HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 27, 2018

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THIS WEEK

IN FOCUS

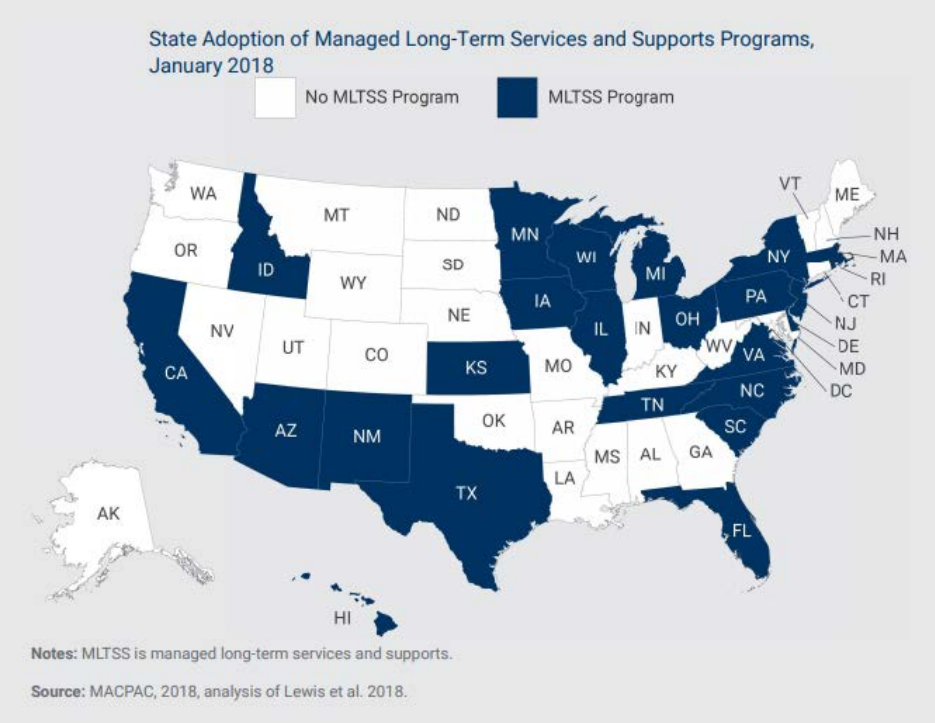
MACPAC JUNE REPORT TO CONGRESS ADDRESSES ROLE OF MANAGED CARE IN LTSS

This week, our *In Focus* comes from Senior Consultant Rachel Patterson, who provides an overview of Chapter 3 of the Medicaid and CHIP Payment and Access Commission (MACPAC) June 2018 Report to Congress on Medicaid and CHIP, which examines the growing role of managed care in long-term services and supports (LTSS). Chapter 3 includes research conducted by teams including HMA Principals Sarah Barth and Karen Brodsky regarding network adequacy for home and community-based service (HCBS) and Principals Sarah Barth, and Sharon Lewis and Senior Consultant Rachel Patterson regarding enrollment of people with intellectual and developmental disabilities (ID/DD) into MLTSS.

MACPAC has undertaken a series of activities to better understand LTSS and managed long-term services and supports (MLTSS), including research on state adoption, goals, federal regulations, implementation, operation, outcomes, and emerging trends – as well as issues MACPAC will continue to monitor related to MLTSS.

MLTSS Penetration Grows

Medicaid is the largest payer of LTSS programs, MACPAC notes, and the use of MLTSS by Medicaid has grown substantially in recent years. In 2004, only eight states had MLTSS programs; by January 2018 that number had grown to 24. Furthermore, the scope of MLTSS continues to expand, with eight states now offering MLTSS programs to individuals with intellectual and developmental disabilities (ID/DD). Many states also operate multiple programs; as of January 2018, 24 states had 41 different MLTSS programs. About 1.8 million people are enrolled in an MLTSS program.



States typically turn to MLTSS for four primary reasons, MACPAC says:

1. Rebalancing of LTSS spending, i.e., increasing the amount of funds going to home and community-based services (HCBS) instead of institutional care;
2. Care coordination and quality;
3. Reductions of HCBS waiting lists and improved access to care;
4. Budget predictability and cost control

MLTSS Operational Issues

But whether LTSS is delivered through MLTSS or fee-for-service, MACPAC finds, the "programs face common challenges." MACPAC notes, for example, that the number of individuals on HCBS waiting lists nationally topped 656,000 in 2016, adding that there is high turnover and shortages among direct support workers.

Initial implementation, procurement, and contracting periods are critical for beneficiaries, MACPAC says, because of the danger of care disruptions. Engagement of beneficiaries, advocates, and providers also plays a key role in successful transitions to MLTSS, MACPAC says, as does adequate training to address the shift providers must make from fee-for-service to managed care payments and contracting.

Research conducted by HMA on behalf of MACPAC found that every MLTSS program studied had existing HCBS network adequacy standards in place, including the following:

- Continuity of care standards beyond federal time requirements;
- Time and distance metrics;
- Criteria defining a minimum number of providers by type or the reporting of the number of HCBS providers by geography;
- Reporting requirements for gaps in service;
- Any willing provider provisions;
- Provider payment rates equal to at least Medicaid fee-for-service rates;
- Single case agreement provisions

These standards are evolving as states gain experience with MLTSS. For example, stakeholders expressed a preference for the gaps in service standard, which requires reporting and/or tracking of missed HCBS visits and gaps or delays from the time of service authorization to service delivery.

Furthermore, as states figure out what's working in term of network adequacy requirements, they are using the reprocurement process to implement changes, MACPAC says.

The Future of MLTSS

MLTSS is expected to continue to evolve, MACPAC notes, as existing programs mature and as more states transition to MLTSS.

Areas to watch include the growing enrollment of individuals with ID/DD into MLTSS, better understanding of how states are aligning MLTSS with dual-eligible special needs plans (D-SNPs), the adequacy of federal and state oversight efforts, and research comparing the cost and quality of MLTSS compared to fee-for-service models.

MACPAC notes, for example, that historically individuals with ID/DD have been excluded from MLTSS programs for several reasons, including a lack of provider familiarity with MLTSS programs, stakeholder skepticism, and challenges in achieving cost savings.

But that's changing as more states consider MLTSS. Research by HMA conducted on behalf of MACPAC finds that the keys to successful program rollout includes slow, incremental transitions by region or eligibility group; and stakeholder engagement to address community concerns.

HMA also found that ID/DD-specific provisions in MLTSS contracts "are more prevalent for separate programs designed for people with ID/DD than for programs that include other populations receiving LTSS." Often these provisions are tied to underlying policy goals. Tennessee, for example, requires case managers to receive training on cultural competency, family supports, dignity of risk, transition planning for youth, and other areas. Other states require MLTSS staff to have ID/DD-specific training, have specific stakeholder engagement requirements, or include ID/DD specific quality provisions.

The chapter also explores MLTSS and design characteristics, including the managed care authority chosen by the state, contract type (comprehensive or LTSS only), covered populations, mandatory or voluntary enrollment, geographic reach, inclusion of institutional services, number of participating plans, types of plan (for-profit, non-profit, and public entities), payment policies, and integration with Medicare benefits. The chapter also goes into detail on the federal requirements for MLTSS, including Medicaid authorities available and what they allow and federal regulations and guidance on MLTSS.

The MACPAC June Report to Congress is available at: https://www.macpac.gov/publication/june-2018-report-to-congress-on-medicaid-and-chip/

HMA Medicaid Roundup

Arizona

Judge Finds State Corrections Department in Contempt, Orders $1.5 Million in Sanctions. *AZ Central* reported on June 22, 2018, that Arizona District Court Judge David Duncan found the state's Department of Corrections in contempt of court for failure to meet the conditions of a 2014 settlement regarding inadequate health care in state prisons. Also named were corrections director Charles Ryan and medical director Richard Pratt. Duncan ordered nearly $1.5 million in sanctions for failing to meet necessary standards. Corizon Health manages health care for the state corrections system. Read More

California

California Budget Raises Rates for Medicaid Doctors, Dentists. *The Washington Post* reported on June 27, 2018, that California Governor Jerry Brown signed a $139 billion budget for fiscal 2019, increasing payment rates to Medicaid doctors and dentists in the state's Medi-Cal program. Read More The budget also allocates additional funding to hepatitis C treatment, according to the Sacramento Bee.

California Nixes Plans to Provide Medicaid to Undocumented Immigrants, Expand Exchange Subsidies. *California Healthline* reported on June 26, 2018, that California has nixed proposed legislation that would have provided Medicaid coverage to undocumented adult immigrants. The measure, along with a proposal to provide state subsidies for Exchange coverage, was cut from the state's fiscal 2019 budget. Undocumented children can already qualify for Medicaid if their parents are eligible. The measure would have impacted more than half of California's uninsured. Read More

Florida

Florida to Award Children's Medical Services Contract to WellCare. *News4Jax* reported on June 27, 2018, that the Florida Department of Health announced it would award its Children's Medical Services contract to WellCare/Staywell Health Plan. The contract, which covers medically frail children, would be effective January 2019. Incumbents Centene/Sunshine State Health Plans and the South Florida Community Care Network have until Friday to challenge the award. Read More

Florida Decision to Award Molina Contract in Region 8 to Be Challenged By Best Care Assurance. *WLRN* reported on June 25, 2018, that Best Care Assurance/Horizon Health Plan intends to challenge Florida's decision to award a comprehensive Medicaid managed care contract to Molina Healthcare of Florida in Region 8 of the state. The region includes Sarasota, DeSoto, Charlotte, Glades, Lee, Hendry, and Collier counties. Best Care Assurance was awarded a contract in April for the same region. Read More

Illinois

Illinois Receives Federal Approval of Hospital Assessment Tax. *FOX 2 Now/Associated Press* reported on June 21, 2018, that Illinois received federal approval for a revamped hospital assessment tax, which will raise billions of dollars in federal Medicaid matching funds for the state. Most of the funds will go to hospitals in low-income communities serving Medicaid patients. Read More

Illinois Freezes Auto-Assigned Medicaid Enrollment in Harmony Health Plan, Cites Inadequate Provider Network. *The Chicago Tribune* reported on June 21, 2018, that Illinois has temporarily frozen the auto-assignment of Medicaid managed care members in WellCare subsidiary Harmony Health Plan, citing an inadequate provider network. The Illinois Department of Healthcare and Family Services may fine the company $20,000 to $50,000 for violating contract terms. The insurer has an estimated 260,000 Medicaid members in the state. In April, the state also blocked enrollment in Blue Cross Blue Shield of Illinois due to similar concerns. Read More

Iowa

Medicaid Director Explains Increase in Managed Care Savings Projections. *The Des Moines Register* reported on June 27, 2018, that a three-fold increase in projected savings from Iowa's transition to Medicaid managed care is largely attributable to the state's shift to calculating the impact of the entire program, rather than attempting to isolate the impact of various individual variables, according to Medicaid director Mike Randol. Official state estimates of potential savings have varied from $232 million initially to $42 million last fall to the current projection of $140.9 million after Randol was appointed. Read More

Kansas

Kansas to Face Protest from Amerigroup Over KanCare Awards. *The Kansas City Star* reported on June 25, 2018, that Amerigroup will protest the recent KanCare 2.0 Medicaid managed care awards, in which Kansas decided to award contracts to Centene/Sunflower State Health Plan, United Healthcare, and Aetna. Amerigroup, which is an incumbent, currently provides care to more than 127,000 KanCare recipients. Read More

Kansas Awards Medicaid Managed Care Contracts. The Kansas Department of Health and Environment announced on June 22, 2018, that it has awarded contracts for its KanCare 2.0 Medicaid managed care program to Aetna, Centene/Sunflower State Health Plan, and UnitedHealthcare. A total of six plans bid for the contracts – Aetna, Amerigroup (incumbent), AmeriHealth Caritas, Sunflower (incumbent), United (incumbent), and WellCare. Amerigroup members will need to select a new plan during open enrollment in October. Current contracts will expire December 31, 2018. The procurement was originally halted in January 2018 amid cost concerns. KanCare served about 390,000 members as of February 2018. Read More

Maine

Supreme Court Gives LePage Administration Until July 18 to File Medicaid Expansion Plan. *US News/Associated Press* reported on June 21, 2018, that the Maine Supreme Judicial Court is giving the administration of Governor Paul LePage until July 18 to file a plan to implement Medicaid expansion. The court will also hear oral arguments on LePage's latest motion to block expansion, which was approved by voters in a ballot measure. Read More

Maine Legislature Approves Funding for Medicaid Expansion. *The Portland Press Herald* reported on June 20, 2018, that the Maine Legislature has approved $60 million in state funding to implement Medicaid expansion. The funding is comprised of $31 million in surplus funds and up to $23.5 million in tobacco settlement funds. Maine voters approved Medicaid expansion in a ballot measure; however, Governor Paul LePage has repeatedly opposed implementation. Read More

Michigan

Governor Signs Medicaid Work Requirements Bill. *The Hill* reported on June 22, 2018, that Michigan Governor Rick Snyder signed the state's Medicaid work requirements bill. The bill requires Medicaid expansion beneficiaries aged 18 to 64 to have 80 hours of work, school, job training, internship, substance abuse treatment, or community service monthly. If approved by federal officials, Michigan will become the fifth state to add work requirements. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Releases January 2019 Amendments to Medicaid MCO Contract. New Jersey's Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has released the January 2018 amendments to the Medicaid MCO contract. HMA compared the latest contract with the previous version from July 2017 and identified the following major changes:

1. The contract now defines and acknowledges the role of caregivers in MLTSS.
2. Several provisions clarify the scope of mental health parity and substance use disorder equity benefits for Medicaid, CHIP and Alternative Benefit Plan members
3. Updates the description of Transportation services
4. Updates HEDIS reporting set measures
5. Adds an extensive annual MCO Drug Utilization Review reporting requirement
6. Makes numerous changes to the MLTSS Behavioral Health Services Dictionary
7. Provides updates to the MLTSS Capitation Rates

A complete set of contract revisions can be found here**.**

Legislature Passes FY 2019 Budget Bill. *NJ Spotlight* reported on June 21, 2018, that the New Jersey Legislature passed a fiscal year 2019 budget bill for the Governor's signature. However, Governor Murphy disagrees with the bill's methods for raising new revenue to support the budget. Murphy maintains that legislators are perpetuating Christie-era "gimmicks and games" to raise revenue and seeks a budget plan that relies on long-term funding tactics. Read More

New Jersey Legislation Proposes Medicaid Establish Value-based Payment Incentive System for Home Health Agencies, Health Care Service Firms. On June 21, 2018, New Jersey Senator Troy Singleton (D-Burlington) introduced a bill to establish an incentive-based value payment (VBP) system to measure improved performance outcomes for Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) enrollees. This would rank participating home health agencies and health care service firms based on how they meet performance targets and realize improvements in the following "Outcome and Assessment Information Set:"

1. Incidence of acute care hospitalization, including preventable hospital admissions and readmissions
2. Incidence of emergent care
3. Patient bathing
4. Patient ambulation or locomotion
5. Patient transfers, including discharge planning during hospitalization and maintaining continuity of care
6. Collaboration between primary care providers and other health care providers
7. Management of medications, including reconciliation of medications throughout the continuum of care
8. Status of surgical wounds, and
9. Incidence of adverse events.

Home health and health care service providers would be required to establish a plan of care for patients and for coordinating their continuum of services, collaborate with hospitals and other providers, establish standards, requirements and programs to educate patients, families and caregivers about their plans of care and unique goals.

Medicaid managed care organizations would administer the VBP system and distribute incentive payments to the providers, which would be funded by a $10 million initial budget less administrative costs to the Division of Medical Assistance and Health Services (DMAHS).

In addition, DMAHS would receive recommendations concerning regulations from a new advisory board of the Department of Human Services. The Home Health Services Incentive-Based Value Payment System Advisory Board would include eight public members with the following representation:

- home care agency providing private duty nursing
- home care agency providing personal care assistance
- the Home Care and Hospice Association of New Jersey
- finance professional with a background in home care administration
- registered nurse who provides long-term home health care services
- certified homemaker-home health aide
- Medicaid managed care organization
- Rutgers Center for State Health Policy

The bill, S2761, has been referred to the Senate Health, Human Services and Senior Citizens Committee. A copy of the bill as introduced can be found here

Governor Murphy Reverses Government Reorganization of Mental Health Division. *NJ Spotlight* reported on June 21, 2018, that eight months after the controversial relocation of the New Jersey Division of Mental Health and Addiction Services (DMHAS) from the Department of Human Services (DHS) to the Department of Health (DOH), it will return to DHS. DOH will continue to control the state's psychiatric hospitals. Read More

New Jersey Budget Negotiations Include Pay Increase for Direct-Support Professionals. *NJ Spotlight* reported on June 14, 2018, that the New Jersey Senate President Sweeney is advocating for increases to hourly wages for direct-support professionals (DSP), providers who deliver daily care to New Jersey residents with intellectual or developmental disabilities (ID/DD). There are about 22,000 residents with ID/DD and 25,000 DSPs with a 44 percent turnover rate and 20 percent job vacancy. DSP wages average $11.36 an hour and the lawmakers aim to increase their pay to about $16 an hour over five years. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Nurse Staffing Mandate Fails in Legislature; Governor Voices Support. The New York State Nurses Association has supported legislation that would establish mandatory nurse staffing levels in hospitals and nursing homes. The measure, known as the Safe Staffing for Quality Care Act, has been introduced every legislative session since 2009. The Act has passed in the Assembly but not in the Senate. After the close of the 2018 legislative session Governor Andrew Cuomo issued a statement in support of the act. He said that he would introduce legislation next session that would allow the Department of Health to set safe staffing levels by regulation as legislative solutions have not been forthcoming. He went on to say that in the meantime he will have the Department of Labor vigorously enforce workplace protections such as nurses being forced to work additional hours and work without additional compensation. The Greater New York Hospital Association remains opposed to the legislation. Read More

New York to Prohibit Short-Term Health Insurance Plans. In response to a proposed rule issued by the federal government, the New York Department of Financial Services (DFS) issued a statement indicating that short-term health insurance plans will be prohibited in New York. The proposed rule would expand the policy term for short-term health insurance plans offered in the individual market from the current three months to 364 days. Short-term insurance plans are not subject to requirements mandated by the Affordable Care Act. The communication from DFS indicates that all health insurance policies issued in New York must be comprehensive and provide all essential health benefits. New York law establishes these requirements and they cannot be circumvented through the issuance of a short-term plan. Read More

New York DOH Presented Information on Delivery System Reform Incentive Payment Program Performance. The New York Department of Health convened a meeting of the Project Approval and Oversight Panel (PAOP) to present information on the performance of the 25 Performing Provider Systems (PPSs) participating in the state's Delivery System Reform Incentive Payment program (DSRIP). The DSRIP program requirements approved by CMS required New York to convene a stakeholder panel to review DSRIP applications. The state subsequently extended the work of the panel to serve as an independent oversight body. The DSRIP program established statewide milestones that are tied to incentive payments. Should these performance metrics not be met statewide, all PPSs would receive a financial penalty. The first statewide test occurred at the end of year 3 of the program; this is the first time the state has been evaluated against these milestones. Statewide penalties grow over time; for the current year $76 million was at risk (five percent of funds); by year 5, it will be $185 million (20 percent of funds).

The Terms and Conditions define four statewide accountability milestones:

- Statewide metrics performance – across 18 performance metrics, more are improving than are worsening;
- Success of DSRIP projects statewide – looking at pay for performance measures on all DSRIP projects across all 25 PPSs, more have achieved an award than not;
- Total Medicaid spending – growth in total Medicaid spending is at or below the target trend rate; and growth in statewide spending on inpatient and emergency department spending is at or below the target trend rate;
- Value-Based Payment – VBP goals as defined in the VBP roadmap are being met (for year 3 – 10 percent of all managed care expenditures are in at least a level one (upside-only) VBP arrangement).

The Department of Health reported that the state achieved all four milestones for year 3. When looking at pay for performance measures, 27 out of 32 measures demonstrated improvement between year 2 and 3. All the avoidable hospital use metrics showed improvement: avoidable readmissions declined by 15.2 percent, avoidable ED visits declined by 14.3 percent, and avoidable ED admissions for persons with a behavioral health diagnosis declined 14.9 percent. Of the five metrics that showed no improvement between years 2 and 3, three were virtually flat while two showed slight declines (HIV/AIDS Comprehensive Care – engaged in care, down 3.0 percent, and Adult Access to Preventive or Ambulatory Care, down 1.2 percent).

The presentation includes charts demonstrating the performance of each of the PPSs over three years on a number of dimensions. For potentially preventable readmissions, 19 of 25 PPSs demonstrated improvement, with 13 meeting the improvement target. For potentially preventable ED visits, 20 PPSs demonstrated improvement, with 11 meeting the target. For potentially preventable ED visits for persons with a behavioral health diagnosis, 18 PPSs showed improvement, with 12 meeting the target. PPSs that are under-performing are given special attention and more regular contact with department staff, particularly around population health management data support. It was noted that the challenge seems to be one of connectivity between hospitals and community-based partners. PPSs with better partnerships demonstrate better performance.

For slides from the presentation click here.

For a recording of the webcast click here.

New York to Try to Recover $426 Million in Medicaid Drug Rebates Related to HARP. *The Albany Times Union* reported on June 22, 2018, that New York will try to recover $426 million in Medicaid drug rebates it had failed to bill for between October 1, 2015, and December 31, 2017, under the state's Health and Recovery Plans (HARP) program. The New York Health Department has since updated its procedures to bill for HARP rebates. Read More

North Carolina

Lawmaker Pulls Bill to Study Single-Payer Health Care. *The News & Observer* reported on June 22, 2018, that a bill to study the impact of universal, single-payer health care in North Carolina was pulled by its sponsor Representative Verla Insko (D-Orange County). The bill had been dormant in the House Appropriations Committee since April 2017, with critics raising concerns about its cost. Read More

Ohio

Ohio Medicaid Pharmacy Benefit Manager Performance Review Results Released. The Ohio Governor's Office for Health Transformation announced on June 21, 2018, the results of Ohio Medicaid's independent third-party analysis of Medicaid health plan Pharmacy Benefit Manager (PBM) performance. Key findings indicated an 8.8 percent spread between the amount PBMs billed Medicaid managed care plans and the amount they paid pharmacies. The review also found independent pharmacies were reimbursed more that CVS pharmacies for brand and generic drugs. The report indicated PBMs have saved Ohio taxpayers at least $145 million annually and there was no evidence found of anticompetitive behavior. Read More

Medicaid Is Stretched Thin by Cost of Treating Opioid Addiction, Audit Says. *The Columbus Dispatch* reported on June 26, 2018, that the cost of treating opioid addiction is putting significant financial pressure on the Ohio Medicaid program, according to a special report by Ohio Auditor Dave Yost. The cost of treating opioid addiction in Ohio was $110 million in 2016, up from just $13 million in 2010. Some of the increase is a result of Medicaid expansion, the report said, with adults newly eligible for coverage being treated for addiction. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Bulletin Announces Amendments of Consolidated, Person/Family Directed Support and Community Living Waivers. Pennsylvania's Department of Human Services made available for public review and comment the Office of Developmental Programs' proposed amendments to the Consolidated, Person/Family Directed Support (P/FDS) and Community Living waivers. The department proposes to amend the Consolidated, P/FDS and Community Living waivers, effective November 1, 2018, as follows:

- Aligning eligibility requirements for individuals with autism, service definitions and provider qualification requirements
- Transitioning rates for transportation to the Medical Assistance fee
- Allowing relatives to provide transportation and adding transportation as an available service through Organized Health Care Delivery Systems

The fiscal impact is $166.382 million for fiscal year 2018-2019 and $183.718 million for fiscal year 2019-2020. Additional state funding for these amendments would be $73.639 million and $81.381 million, respectively. Read More

Governor Signs 2018-19 Budget Spending Bill. *The Morning Call* reported on June 22, 2018, that Pennsylvania Governor Tom Wolf signed a $32.7 billion spending package a week ahead of the June 30 deadline. The budget received bi-partisan support, overwhelmingly passed in both the House and Senate. The package increases spending through the state's main operating account by 2 percent over the current year's budget of $32 billion. The increase goes largely to public schools, social services, pensions and prisons. It also creates a $60 million off-budget grant program for school safety. The budget increases funding by $5.3 million for community-based family centers, which includes $4.5 million to provide home-visiting services for families affected by opioid use disorder and $800,000 in increased rates for home-visiting providers. It also provides additional investments to assist individuals with intellectual disabilities and autism, including $16 million for an additional 965 individuals with intellectual disabilities or autism to access waivers that provide supports and services enabling individuals to remain in their home and community. The General Assembly rejected Wolf's attempts for a fourth straight year for a severance tax on Marcellus Shale natural gas drilling and for municipalities to start paying a fee to cover a portion of the state police coverage they receive. The new fiscal year begins July 1. Read More

South Carolina

Medicaid Work Requirements Proposal Raises Concerns Among Children's Advocates. *The Post and Courier* reported on June 24, 2018, that children's advocates are concerned with a South Carolina plan to implement Medicaid work requirements, requiring adults on Medicaid to work at least 80 hours a month with exemptions for caregivers of children or the disabled. Children's advocates from the Center for Children and Families at Georgetown University and Appleseed Legal Justice Center have expressed concerns, citing the need to address a lack of employment opportunities, transportation, and child care. Of the one million Medicaid enrollees in the state, an estimated 180,000 adults could be impacted by the work requirements. Read More

National

CMS to Increase Oversight of Medicaid Managed Care Plans, States. *CQ Health* reported on June 26, 2018, that the Centers for Medicare & Medicaid Services (CMS) announced plans to increase regulatory oversight of Medicaid managed care plans and states. The initiatives will include audits of some Medicaid plans, including increased scrutiny of claims data and examinations of how much funding goes to care versus administration expenses. CMS will also audit Medicaid eligibility determinations by states, and may penalize states for covering individuals deemed ineligible. Read More

65 Percent of Voters Say Pre-Existing Conditions Are Top Election Issue, Kaiser Poll Finds. *The Hill* reported on June 27, 2018, that 65 percent of voters surveyed said that continued protections for people with pre-existing health conditions is a top election issue, according to the Kaiser Family Foundation's latest tracking poll. The majority of respondents also indicated the importance of provisions prohibiting insurance companies from denying coverage because of a person's medical history. Kaiser surveyed 1,492 adults for the poll. Read More

House Passes Comprehensive Opioid Legislation. *The Washington Post/Associated Press* reported on June 22, 2018, that the U.S. House overwhelmingly passed legislation to increase Medicaid coverage of treatment for substance abuse disorders, expand the use of medications to treat opioid abuse, and encourage the development of alternative pain treatments. The Senate will need to approve the legislation before it moves to the President. Read More

Senate Budget Committee Urges HHS to Address $89 Billion in Improper Medicaid, Medicare Payments. *HealthPayer Intelligence* reported on June 25, 2018, that the U.S. Senate Budget Committee is urging the Department of Health and Human Services (HHS) to address $89 billion in improper Medicaid and Medicare payments. The lawmakers stated that HHS has not acted on recommendations from Comptroller General Gene Dorado to improve state-federal collaboration on Medicaid audits and increase Medicaid data availability for program oversight. HHS has until July 20, 2018, to respond to the Senate Budget Committee's letter. Read More

US House Passes Bills to Partially Repeal IMD Exclusion, Reduce Opioid Use Privacy. *Modern Healthcare* reported on June 20, 2018, that the U.S. House of Representatives passed legislation to loosen the Institution for Mental Diseases (IMD) exclusion, which prohibits the use of Medicaid funds for substance abuse treatment in mental and behavioral inpatient settings. Another bill would waive enhanced privacy protections for individuals addicted to opioids. Read More

Insurers to Expand ACA Exchange Participation Next Year. *The Wall Street Journal* reported on June 21, 2018, that health insurers are looking to expand their participation in the Affordable Care Act (ACA) Exchanges in 2019. Centene and Molina will enter or return to states like North Carolina, Wisconsin, and Utah, for example. Oscar will enter Arizona, Florida, and Michigan, and expand in Ohio, Tennessee, and Texas. Smaller health plans like Bright Health in Tennessee, Virginia Premier, and Presbyterian Health Plan in New Mexico are also expected to expand their ACA presence. Read More

CMS Recommends Legislation to Improve Care Coordination for Dual Eligibles. *Modern Healthcare* reported on June 20, 2018, that the Centers for Medicare & Medicaid Services (CMS) has submitted a series of legislative recommendations to Congress aimed at improving care coordination for dual eligibles. Recommendations include permanently adopting retroactive Medicare Part D coverage for low-income beneficiaries, streamlining the appeal process for denied claims, limiting the ability to change plans via special enrollments, and simplifying marketing for dual eligible special needs plans (D-SNPs). Read More

Industry News

Texas Finds Xerox Responsible for Approving $1 Billion in Improper Medicaid Dental Claims. *The Texas Tribune* reported on June 22, 2018, that the Texas Supreme Court ruled that Xerox was responsible for approving and paying $1 billion in unnecessary Medicaid dental claims since 2008. The state, dental providers, and Xerox have been in a legal battle to determine who should pay back the funds. The Texas Health and Human Services Commission had a five-year, $759 million contract with Xerox's Texas Medicaid and Healthcare Partnership, which oversaw the preauthorization of Medicaid dental claims. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Summer 2018	North Carolina	RFP Release	1,500,000
June 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 8, 2018	Mississippi CHIP	RFP Release	47,000
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 Complete Care	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
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
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 News

NEW THIS WEEK ON HMA INFORMATION SERVICES (HMAIS):

Medicaid Data and Updates:

- Florida Medicaid Managed Care Enrollment is Down 2.7%, Jun-18 Data
- Indiana Medicaid Managed Care Enrollment is Down 2.0%, May-18 Data
- Louisiana Medicaid Managed Care Enrollment is Flat, May-18 Data
- Maryland Medicaid Managed Care Enrollment is Up 1.8%, May-18 Data
- OH Dual Demo Enrollment is Flat, Jun-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 1.6%, Jun-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Delaware Diamond State Health Plan Delivery System Transformation RFQ, Proposals and Scoring, 2017
- Virginia MEDALLION 4.0 Managed Care, RFP, Proposals Scoring and Negotiation Documents, 2017-2018
- Kansas KanCare 2.0 Medicaid & CHIP Capitated Managed Care RFP Evaluations, 2018
- Florida Children's Medical Services Managed Care Plan ITN, Rankings, and Related Documents, Jun-18
- Iowa Medicaid Actuarial Services RFP Award, 2018
- Michigan Pharmacy Benefits Manager Services (PBM) RFP, Jun-18
- Arkansas Non-Emergency Medical Transportation Services (NET) Draft IFB, Jun-18
- New Jersey FamilyCare MCO Contract, 2016-18
- New Hampshire Evaluation Plan Designs for Granite Advantage Waiver and Substance Use Disorder Waiver RFA, Jun-18

Medicaid Program Reports and Updates:

- Illinois Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Years 1 and 2, Jun-18
- California Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Years 1 and 2, Jun-18
- Massachusetts Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Years 2 and 3, Jun-18
- Michigan Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Years 1, Jun-18
- New York Medicaid Managed Care Advisory Review Panel Meeting Materials, Jun-18
- New York FIDA Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Years 1, 2, and CY 2016
- Texas Managed Care: Contract Oversight and Monitoring Presentation, Jun-18
- CMS Medicare-Medicaid Coordination Report to Congress, FY 2017
- CMS Comprehensive Medicaid Integrity Plan, FY 2014-18
- CMS Report on Growth of Managed Long-Term Services and Supports Programs, 2017
- GAO Report on Medicaid Improper Payments and Program Integrity Risks, Jun-18

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