HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 23, 2018

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THIS WEEK

IN FOCUS

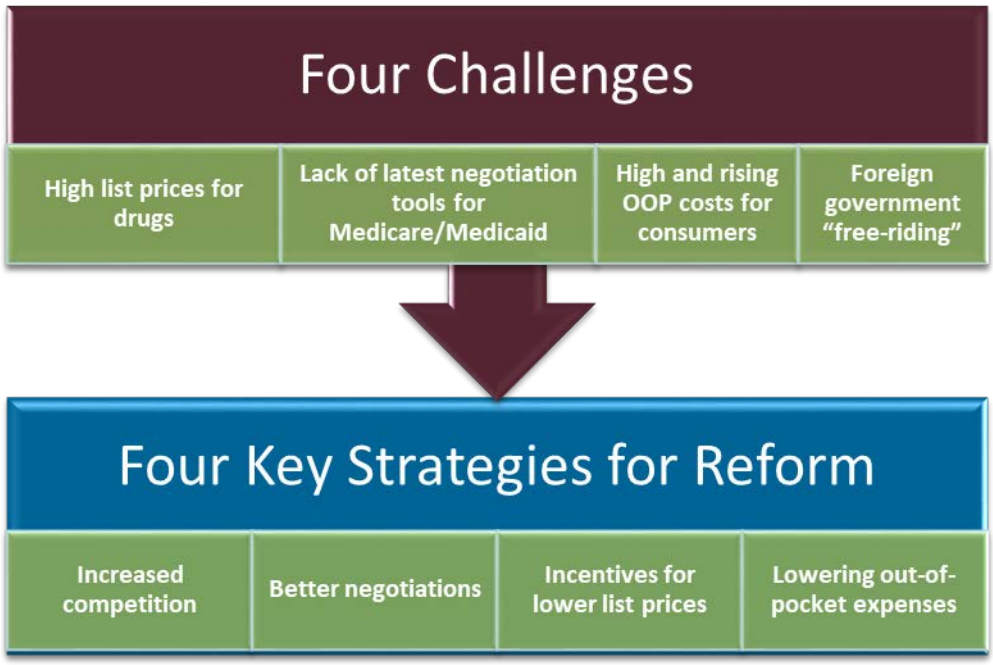
HHS RELEASES BLUEPRINT TO ADDRESS PRESCRIPTION DRUG COSTS

This week, our *In Focus*, written by HMA Principal Anne Winter and Senior Consultant Aimee Lashbrook, examines *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs*, released May 11, 2018. Over time, the pharmaceutical supply chain has become a complex ecosystem, responding to the ever-changing dynamics of new drug products, pricing strategies, health care reform, benefit design, and the regulatory environment making it, arguably, the most complicated in health care. Due to this complexity, solutions to equitably control drug pricing will take a multiprong approach that includes regulatory redesign.

The Blueprint identifies several challenges to addressing drug pricing:

- A business model born on the complexity of supply chain dynamics
- Loss of patent exclusivity and increase in generic alternatives
- Impact of the Affordable Care Act (taxes, rebates)
- Expansion of the 340B drug discount program
- Expansion of international price controls
- Lack of negotiation tools for government programs
- Changes in insurance benefit design that shifts costs to consumers
- Growth in high-cost drugs

The Blueprint offers multiple strategies to address these challenges:



The multiple strategies outlined in the Blueprint are categorized by whether the U.S. Department of Health and Human Services (HHS) believes they can be addressed now, in the short term, or whether they require additional research and stakeholder input. HHS believes it can take many actions now within the current regulatory environment. These actions, which may only require a "stroke of a pen", and more long-term solutions that will require additional stakeholder feedback, are outlined in the tables below. HHS is requesting public comment on many of these longer-term solutions and interested parties should participate in this stakeholder feedback process.

The majority of the strategies to increase competition involve bringing more therapeutic alternatives to single source brand drugs to market. Increased competition is accomplished through improving pathways for generic drug and biosimilar development and prescribing.

Strategies to Increase Competition			
Issue	**Action**	**Can be Done Today**	**Feedback Requested**
Generics	Take steps to prevent manufacturer gaming of regulatory processes such as the Risk Evaluation and Mitigation Strategies (REMS) program. FDA will issue guidance	**X**	
Generics	Encourage sharing of samples needed for generic drug development (REMS, samples for biosimilars and interchangeables)		**X**
Biosimilars	Establish measures to promote innovation and competition for biologics. FDA will issue new policies to improve availability, competitiveness, and adoption. Increase awareness of biosimilars through education	**X**	
Biosimilars	Employ additional efforts to promote the use of biosimilars (e.g., Purple Book, interchangeability, provider education)		**X**
Prices	Review, assess and understand the impact, if any, of the Medicaid Drug Rebate Program, ACA taxes and other rebates on rising prices and cost-shifting to the private sector		**X**

Strategies for better negotiations focus on value-based purchasing of drugs, Medicare Part B and D, and foreign government actions. Medicare reforms include allowing Part D plans to negotiate tighter formularies and administering drugs normally paid through the Part B benefit.

Strategies for Better Negotiations			
Issue	**Action**	**Can be Done Today**	**Feedback Requested**
Value	Experiment with value-based purchasing (VBP) in Medicare and Medicaid through demonstration authority	X	
Value	Further use of VBP, such as indication-based pricing and long-term financing in Medicare and Medicaid		X
Value	Remove government-created impediments to VBP by private payers		X
Medicare	Allow more substitution in Part D to address price increases for single-source generics	X	
Medicare	Give Part D plan sponsors significantly more power when negotiating with manufacturers, including the protected classes	X	
Medicare	Update Part D star ratings methodology to support plans appropriately managing utilization of high-cost drugs by addressing Independent Review Entity appeals issues	X	
Medicare	Evaluate opportunities to allow high-cost drugs to be priced or covered differently based on health indication	X	
Medicare	Report to President on potential for savings by moving some Part B drugs to Part D plans	X	
Medicare	Leverage Competitive Acquisition Program for Part B	X	
Medicare	Require site neutrality for Part B drug administration		X
Foreign Governments	Assess the problem of foreign "free-riding"		X
Foreign Governments	Address foreign government threats of compulsory licensing or intellectual property theft		X
Transparency	Evaluate accuracy and usefulness of current national drug spending data		X

Strategies to incentivize lower list prices focus on government programs, pharmacy benefit manager (PBM) rebate strategies, the 340B drug discount program, and drug coupons. Rebates have a particular focus due to the dynamic between the list price of drugs and the net price of drugs post-rebate.

Strategies to Develop Incentives for Lower List Prices			
Issue	**Action**	**Can be Done Today**	**Feedback Requested**
Transparency	Ask FDA to evaluate requiring manufacturers to include list prices in direct-to-consumer advertising	**X**	
Medicare	Update Medicare's drug pricing dashboard to make price increases and generic competition more transparent	**X**	
Medicare	Provide incentives to discourage manufacturer price increases for Part B and Part D drugs		**X**
Medicaid	Develop proposals related to ACA Maximum Rebate Amount, which limits rebates in Medicaid to 100% of the average manufacturer price (AMP)	**X**	
Medicaid	Implement reforms to the Medicaid Drug Rebate Program		**X**
Rebates	Restrict use of rebates, including revisiting the safe harbor under the Anti-kickback statute		**X**
Rebates	Implement additional reforms to rebating processes		**X**
Rebates	Consider creating fiduciary status for PBMs		**X**
340B	Implement reforms to the 340B Drug Discount Program		**X**
Drug Coupons	Consider changes to how they factor in pharmacy reimbursement (for example, do they lower consumer costs or increase list prices?)		**X**

All the strategies to reduce out-of-pocket costs are Medicare-driven and focused on providing Medicare beneficiaries with information on drug costs and lower cost alternatives.

Strategies to Lower Out-of-Pocket Expense			
Issue	**Action**	**Can be Done Today**	**Feedback Requested**
Medicare	Prohibit "pharmacy gag clauses" in Part D contracts	**X**	
Medicare	Improve Part D explanation of benefits by including information about drug price increases and lower cost alternatives	**X**	
Medicare	Inform Medicare Part B and D beneficiaries about lower-cost alternatives		**X**
Medicare	Provide better information on Part D costs to beneficiaries, annually or more frequently		**X**

HHS is already taking action on policies outlined in the Blueprint, such as issuing a Health Plan Management System (HPMS) memorandum prohibiting pharmacy gag clauses in Part D contracts, releasing the names of manufacturers who have had complaints filed against them regarding sample availability, and publishing an updated Medicare drug pricing dashboard. These actions are in addition to policies already being pursued by HHS prior to releasing the Blueprint, which are identified in the table on the next page.[1]

For additional information, please contact HMA Principal Anne Winter at awinter@healthmanagement.com.

[1] *Proposed in the President's 2019 budget.

Increased Competition	Better Negotiation	Incentives for Lower List Prices	Lowering Out-of-Pocket Expenses
✓ Accelerating FDA approval of generics ✓ Drug Competition Action Plan ✓ FDA announced it will facilitate enhanced information sharing across stakeholders to improve access, including through VBP arrangements ✓ Proposing to seek legislative change to prevent abuse of 180-day exclusivity for generics* ✓ Finalized separate billing and payment codes for biosimilars under Part B	✓ Allowing faster mid-year substitutions of generics onto Part D formularies ✓ Proposing to enhance Part D negotiating power by reducing the required number of drugs per class* ✓ Proposing Part B changes, including establishing inflation limit; reducing WAC when ASP no available; improving ASP reporting* ✓ Proposing improvements to Medicaid Drug Rebate Program to improve reporting integrity* and manually reviewing classifications ✓ Proposing to further classify Medicaid definition of brand drugs to address inappropriate interpretations* ✓ Proposing new Medicaid demonstration authority for up to 5 states to test Medicaid drug coverage and financing reforms (e.g., drug formulary w/ appeals)* ✓ Proposing to leverage Part D negotiation for Part B drugs* ✓ Updating historical studies to analyze drug prices paid to OECD countries	✓ Proposing to exclude manufacturer discounts from calculation of OOP costs in Part D coverage gap* ✓ Proposing to establish MOOP in Part D coverage gap to shift more risk to plans* ✓ Proposing 340B reforms to ensure program benefits patients*	✓ Finalizing Medicare rules to reduce beneficiary OOP spending on 340B drugs ✓ Solicited feedback on how to increase transparency in Part D, including approaches for applying certain rebates and all price concessions to price of drug at POS ✓ Finalized Medicare rules to allow LIS beneficiaries to access biosimilars at a lower cost ✓ Proposing to eliminate cost-sharing on generics for Part D LIS beneficiaries and require Part D plans to apply substantial portion of rebates at POS*

HMA Medicaid Roundup

Arizona

Centurion Awarded Correctional Health Contract in Tucson, Arizona. Centene Corp. announced on May 18, 2018, that its Centurion Detention Health Services division was awarded a correctional health care contract in Tucson, Arizona. The contract is effective July 1, 2018, and runs for three years, with two optional one-year renewals. Read More

Florida

Florida Advocates Urge Hold on Prison Budget Cuts. *Spectrum News* reported on May 22, 2018, that the Florida Alcohol and Drug Abuse Association is urging Governor Rick Scott to forego planned cuts of $7.6 million to inmate substance abuse programs and $9.1 million to post-release treatment programs. The cuts are set to take effect on Friday; however, Scott could order the use of state reserve funds to maintain the programs. Read More

Florida Meets with MCOs Protesting Medicaid Awards. *Health News Florida* reported on May 17, 2018, that the Florida Agency for Health Care Administration (AHCA) is meeting this week with the 12 health plans that have filed petitions protesting the state's recent Medicaid managed care awards. AHCA Secretary Justin Senior and other state officials are meeting with Aetna Better Health, Magellan, Molina, Prestige Health Choice, and others in hopes of avoiding legal action. The Medicaid managed care contracts are worth $90 billion. Read More

Indiana

Marion County, Indiana Declares Hepatitis C Epidemic. The Marion County Indiana Health Department, which includes the city of Indianapolis, has declared a Hepatitis C epidemic and proposes to initiate the first ever needle exchange in the county to combat the spread of Hep C and HIV. This is the fourth county in Indiana to declare an emergency because of the spread of Hepatitis C and HIV that is attributed to the increase in opioid addiction. Previously in other counties, the Department of Health and the Medicaid agency worked together as a "one-stop shop" to provide comprehensive services to individuals using the needle exchange. That model will be replicated in Marion County.

The rate of reported acute hepatitis C in Marion County rose from 0.6 to 7.6 per 100,000 population between 2013 and 2017, much of it due to the opioid epidemic, Dr. Virginia Caine, the county's health director, said Thursday morning. Most of the affected population are Medicaid enrollees or Medicaid-eligible individuals.

She said those figures are likely underestimates, pointing out that the Centers for Disease Control and Prevention estimates that the true number of acute hepatitis C cases are nearly 14 times what is reported. That translates to approximately 1,000 new cases in Marion County in 2017 alone. "The proposed syringe exchange program is medically necessary and will save lives by reducing the transmission of hepatitis C and HIV," she said. "Both are growing national problems brought on by the widespread increase in opioid addiction."

In at least 86 percent of the new cases in 2017, patients reported injecting drugs within the last six months, and at least 58 percent reported sharing drugs and paraphernalia, the health department said.

The health department said the program would operate initially as a mobile unit, choosing sites based on overdose deaths and the recommendations of the Indianapolis Metropolitan Police Department. Services would include drug and disease screenings, wound care education, immunizations, and referrals to Medicaid substance-use disorder and mental-health treatment. Indiana's 1115 HIP waiver was amended to include a waiver of the IMD exclusion to allow inpatient treatment of withdrawal management services.

Iowa

Iowa Total Care Wins Medicaid Managed Care Contract. The Iowa Department of Human Services announced on May 21, 2018, that it intends to award a Medicaid managed care contract to Iowa Total Care, Inc., a subsidiary of Centene. The state released a request for proposals in October 2017 to add a third Medicaid managed care plan after AmeriHealth Caritas Iowa exited the program.

Iowa Revises Medicaid Managed Care Savings Estimates. *The Des Moines Register* reported on May 19, 2018, that the Iowa Department of Human Services is now projecting that that the state will save $140.9 million in fiscal 2019 from the implementation of Medicaid managed care, or three times prior projections. However, state lawmakers who oppose the transition to Medicaid managed care complained about a lack of transparency in the savings estimates. Read More

Louisiana

Louisiana Senate Committee Tables Tax Reviews for Medicaid Eligibility. *The Advocate/Associated Press* reported on May 15, 2018, that the Louisiana Senate Revenue and Fiscal Affairs Committee has voted against a proposal that would allow the state to review tax returns to confirm Medicaid eligibility. Lawmakers expressed concern that the move would unfairly target low-income residents. The House-approved legislation was intended to tackle Medicaid fraud and abuse. Read More

Maine

Governor Blames State Legislature for Not Allocating Funds for Medicaid Expansion. *The Portland Press Herald* reported on May 17, 2018, that Maine can't legally implement voter-approved Medicaid expansion until the state legislature allocates funding, according to a statement from Governor Paul LePage. The statement came in response to a lawsuit filed by Maine Equal Justice Partners, which argues that the LePage administration is violating the law by not expanding Medicaid, adding that funding is in place through May 2019. LePage is a staunch opponent of Medicaid expansion. Read More

Michigan

Michigan Medicaid Work Requirements Bill Excludes Exemption Tied to County Unemployment Rate. *The Detroit Free Press/Associated Press* reported on May 21, 2018, that Michigan Senator Mike Shirkey (R-Clarklake) removed a provision from a proposed Medicaid work requirements bill that would have exempted individuals living in counties with unemployment rates of 8.5 percent or higher. Shirkey stated that the provision would be too difficult to administer. The bill will instead include a broader exemption giving beneficiaries a grace period to find work in areas with high unemployment. Read More

Minnesota

Minnesota Reform Efforts to Protect Seniors Fall Short. *The Star Tribune* reported on May 22, 2018, that the Minnesota legislature adjourned without adopting significant reforms to protect seniors from maltreatment and elder abuse. Governor Mark Dayton was seeking a licensing framework for Minnesota assisted living communities as well as protections against evictions. The proposals faced opposition from the nursing home industry. An estimated 85,000 residents live in senior care facilities across the state. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey DHS Reports on Rate of Churn During Budget Testimony. During budget testimony for State Fiscal Year 2019, the New Jersey Department of Human Services (DHS) reported on the rate of churn— defined as the proportion of eligible individuals who newly enter and exit the program per year—in each eligibility category for calendar year 2017. The overall average enrollment in CY17 was 2.6 percent and disenrollment was 2.7 percent.

NJ Monthly average enrollment/disenrollment by eligibility group over CY17		
ELIGIBILITY GROUP	ENROLLMENT	DISENROLLMENT
Aged Blind Disabled (ABD)	1.00%	1.30%
Non-ABD children	2.50%	2.40%
Non-ABD adults	3.50%	3.70%

New Department of Human Services Commissioner Interviewed on Medicaid Vision. New Jersey Health Care Quality Institute's president, Linda Schwimmer, interviewed on May 10, 2018, Carole Johnson, New Jersey's new DHS commissioner about her vision for the state's Medicaid program. This brief interview touches on the state's plans for investing in care for complex populations, how Medicaid will support the move to outcome-based and value-based purchasing models, and the improving the capacity to address opioid use. Read More

Medicaid Agency Releases Updated FAQs About MLTSS to Providers. On May 16, 2018, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services published an updated set of Frequently Asked Questions (FAQs) for providers serving individuals in the Medicaid program's managed long-term services and supports (MLTSS) program. The FAQs cover the parameters of several topics:

- Authorization and claims
- MLTSS eligibility
- Pre-admission screening
- Coordination of benefits
- Residential providers
- Provider network
- Utilization appeals
- Nursing facility resident discharge
- Office of Community Choice Options (OCCO)
- Operations (e.g., coordination of behavioral health services for members in long-term care facilities, processing of pharmacy benefits for Assisted Living residents, care manager meetings with long-term care facility residents)
- Transition from fee-for-service approval to managed care
- Resources for MLTSS providers

New Jersey Announces Revisions to State Government Revenue Estimates for SFY18 and SFY19. New Jersey State Treasurer Elizabeth Maher Muoio delivered revised revenue estimates to the Assembly Budget Committee today and addressed the "serious structural deficit and structural fund imbalance…not keeping pace with our obligations." General Fund revenues are growing slowly and in many cases are in decline. Without major actions to counter this trend, the state could end the fiscal year with little or no reserves in the General Fund and with a $2.4 billion deficit in the General Fund in FY19. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

NYC Health & Hospitals Pursues Arbitration to Recover $11.5 Million in Insurance Claims. *Modern Healthcare* reported on May 22, 2018, that NYC Health & Hospitals is pursuing arbitration to recover $11.5 million in inpatient medical claims denied by UnitedHealthcare. The claims were submitted between July 1, 2014, and December 31, 2017, for emergency room visits of Medicaid and Medicare patients. Read More

New York Releases Marketplace Report on 2018 Open Enrollment Period. New York State of Health (NYSOH), the New York Health Exchange, released a report on its most recent open enrollment period, which ended January 31, 2018. Despite a year marked by concerns about the future of the Affordable Care Act, consumer demand for insurance through the Marketplace remained strong. 4.3 million people enrolled in coverage through the marketplace, including almost 3 million people enrolling or renewing coverage in Medicaid, and the rate of uninsured in the state is the lowest it has ever been. NYSOH reports that individual premium rates for qualified health plans are nearly 50 percent lower on average than before the establishment of the Marketplace. A majority of individuals purchasing coverage receive some financial assistance; 41 percent enrolled without financial assistance. The age mix of enrollees has remained constant, with 31 percent of enrollees younger than 35. 2018 saw a shift to more affordable levels of coverage, with more people choosing a plan at the Bronze level of coverage. Enrollment in the Essential Plan, New York's Basic Health Program, increased by 11 percent and now covers almost 740,000 people. In addition, 2,162 businesses offer insurance to their employees through the Small Business Marketplace, providing coverage to almost 10,000 individuals. Read More

New York Submits Children's Medicaid Health and Behavioral Health System Transformation Waiver. New York submitted a revised 1115 waiver amendment to CMS that reflects changes in the timeline for implementation of the Children's Medicaid Health and Behavioral Health System Transformation. The waiver amendment can be found on the Department of Health website. Read More

Children's Transition Timeline	
Health Home Care Management	
Milestone	Implementation Dates
Current 1915c Waiver Care Manager Transitioning to Health Home Care Management	Beginning 10/1/2018
VFCA 29I Licensure	
Licensure of all VFCAs	November 15, 2018 – December 31, 2018
Applications Due	July 31, 2018
VFCA contract and claims test with Managed Care Plans	January 1, 2019 – June 30, 2019
State Plan Services	
Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports (OLP, PSR, CPST)	January 1, 2019
Family Peer Support Services (FPSS)	July 1, 2019
Youth Peer Support and Training & Crisis Intervention (YPS, CI)	January 1, 2020
1915c Waiver(s) Transition to 1115 Waiver	
Authority for the following six 1915c Children's waiver(s) will transition to 1115 Waiver: • OMH SED • DOH Care at Home (CAH) I/II • OPWDD CAH • OCFS Bridges to Health (B2H) SED • OCFS B2H Developmentally Disabled • OCFS B2H Medically Fragile	January 1, 2019
HCBS will be part of Managed Care benefit	January 1, 2019
OMH SED, DOH CAH and OPWDD Care at Home will transition to Managed Care	January 1, 2019
A child that is in B2H, receiving HCBS services and that is no longer in Foster Care will transition to Managed Care and receive their HCBS from the plan	January 1, 2019
B2H transitioning children in Foster Care will receive HCBS through fee-for-service	January 1, 2019 through June 30, 2019
B2H children in Foster Care will transition to Managed Care	July 1, 2019
Note: Children transitioning to 1115 that are currently receiving crisis intervention, family peer supports, and youth peer supports and training under a 1915c waiver will continue to receive these services under the 1115 authority; this ensures no break in service for these children.	

New Mexico

New Mexico Rejects Protests of Medicaid Managed Care Contract Awards. *The Santa Fe New Mexican* reported on May 17, 2018, that the New Mexico Human Services Department rejected protests filed by four health plans that weren't awarded contracts in the state's recent Medicaid managed care procurement. The protesting plans, which include UnitedHealthcare of New Mexico and Molina Healthcare of New Mexico, can still seek relief in state court. New Mexico awarded contracts to Presbyterian Health Plan, Health

Care Service Corp./Blue Cross Blue Shield of New Mexico, and Western Sky/Centene effective January 1, 2019. Read More

North Carolina

North Carolina Medical Society Raises $1.1 Million to Form Medicaid Plan. *Triangle Business Journal* reported on May 18, 2018, that a wholly owned subsidiary of the North Carolina Medicaid Society (NCMS) has raised $1.1 million in a private placement for use in the planned formation of a Medicaid managed care plan. NCMS' Carolina Complete Health Network (CCHN) is expected to form the health plan – Carolina Complete Health – through a joint venture with Centene Corp. The private placement was made with the North Carolina Community Health Center Association and certain community health centers. NCMS was formed to create a physician-led provider network for Medicaid beneficiaries. Read More

Ohio

Ohio Fails to Win CMS Approval to Waive Individual Insurance Mandate. *Modern Healthcare* reported on May 18, 2018, that the Centers for Medicare & Medicaid Services (CMS) rejected a 1332 waiver request from Ohio to exempt the state from the individual health insurance mandate. CMS stated that Ohio was unable to show that the number of covered individuals would remain the same and that benefits would remain comprehensive. While Congress eliminated the penalty for failing to have insurance, state waivers must still meet the requirements of the Affordable Care Act. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Releases Community HealthChoices Q&A Document. The Pennsylvania Department of Human Services has released a comprehensive Questions & Answers document for Community HealthChoices (CHC). CHC, the commonwealth's managed long term services and supports program, has been implemented in the southwest region of the state and is scheduled to be rolled out in the southeast in January 2019, followed by the rest of the state in January 2020. The Q&A document is a product of multiple stakeholder events and previous FAQs put together for both providers and participants. Read More

Virginia

Virginia Senate Delays Budget, Medicaid Expansion Talks. The *Associated Press* reported on May 22, 2018, that the Virginia Senate has delayed talks regarding the state budget and Medicaid expansion until next week. Senate Majority Leader Tommy Norment (R-Williamsburg) stated that he predicts the budget will pass next week along with expansion. Senate Minority Leader Dick Saslaw (D-Fairfax) said he is willing to force a full floor vote but will wait one more week. Read More

National

UnitedHealth Report Finds Exchange Coverage Is More Costly Than Medicaid. UnitedHealth Group released a report in May 2018, which found that Medicaid coverage costs 43 percent less than health insurance Exchange coverage. The report also says that Exchanges face low expectations for new growth. The report recommends moving Exchange members to "suitably managed State-based public and private market structures." Read More

ACA Repeal Effort Continues in the Senate. *Modern Healthcare* reported on May 18, 2018, that Republicans are considering another attempt to repeal and replace the Affordable Care Act (ACA) ahead of the fall midterm elections. A repeal bill co-sponsored by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) would convert ACA premium subsidies and Medicaid expansion funds into block grants for states. In addition to passing the repeal bill, Congress would have to approve a new budget resolution. Read More

Medicaid Expansion in Remaining States Would Pay for Itself, Report Says. A report released by the Urban Institute and the Robert Wood Johnson Foundation on May 16, 2018, concluded that the expansion of Medicaid to all 19 remaining non-expansion states would increase health coverage by more than 4.5 million in 2019 and reduce demand for uncompensated care by $8 billion. The analysis suggests that increases in state spending to cover the additional lives would be offset by savings elsewhere. As of March 2018, 31 states had expanded Medicaid. Read More

Trump to Cut Off Funding for Family Planning Clinics That Discuss Abortion. *The Associated Press* reported on May 18, 2018, that the Trump administration plans to announce a proposal that would cut off federal funds to family planning clinics that refer women for abortions or share space with abortion providers. The Title X family-planning program serves an estimated four million women annually through clinics at a cost of about $260 million. Read More

U.S. Appeals Court Finds CSR Payments Were Improper. *CQ Roll Call* reported on May 16, 2018, that the U.S. Court of Appeals agreed with a lower court ruling that the Obama administration was improperly making Exchange plan cost sharing reduction (CSR) payments without an appropriation from Congress. The ruling prompted the White House, House of Representatives, and several states to settle the long-standing dispute without resolving whether the House has the standing to file a lawsuit against the executive branch. The Trump administration had already stopped funding CSR payments, which help reduce out-of-pocket costs for members. Read More

House Is Working on Bill to Loosen IMD Exclusion. *Modern Healthcare* reported on May 16, 2018, that providers are struggling to treat opioid addiction because of the institutions for mental disease (IMD) exclusion, which bans Medicaid funding to facilities with more than 16 beds. The House Energy and Commerce Committee is currently working on a bill to loosen the exclusion. Under the bill, states would be allowed to adopt an amendment to cover opioid residential treatment of up to 30 days under Medicaid. Read More

Industry News

Brand-Name Drugmakers Called Out for Stalling Generic Competition. *Kaiser Health News* reported on May 23, 2018, that the Food and Drug Administration recently posted a list of brand-name drug makers that have refused to sell samples of more than 50 drugs needed by generic manufacturers to develop low-cost alternatives. The Trump administration has called out these companies, including Celgene and Acetelion, for potentially stalling generic competition and costing Medicare and Medicaid nearly $12 billion in 2016, according to a Kaiser Health News analysis. The Creating and Restoring Equal Access to Equivalent Samples Act is now being considered by Congress to increase transparency and deter anti-competitive practices among pharmaceutical companies. Read More

Anthem to Acquire Aspire Health. Anthem, Inc. announced that on May 23, 2018, that it has entered into an agreement to acquire Aspire Health, the largest non-hospice, community-based palliative care provider in the country. Aspire currently provides comprehensive coordinated care services under contracts with over 20 health plans to consumers in 25 states. The financial terms of the transaction, which is expected to close in the third quarter of 2018, were not disclosed. Read More

HCA, KKR to Jointly Bid for Envision. *Reuters* reported on May 18, 2018, that hospital operator HCA Healthcare Inc. and private equity firm KKR & Co. will jointly bid to acquire Envision Healthcare Corp., a Nashville-based physician services provider. Potential acquirers are to submit final offers by the end of the month. Read More

Kelso & Company, Blue Wolf Capital Partners Acquire Jordan Health Services. Cain Brothers announced on May 17, 2018, that Kelso & Company and Blue Wolf Capital Partners have acquired Jordan Health Services, a portfolio company of Palladium Equity Partners, LLC. Jordan, a Texas-based home health and hospice services provider, has also merged with Wolf-backed Great Lakes Caring and National Home Health Care and will now serve more than 63,000 patients combined. Cain Brothers served as a financial advisor to Jordan. Financial terms 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 2018	Washington Integrated Managed Care (Remaining Counties)	Contract Awards	~1,600,000
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 Integrated Managed Care (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 Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA WELCOMES

Carrie Cochran-McClain, Principal, Washington D.C.
Carrie Cochran-McClain joins HMA from the Health Resources and Services Administration (HRSA) at the U.S. Department of Health & Human Services (HHS) where she most recently served as Director of the Office of Planning, Analysis, and Evaluation (OPAE). As a member of the Senior Executive Service, she provided strategic leadership to HRSA programs on areas of policy, evaluation, planning, and external engagement. She worked across HRSA portfolio touching all HRSA programs, including health centers/FQHCs, maternal and child health, Ryan White, 340b drug discounts, and workforce training and distribution, to help the agency move toward meeting long-term organization goals of transforming healthcare, and increasing efficiency, transparency and accountability of programs.

Carrie served as chief advisor on all cross-agency policy issues arising from legislation, budget proposals, regulatory actions, and federal and state policies and their impact on HRSA populations and providers. She provided strategic direction to HRSA leadership regarding the implications of new payment policies including Medicare, Medicaid, and private health insurance and proactively develop solutions to ensure the viability of safety net providers. Carrie developed and executed HRSA-wide strategies on cross-agency initiatives and departmental priorities, including delivery system reform, value based payment, and opioids.

Carrie earned her bachelor's degree in sociology from Willamette University and her Master of Public Administration from Maxwell School of Citizenship and Public Affairs at Syracuse University. She is currently pursuing a Doctorate of Public Health from the University of North Carolina.

Joe Moser, Principal, Indianapolis
Joe Moser joined HMA most recently from the Indiana Family and Social Services Administration where he served as Medicaid director. Joe was appointed to this position in 2013 by then-Governor Mike Pence. In this role, he oversaw the policy and program direction for Indiana's Medicaid programs, which currently cover 1.4 million people. Joe was a key architect of Gov. Pence's team that developed the Healthy Indiana Plan 2.0, an alternative Medicaid expansion program approved by CMS under Section 1115 Waiver Authority that is based on a consumer-driven health insurance model. Additionally, Joe planned and implemented Indiana's first aged, blind, and disabled Medicaid managed care program, which served 100,000 members with special needs. He served as Midwest regional representative on the National Association of Medicaid Directors (NAMD) board and co-chaired the managed care workgroup.

Prior to joining Indiana Medicaid, Joe served as interim executive director, then director of government affairs at Medicaid Health Plans of America (MHPA), a leading national trade association for Medicaid managed care organizations. In these roles, Joe coordinated Medicaid health plans' response to legislative and regulatory proposals, and led efforts to advance an aggressive policy agenda on behalf of the industry. He played a key role in successfully lobbying Congress for passage of Medicaid prescription drug rebate equalization legislation, the top legislative priority of the Medicaid managed care industry. Joe started and managed a Political Action Committee for the organization and hosted fundraising events for members of congress. In addition, he chaired the Partnership for Medicaid, a national coalition of provider groups organized with the purpose of advocating in Congress and the administration to strengthen and improve the program. Joe also organized a health plan coalition for starting North Carolina Medicaid managed care program and participated in new program development efforts in Louisiana and New Hampshire. He worked with Medicaid stakeholders, including doctors, hospitals, and nursing homes to build consensus around improving Medicaid's financial sustainability.

Joe earned his master's degree in political science from Miami University and his bachelor's degree in biology from Marian University.

Elizabeth Lopez, Senior Associate, Denver
Elizabeth Lopez joins HMA Community Strategies (HMACS) from the Department of Healthcare Policy and Financing where she most recently served as a rate payment analyst. In this role, Elizabeth worked with a team to analyze payment rates and compare them with other payers as part of a larger project measuring access to healthcare. She researched various data sources and blended them with claims information using SQL, completed statistical analysis, and created visualizations using Tableau. Elizabeth worked on the implementation of a new outpatient hospital payment methodology and calculated the hospital's base rate used for reimbursement. She managed the audit contract which included determining rates for Federally Qualified Rural Health Clinics, Rural Health Clinics, and hospital cost audits and settlements. Lastly, she worked on hospital payment reform, including planning, data analysis, evaluation of models, stakeholders outreach, and provider participation.

Prior to this, Elizabeth served as a statistical analyst for the Department of Healthcare Policy and Financing. In this role, she created the eligibility file, a large and complex data set that contained client-specific Medicaid health information and required statistical analysis with SQL and SAS.

Prior to this, Elizabeth served as a consultant at Bentek Energy LLC. In this role, she conducted research on the structure of the petroleum industry in the US, which was used to forecast future market trends. Additional roles Elizabeth has held include computer laboratory assistant at the University of Colorado at Denver, instructor of economics at the University of Carabobo in Valencia, Venezuela. She also taught classes at Jose´ Antonio Pa´ez and Centro de Extensio´n y Asistencia Te´cnica a las Empresas, both in Venezuela.

Elizabeth received her bachelor's degree in economics and business form Carabobo University in Valencia, Venezuela. She earned her master's degree in economics from the University of Colorado at Denver and Health Science Center.

HMA News

Upcoming Webinar - Electronic Visit Verification for Personal Care Services, Home Health: Understanding and Implementing New CURES Act Requirements on May 24, 1-2 EDT. Read More
Upcoming Webinar - Partnership Opportunities for Payers, Providers and States: Supportive Housing for High Utilizers on June 7, 1–2 EDT. Read More

New this week on HMA Information Services (HMAIS):

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Iowa Health Link RFP for Additional MCOs and Award, 2017-18
- Pennsylvania Community HealthChoices RFP Comprehensive Q&A Document, May-18
- New York Disproportionate Share Hospital (DSH) Audits RFP, May-18
- Florida Statewide Medicaid Managed Care Re-procurement ITN Awards, Data Book, Detailed Scoring, Proposals, Protests and Related Documents, 2017-18

Medicaid Program Reports and Updates:

- North Carolina Proposed Policy Paper: Supporting Provider Transition to Medicaid Managed Care Proposed, May-18
- North Carolina Prepaid Health Plans in Medicaid Managed Care Proposed Policy Paper, May-18
- Pennsylvania Medical Assistance Advisory Committee Meeting Materials, May-18
- Iowa Medicaid MCO Quarterly Performance Reports, 2016-18
- Texas State Supported Living Center Long Range Planning Report, 2018
- Nebraska Acute Inpatient Psychiatric, Rehabilitation Hospital Rates, SFY19

Medicaid Data and Updates:

- California Medicaid Managed Care Enrollment is Down 0.6%, Apr-18 Data
- MLRs at Ohio Medicaid MCOs Average 82.9%, 2017 Data
- Indiana Medicaid Managed Care Enrollment is Down 1.1%, Apr-18 Data
- Iowa Medicaid Managed Care Enrollment is Up 5.2%, Apr-18 Data
- Colorado RCCO Enrollment is Down 3.1%, Apr-18 Data
- Florida Medicaid Managed Care Enrollment is Down 2.5%, May-18 Data
- New Mexico Medicaid Managed Care Enrollment is Up 0.8%, Apr-18 Data
- New Hampshire Medicaid Managed Care Enrollment is Down 1.3%, 2017 Data
- MLRs at New Mexico Medicaid MCOs Average 85.4%, 2017 Data
- Georgia Medicaid Managed Care Enrollment is Up 1.1%, May-18 Data
- Nebraska Medicaid Managed Care Enrollment Rises 2.3%, May-18 Data

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