of variation in policy, the three states with approved community engagement demonstrations have each planned very different roll-outs for their demonstrations. Each of the states differs in its roll-out date and the populations and geographic areas to which the requirements will apply. The states are also considering their options and existing resources for stakeholder outreach and education, as well as necessary systems and contract updates to ensure necessary information is captured and evaluated, in compliance with federal requirements and the terms of their demonstrations.

Implementation dates for the three approved demonstrations will be spread out, and the non-exempt populations will be affected differently over time. Arkansas will be the first state to implement the community engagement aspects of its program, starting June 1, 2018. Kentucky will follow Arkansas with a go-live date of July 1, 2018; and Indiana is scheduled to be the last to implement community engagement, starting January 1, 2019.

None of these states will have a statewide implementation for their entire non-exempt population on those implementation dates. Arkansas anticipates a statewide implementation, starting with its 30-49-year-old non-exempt beneficiaries, and is planning to add the 19-29 year old non-exempt beneficiaries later. Kentucky will require its full age range to participate, but will roll out the initiative by region. Indiana's requirements will apply to the entire non-exempt population statewide, but will implement community engagement with an initial hour requirement of zero, and gradually increase the hour requirements over time.

The three states are also in the process of evaluating how they will gather and process all the new data related to community engagement. They will all need to be able to:

1. Capture data to help them evaluate whether their community engagement initiative met its goals
2. Assess which demonstration participants are eligible for exemptions
3. Track which beneficiaries are meeting the requirements and which are not

Kentucky, Indiana, and Arkansas have also considered how non-exempt beneficiaries will track their hours and how those hours will be verified. This could result in necessary systems changes for their Medicaid eligibility systems and the systems of their vendors and partners, such as managed care organizations (MCOs). These states have also been looking at whether the necessary functionality exists in their current systems or if they will need to build or procure new systems. The three states are all still preparing to implement their community engagement initiatives, so there are still many operational unknowns; but both Kentucky and Arkansas have opted to leverage their existing SNAP work requirement tracking systems as a way for beneficiaries to report their time. It is also likely that Indiana will leverage one of its existing systems.

As community engagement will have an impact on beneficiary eligibility, the states and their partners are also developing or adapting member notices and appeals processes to address participation requirements, exemptions (including good cause exemptions), and non-compliance. The new notices could also draw more beneficiary questions, which could in turn increase call volume for Medicaid call centers and foot traffic for local Medicaid offices. To make sure call centers and local office workers are prepared to answer beneficiary questions, the states and/or their vendors are developing internal trainings and communications.

Kentucky, Indiana, and Arkansas may develop relationships with other state agencies and community-based organizations to garner their buy-in to the initiative and leverage their resources and expertise to help the states meet their goals around community engagement. All three states appear to look to their departments of workforce development as key resources to help connect beneficiaries to activities that would meet the community engagement requirements. Kentucky has also started holding stakeholder forums to educate possible community partners about the program.

If you are interested in learning more about this topic, please contact Lora Saunders at lsaunders@hmamedicaidmarketsolutions.com.

HMA Medicaid Roundup

Alaska

Alaska IDD Provider to Pay $2.3 Million to Settle False Medicaid Claims Allegation. *KTUU/Associated Press* reported on April 24, 2018, that Alaska-based Arc of Anchorage, a not-for-profit provider of services to individuals with intellectual and developmental disabilities, will pay $2.3 million to settle allegations it submitted false Medicaid claims. The settlement covers claims and penalties for the period between 2012 and 2016. Read More

Florida

12 MCOs Protest Florida Medicaid Managed Care Awards. *Health News Florida* reported on May 2, 2018, that a dozen Medicaid managed care organizations (MCOs) have protested the Florida Statewide Medicaid Managed Care awards, including Molina and United. The five year contracts are worth $90 billion, with implementation beginning January 1. Read More

Florida Announces Winners of Statewide Medicaid Managed Care Procurement. On April 24, 2018, the Florida Agency for Health Care Administration announced the winners of its Statewide Medicaid Managed Care Program procurement. A summary of the awards by region can be found in the data package below. To view the Notices of Intent to Award, click here. Read More

Idaho

Idaho to Decide on Medicaid Expansion with Ballot Initiative. *The Hill* reported on April 30, 2018, that advocacy group Reclaim Idaho has obtained the required 56,192 signatures for a November ballot initiative on Medicaid expansion. The program would cover a projected 62,000 Idaho residents. The Idaho legislature and Governor can still alter or overturn a voter-approved ballot initiative. Read More

Illinois

Illinois Pharmacies Complain of Drastic Cuts to Medicaid Drug Reimbursements. *The State Journal-Register* reported on April 29, 2018, that hundreds of independent and small chain pharmacies in Illinois are complaining of drastic cuts to Medicaid prescription reimbursements. The Illinois Pharmacists Association says many pharmacies are being paid less than the wholesale cost for drugs, adding that Medicaid drug dispensing fees have fallen to just $0.45 per prescription. The Association says the problem intensified after the transition to statewide Medicaid managed care. Read More

Iowa

Iowa Delays Managed Care Awards Until May 21. The Iowa Department of Human Services announced on April 30, 2018, that the Medicaid managed care awards for IA Health Link will be delayed until May 21, 2018.

Iowa Managed Care Contract Negotiations Are Delayed. *The Des Moines Register* reported on April 23, 2018, that Iowa managed care contract negotiations for the state's $5 billion Medicaid program have still not been completed after several months of waiting. UnitedHealthcare and Amerigroup have expressed the need for substantial rate increases in order to move forward with the contracts. Meanwhile, the state legislature is poised to pass a state budget before it adjourns. Without the Medicaid contracts in place, it's unclear if funding will be adequate. Medicaid is Iowa's second largest expense at about $1.5 billion annually, not including federal funds. Read More

Kansas

Trump Administration Delays Decision on Kansas Medicaid Lifetime Limits. *The Hill* reported on May 2, 2018, that the Trump administration has delayed an announcement rejecting Kansas' request to implement a three-year lifetime limit on Medicaid benefits due to internal disagreement within the administration. Centers for Medicare & Medicaid Services Administrator Seema Verma hinted at concerns on capping Medicaid benefits to three years during Tuesday's press conference, which was originally scheduled to announce the rejection of Kansas' request to implement the lifetime limits. Read More

Governor Continues to Push for Medicaid Work Requirements. *KCUR* reported on April 24, 2018, that Kansas Governor Jeff Colyer continues to push for Medicaid work requirements through the state's KanCare 2.0 Medicaid managed care waiver proposal. The state Senate is currently adding language to the budget bill to prohibit the Governor from moving forward with KanCare 2.0. However, even if the legislature passes the provision, the Governor holds a line-item veto. Read More

Maine

Maine Advocates File Lawsuit to Force Governor to Expand Medicaid. *Maine Public News* reported on April 29, 2018, that advocacy group Maine Equal Justice Partners filed a lawsuit to force Governor Paul LePage to expand Medicaid as approved by voters in a referendum in November. LePage has been a vocal opponent to expansion, stating publicly he won't implement expansion unless it's funded without raising taxes or dipping into the state's rainy day fund. Expansion in Maine would extend coverage to an estimated 70,000 individuals. Read More

Massachusetts

House Budget to Include $1 Million for Baystate Health. *MASS Live* reported on April 25, 2018, that Baystate Health would receive $1 million to help make up for regional inequities in Medicaid payments, according to the Massachusetts House version of the state budget. An estimated 62 percent of Baystate revenues come from Medicaid and Medicare. Read More

Michigan

Michigan to Include FFS Medicaid Members in Behavioral Integration Pilots. *Crain's Detroit Business* reported on April 29, 2018, that Michigan will add about 61,000 Medicaid fee-for-service members to a pilot program designed to test the integration of physical and behavioral health using managed care. The pilots, which begin Oct. 1 in Genesee, Saginaw, Muskegon, Lake, Mason, and Oceana counties, authorize community mental health agencies to contract with Medicaid plans to integrate physical and behavioral health. Read More

Michigan Sees Growth in Publicly Sponsored Insurance Programs. *The Detroit News* reported on April 25, 2018, that the number of Michigan residents with health insurance grew by 321,000 from 2014 to 2016, largely from the state's decision to expand Medicaid, according to the 2018 Michigan Health Market Review by Allan Baumgarten. The state's Healthy Michigan expansion plan has a total of about 690,000 members. About a third of the state's population is now covered by some form of publicly sponsored health insurance, the report says. Read More

New Hampshire

New Hampshire House Committee Clears Amended Medicaid Expansion Legislation. *The Concord Monitor* reported on April 25, 2018, that the New Hampshire House Finance Committee unanimously cleared amended legislation that reauthorizes the state Medicaid expansion program for an additional five years and adds work requirements. The amended version of the plan also ends 90-day retroactive Medicaid eligibility. The bill heads to the House floor next week. Medicaid expansion covers about 50,000 individuals in the state. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey MCO Carve-In of Mental Health, SUD Services for Certain Eligibility Groups Planned for July 1. The New Jersey Division of Medical Assistance and Health Services (DMAHS) released a newsletter to providers to inform them of changes to the managed care health benefit plan for certain beneficiary groups as it pertains to mental health and substance use disorder (SUD) services. DMAHS will carve in all mental health benefits and expand the managed care benefit to include coverage for all SUD services for the following groups: 1) beneficiaries enrolled in MLTSS, 2) beneficiaries enrolled in Fully Integrated Dual Special Needs Plans (FIDE-SNPs) and Division of Developmentally Disabled (DDD) managed care members.

Further, partial care services provided to DDD-enrolled beneficiaries will become the responsibility of the MCO. Further, beginning July 1, 2018 the MCOs will be responsible for all acute care admissions to any hospital, including admissions for an acute psychiatric diagnosis. This change applies to all Medicaid MCO enrollees and age groups.

The changes that will go into effect in July were made to align behavioral health benefit coverage for MLTSS, FIDE-SNP and DDD beneficiaries in managed care, and to comply with the Managed Care Final Rule.

The following behavioral health services will remain covered under Medicaid fee-for-service:

- Programs in Assertive Community Treatment (PACT),
- Behavioral Health Homes (BHH), and
- Community Support Services (CSS)
- Admissions to facilities that are State and County psychiatric facilities Read More

New Jersey DOH Commissioner Promotes Vision of Single-licensing Plan for Providers Integrated Physical and Behavioral Health Services. New Jersey Department of Health (DOH) Commissioner Dr. Shereef Elnahal addressed the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) at their annual conference this month to share his vision for integrating behavioral and physical health services. The Division of Mental Health and Addiction Services merged under DOH last year. Elnahal anticipates having updated licensing regulations ready by February 2019 for providers of integrated care. DOH is also planning to survey providers in the next few weeks to learn what works best in their practices. Read More

Governor Murphy Names Ombudsman for People with Disabilities. New Jersey Governor Phil Murphy announced on April 19, 2018, the appointment of Paul Aronsohn to lead a newly created Office of the Ombudsman for Individuals with Intellectual or Developmental Disabilities and Their Families. Mr. Aronsohn previously served on the Governor's Transition Team's Human and Children Services Committee and is a founding member of the Ridgewood Community Access Network (CAN) which represents the needs of residents and visitors with special needs. He has been a long-time advocate in the disability community and has many years of national, state and local government experience. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Health Foundation Reports on Progress in Building Health Communities. The New York State Health Foundation (NYSHealth) launched a new priority area in 2015 focused on improving access to healthy, affordable foods and safe places for physical activity in six diverse neighborhoods throughout New York State. Known as the Building Healthy Communities initiative, the grantees are partnering with community-based organizations, government agencies, local businesses, advocacy groups, and other stakeholders on a range of efforts targeting neighborhoods to help New Yorkers lead healthier, more active lives. Two recent reports address progress to date. "Building Healthy Communities: One Funder's Place-Based Approach to Help Neighborhoods Transform," explores the start-up and early phase of its work in this area. The report documents NYSHealth's approach to develop the new priority area; identify targeted neighborhoods, partners, and grantees; adapt and adjust its work over time; and assess its progress and impact. "One Size Doesn't Fit All: The Need for Local Approaches to Improve Neighborhood Health" takes an in-depth look at the commonalities and differences of the six communities that are part of this initiative, examining the characteristics of these communities, including demographic, as well as health status and health care utilization attributes. It has a particular focus on the Medicaid population within these communities. The reports can be found on the NYSHealth web site. Read More

New York Continues to Wrestle with Pay for Home Care Workers. *Crain's HealthPulse* reported on April 27, 2018, that the New York Department of Labor will be holding a public hearing on its policy of allowing employers to pay home health aides for 13 hours out of each 24-hour shift. A state Appellate Court ruled in September that home care agencies must pay live-in home health aids 24 hours per day, and not the 13 hours that is the industry standard. Home care agencies in NY 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 Department of Labor has issued a series of emergency regulations that maintains the policy of allowing employers to pay home care workers for 13 hours of a 24-hour shift. They will now hold a public hearing allowing advocates to weigh in on the issue. Home care workers have opposed the 13-hour rule as exploitative; home health agencies counter that if the court rulings striking down the 13-hour rule are upheld, they could destabilize the industry by making employers liable for back wages for any employee who has worked a 24-hour shift in the past six years. Read More

New York Seeks Input for NYS Prevention Agenda. New York will be updating its Prevention Agenda for 2019 – 2024. The current Prevention Agenda covers the time span 2013 – 2018, with the goal of improving health and reducing health disparities through an increased emphasis on prevention. The update will incorporate demographic and health status changes, as progress on current Prevention Agenda objectives. They also want to incorporate social determinants of health, and strengthening local action. The New York Department of Health has posted a slide deck describing the proposed update, and is asking for public feedback. They have developed a questionnaire for providing feedback, which is available on the department web site. They are also asking stakeholders to participate in priority-specific planning to develop updated plans. Read More

New York Holds Webinar on Children's Medicaid Redesign. The New York Department of Health held a webinar on April 24, 2018, explaining the updated timeline for the Children's Medicaid Redesign. The Children's Medicaid System Transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new Home and Community Based Services to the Medicaid benefit. The transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new Home and Community Based Services to the Medicaid benefit. Implementation, initially scheduled for January 2018, has been slowed down due to financial constraints. The implementation timeline established based on the current state budget delays implementation of three of six new Medicaid State Plan Amendment services for one year. Expansion of eligibility criteria for Home and Community-Based Services will be phased in over a several-year period, within the limits of the Medicaid Global Spending Cap. Read More

New York Nonprofit Insurance Plans Post Gains. *The Buffalo News* reported that three of Western New York's major nonprofit health insurers, all of which participate in Medicaid, performed better in 2017, helped by gains in investments and lower administrative expenses. Independent Health reported a $22.4 million surplus, up from $13 million in 2016, which they attribute to effective management of medical costs, reduced administrative expenses, and positive performance of investments. Independent Health has 60,000 Medicaid members. HealthNow New York, the parent company of BlueCross BlueShield of Western New York, finished with a $55 million surplus, up from $4.2 million in 2016, on revenue of $2.5 billion. The company, which also operates a subsidiary in the Albany region, reported $44 million in investment gains and more than $20 million attributed to a "carry forward" from prior years. HealthNow has 31,000 Medicaid members. Univera Healthcare is the local operation of Excellus BlueCross BlueShield. Excellus generated net income, or surplus, of $182.3 million last year, up from $99.5 million in 2016, on total premium revenue of $5.6 billion. Excellus provides coverage to 172,000 Medicaid enrollees. Read More

Governor Announces Medicaid Pilot to Offer Doula Services. *The New York Times* reported on April 22, 2018, that in light of the high rate of maternal mortality among African-American women in New York, Governor Cuomo has announced a series of initiatives designed to address the problem. One of the initiatives is a pilot program that would offer doula services as a Medicaid benefit. The design of the doula pilot program will be finalized by the state's Health Department within 45 days, and the program will start immediately thereafter. A challenge for the program, however, is that Medicaid can only pay licensed providers to received matching funds, and doulas are not licensed in New York.

The governor is also creating the Task Force on Maternal Mortality and Disparate Racial Outcomes, which in collaboration with the Maternal Mortality Review Board, will review each maternal death in the state. The state is also expanding prenatal education programs for women and reviewing best practices in hospitals to address hemorrhaging, one of the leading causes of pregnancy-related deaths. Read More

Ohio

Ohio Medicaid Submits Work Requirements Waiver. *The Columbus Dispatch* reported on April 30, 2018, the Ohio Department of Medicaid submitted a request to the Centers for Medicare & Medicaid Services (CMS) for approval to impose work requirements for Medicaid expansion enrollees. Ohio's proposal is noted to be less stringent than the three work requirement waivers that have been approved by CMS so far. Ohio's plan will exempt individuals who are over age 50, in treatment for drug or alcohol addiction, have intensive health-care needs or serious mental illness, and parents or caretakers. A CMS decision is expected any time after mid-June, and state officials indicate it will take about six months to implement after that. Read More

Ohio Medicaid Work Requirements Proposal Draws Criticism from Providers. *Crain's Cleveland Business* reported on April 29, 2018, that Ohio health care providers, including Cleveland Clinic, MetroHealth, and University Hospitals, have joined advocate organizations in raising concerns over the state's proposed Medicaid work requirements for the expansion population. The proposal would require able-bodied Medicaid recipients to work or volunteer for approved community activities. According to the Ohio Department of Medicaid, only 5 percent of expansion enrollees would be out of compliance with the work requirement; about 44 percent already have jobs. Read More

Ohio Report Examines Role of Medicaid Managed Care Organizations In Addressing Food Insecurity. *Cleveland.com* reported on April 23, 2018, that according to a study from the Center for Community Solutions, Medicaid Managed Care Organizations (MCOs) can improve health outcomes and cut Medicaid spending by doing more to increase access to healthy foods. The report highlights a program offered by Ohio Medicaid MCO Paramount Advantage that screens ProMedica health system patients for food insecurity and makes referrals to prescription food clinics. Read More

Oregon

Oregon Raises CCO Rates by 5.3 Percent; CCOs Owe $41 Million in Overpayments. *Portland Business Journal* reported on April 26, 2018, that Oregon will increase coordinated care organization (CCO) per member per month payment rates by 5.3 percent to $427.70 in 2018. However, CCOs still owe the state $41.5 million in capitated overpayments for dual eligibles from 2014 and 2015. CCOs already paid back $7.5 million for dual overpayments from 2016. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Holds April MAAC Meeting. At the April 26, 2018, meeting of the Pennsylvania Medical Assistance Advisory Committee, Acting Deputy Secretary of the Office of Medical Assistance Programs, Sally Kozak, informed the committee that the department was in the process of evaluating the PA Commonwealth Court's decision to rule in favor of UnitedHealthcare's protests of the HealthChoices awards. HealthChoices awards were announced early last year and a Court hearing addressing multiple protests was held in October 2017. Acting Deputy Secretary Kozak said any action by the department in response to the court decision in favor of United would likely come this summer.

Pennsylvania House Passes Medicaid Work Requirements; Governor Opposes. *Trib Live* reported on April 17, 2018, that the Pennsylvania House passed House Bill 2138, a Medicaid work requirement bill that would require "able-bodied" adults enrolled in Medicaid to work at least 20 hours a week or complete job training programs to retain their health insurance coverage, with a vote of 115-80. HB 2138 would require state officials to seek federal approval for a work requirement and includes exceptions for pregnant women, the permanently disabled, those under age 19 or older than 64, prisoners and residents of mental health institutions. Department of Human Services Secretary, Teresa Miller, estimates the bill will cost some $800 million to implement in its first year. Pennsylvania Governor Tom Wolf did not commit to a veto, but has made it clear that he opposes the bill. Wolf vetoed a bill last fall that contained a similar requirement. HB 2138 has been sent to the Senate. Read More

Rhode Island

Rhode Island Medicaid Director Opposes Cuts to DSH Funding. *The Providence Journal* reported on April 23, 2018, that Rhode Island Medicaid Director Patrick Tigue is opposed to an estimated $15.7 million in state disproportionate share hospital funding cuts. The cuts were included in a fiscal 2019 budget proposal by Governor Gina Raimondo. The legislature and Governor must now decide whether to restore the funds in the final budget proposal set for a vote this legislative session. Read More

Texas

Lawmakers Seek Improvements to Medicaid Managed Care Program. *Concho Valley Homepage* reported on April 25, 2018, that the Texas House Committee on Human Services held a series of meetings to obtain and evaluate feedback on the state's Medicaid managed care program in an effort to identify areas in need of improvement. Areas of discussion included patient and provider satisfaction, the complaints process, and care quality. The committee meets again in May. Read More

Texas Modifies Medicaid Eligibility Rules for U.S.-Born Children of Immigrants. *Modern Healthcare* reported on April 23, 2018, that Texas will no longer consider the income of an immigrant's sponsor to determine the Medicaid eligibility of the immigrant's U.S.-born children. The state will still use the sponsor's income to determine the Medicaid eligibility of the parent, aligning with federal requirements. According to the American Immigration Council, an estimated 4.2 million Texas residents are native-born U.S. citizens with at least one immigrant parent. Read More

National

Non-Expansion States Should Reconsider Medicaid Work Requirements, CMS Cautions. *Modern Healthcare* reported on May 1, 2018, that the Centers for Medicare & Medicaid Services (CMS) has warned non-expansion states to reconsider Medicaid work requirements, citing concerns that some individuals would lose coverage. Although CMS Administrator Seema Verma has not explicitly ruled out approving Medicaid work requirement waivers in non-expansion states, she cautioned during a Tuesday press conference that individuals in these states would experience a "subsidy cliff," meaning they would earn more than the amount required to be eligible for Medicaid but not enough for financial assistance on the individual insurance exchanges. The agency has approved work requirement waivers in Arkansas, Indiana and Kentucky, which are Medicaid expansion states. Several non-expansion states, including Kansas, Maine, Mississippi, Utah, and Wisconsin, are seeking approval from CMS to implement work requirements. Read More

Telemedicine Increases Access to Specialized Health Services in Correctional Facilities. *Kaiser Health News* reported on May 1, 2018, that correctional facilities across the country are increasingly relying on telemedicine to provide inmates with access to medical specialists and psychiatrists. According to a survey of prison health care conducted by the Centers for Disease Control and Prevention, 30 out of 45 participating states used telemedicine for specialty or diagnostic services in 2011, most commonly for psychiatry. Read More

Uninsured Rate Rises, Commonwealth Fund Report Shows. The Commonwealth Fund reported on May 1, 2018, that the uninsured rate among working-age adults is about 15.5 percent, according to the organization's Affordable Care Act Tracking Survey for February-March 2018, up from 12.7 percent in 2016. The report attributes the increase to a "lack of federal legislative actions to improve specific weaknesses in the ACA and actions by the current administration that have exacerbated those weaknesses." The report predicts further pressure on enrollment from repeal of the individual mandate, Medicaid work requirements, and the introduction of plans that do not comply with ACA minimum benefit standards. Read More

Medicaid Managed Care Denies Fewer Claims than Fee-for-Service. *Healthcare Dive* reported on April 4, 2018, that Medicaid fee-for-service programs had the highest claims denial rates of any payer, according to a *Health Affairs*report. Medicaid fee-for-service denials are 18 percentage points higher than fee-for-service Medicare. In contrast, Medicaid managed care denials are about six percentage points higher than fee-for-service Medicare. The report notes that Medicaid also has highest billing complexity of any type of health insurance. Read More

Senators Seek to Exempt Native Americans from Medicaid Work Requirements. *The Hill* reported on April 27, 2018, that a bipartisan group of 10 senators submitted a letter to Health and Human Services (HHS) Secretary Alex Azar seeking to exempt Native Americans from Medicaid work requirements. The letter expressed grave concerns over the impact of the requirement on health care access. In January, HHS rejected a similar request from Native Americans. The senators who signed the letter are: Charles Schumer (D-NY), Tom Udall (D-NM), Maria Cantwell (D-WA), Jeff Merkley (D-OR), Heidi Heitkamp (D-ND), Elizabeth Warren (D-MA), Martin Heinrich (D-NM), Catherine Cortez Masto (D-NV), Tina Smith (D-MN), and Lisa Murkowski (R-AK). Read More

CMS Proposes Changes to EHR Meaningful Use, Seeks Further Price Transparency. *Modern Healthcare* reported on April 24, 2018, that the Centers for Medicare & Medicaid Services has proposed an overhaul of the meaningful use program associated with electronic medical records (EMR) to better foster exchange of information between providers and to make it easier for patients to obtain their EMRs. CMS, which suggested the changes as part of the proposed annual inpatient hospital rule, is also seeking to require hospitals to post their prices. Read More

States Consider Medicaid Expansion Ballot Initiatives, Work Requirements, Other Changes. *CQ* reported on April 23, 2018, that this year, states are considering a variety of changes to their Medicaid programs, including expansion and work requirements. Idaho, Montana, Nebraska, and Utah currently have ballot initiatives underway for November. Arkansas, Indiana, and Kentucky have been approved by the Trump administration to introduce Medicaid work requirements. Read More

Industry News

Delphi Behavioral Health Group, Summit Behavioral Health Announce Merger. Delphi Behavioral Health Group, majority-owned by The Halifax Group, announced on April 26, 2018, that it has merged with Summit Behavior Health. The combined company, which will be known as Delphi, will operate 14 facilities across six states providing treatment services for individuals struggling with substance use disorder and addiction. Financial terms of the transaction were not disclosed. 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/Summer 2018	North Carolina	RFP Release	1,500,000
May 21, 2018	Iowa	Contract Awards	600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
May 30, 2018	New Hampshire	RFP Release	160,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 7, 2018	Alabama ICN (MLTSS)	Proposals Due	25,000
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 1, 2018	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 11, 2018	Alabama ICN (MLTSS)	Contract Award	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 1, 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 or Rebid 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

New this week on HMA Information Services (HMAIS):

Public Documents:
Medicaid RFPs, RFIs, and Contracts:

- Florida Statewide Medicaid Managed Care Re-procurement ITN Awards, Data Book, Detailed Scoring, Proposals and Related Documents, 2017-18
- Texas CHIP Rural and Hidalgo Service Areas RFP, Submitted Proposals and Scoring Documents, 2017-18
- Nebraska Medicaid Managed Care Actuarial and Consulting Services RFP, Apr-18
- New Mexico Centennial Care 2.0 MCO Contracts, 2018

Medicaid Program Reports and Updates:

- Indiana Medicaid Advisory Committee Meeting Materials, Feb-18
- Florida Medical Care Advisory Meeting Materials, Mar-18
- Pennsylvania Medical Assistance Advisory Committee Meeting Materials, Mar-18

Medicaid Data and Updates:

- Rhode Island Medicaid Managed Care Enrollment Share, 2017 Data
- Rhode Island Medicaid Managed Care Enrollment is Up 5.0%, 2017 Data
- Oregon Medicaid Managed Care Enrollment Share by CCO, Mar-18 Data
- Oregon Medicaid Managed Care Enrollment is Up 1.1%, Mar-18 Data
- Colorado RCCO Enrollment Share by Plan, Mar-18 Data
- Colorado RCCO Enrollment is Down 1.9%, Mar-18 Data
- Massachusetts Medicaid Managed Care Enrollment Share by Plan, 2017 Data
- Massachusetts Medicaid MCO Enrollment Drops 4.6%, 2017 Data
- Nevada Medicaid Managed Care Enrollment Share, 2017 Data
- Nevada Medicaid Managed Care Enrollment is Up 6.4%, 2017 Data

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- Excel data packages
- RFP calendar

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