HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 13, 2019

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THIS WEEK

SAVE THE DATE: HMA CONFERENCE ON TRENDS IN PUBLICLY SPONSORED HEALTHCARE

The Next Wave of Medicaid Growth and Opportunity:
How Payers, Providers, and States Are Positioning Themselves for Success

Monday, September 9 to Tuesday, September 10
Pre-conference workshop: Sunday, September 8
Marriott Marquis Chicago

Confirmed Keynote Speakers: (in alphabetical order; others to be announced)

Opportunities and Pitfalls of Medicaid Innovation at the State Level
Mari Cantwell, *Chief Deputy Director, Health Care Programs, CA Dept. of Health Care Services*
Mandy Cohen, *MD, Secretary, North Carolina Dept. of Health and Human Services*
Jami Snyder, *Director, Arizona Health Care Cost Containment System*
Carol Steckel, *Commissioner, Kentucky Division of Medicaid Services*

The Growing Role of Medicaid Managed Care in Serving the Nation's Most Vulnerable
Paul Tufano, *Chairman, CEO, AmeriHealth Caritas*

Delivering on the Promise of Medicaid Managed Care
Heidi Garwood, *President Medicaid, Health Care Service Corp.*
Janet Grant, *Regional Vice President, Great Plains Region, Aetna Medicaid*
Joanne McFall, *Market President, Keystone First Health Plan*
Dennis Mouras*, CEO, UnitedHealthcare Community Plan of Michigan*
Patrick Sturdivant, *President, Virginia Medicaid Health Plan, Anthem, Inc.*

Innovative Care Delivery Models for High Cost, High-Acuity Patients
René Santiago, *Deputy County Executive, County of Santa Clara, CA*

Plus: Special Sessions Featuring HMA Insights on Key Healthcare Topics
The Growing Role of Medicare Advantage and the Future of Medicare
Jonathan Blum, *Managing Principal, HMA; former CMS Deputy Administrator for Medicare*

Substance Abuse Treatment and the Opioid Crisis: A New Way Forward
Corey Waller, *MD, Principal, HMA*

Additional planned sessions to focus on Medicare-Medicaid Dual Eligibles, Medicaid expansion, drug spending, community engagement, Value-Based Payments, and behavioral health integration. HMA will also host a pre-conference workshop on Sunday, September 8, offering a primer on Medicaid's basic structure, programs, benefits, and terminology.

HMA's 2019 Conference on Trends in Publicly Sponsored Healthcare to Focus on the Next Wave of Medicaid Opportunity and Growth

Health Management Associates (HMA) is proud to announce its annual conference on *Trends in Publicly Sponsored Healthcare*, September 9-10, in Chicago. The theme of this year's event is *The Next Wave of Medicaid Growth and Opportunity: How Payers, Providers, and States Are Positioning Themselves for Success* and features keynote speakers who are some of the nation's most innovative healthcare leaders.

This is the fourth conference HMA has presented on trends in publicly sponsored healthcare. Last year's event brought together more than 460 executives from health plans, providers, state and federal government, community-based organizations and others serving Medicaid and other vulnerable populations. It was a collaborative, high-level event featuring more than 40 speakers and representing the interests of a broad-based constituency of healthcare leaders.

This year's meeting promises to be even better, with a sharp focus on the challenges and opportunities for organizations serving Medicaid and other vulnerable populations in the months and years ahead. Additional details, including a complete agenda, will be available in the weeks ahead.

Sponsorships and group discounts are available. For additional information, contact Carl Mercurio, cmercurio@healthmanagement.com, (212) 575-5929.

IN FOCUS

EVOLVING INTEGRATED MANAGED CARE MODELS FOR MEDICARE-MEDICAID DUAL ELIGIBLE BENEFICIARIES: KEY CONSIDERATIONS FOR HEALTH PLANS

This week we are providing a brief recap of our January 8th webinar Evolving Integrated Managed Care Models for Medicare-Medicaid Dual Eligible Beneficiaries: Key Considerations for Health Plans presented by Principals Sarah Barth, JD and Ellen Breslin, MPP.

Many states, in collaboration the federal government, are focused on the development of integrated care models through health plans that strive to create a better system of care that addresses dually eligible individuals' diverse needs in a comprehensive and holistic way.

There are currently over 12 million people nationwide who are dually eligible for Medicare and Medicaid[1]. They are a diverse population in age, race, ethnicity and language, with high rates of chronic conditions, behavioral health, long term services and supports (LTSS) and social determinant of health (SDOH) needs. They account for a disproportionate share of spending for the Medicare and Medicaid programs. Dually eligible beneficiaries are:

20 percent of the Medicare population accounting for 34 percent of program spending; and,

15 percent of the Medicaid population accounting for 33 percent of program spending.[2]

Access and navigational issues for this population often contribute to health disparities and equity issues, higher rates of hospital emergency department and inpatient use and lower quality of life.

There is widespread recognition among states and federal governments, health plans, providers and community-based organizations that dually eligible individuals and their family, friends, and caregivers must be at the center of integrated care program models that support their needs and goals. These goals include health, quality of life, and their ability to engage in the communities in which they live.

[1] CMS State Medicaid Director Letter #18-012, *Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare,* December 2018.

[2] Ibid.

Over 20 states have Medicaid managed long-term services and supports (MLTSS) programs serving Medicaid beneficiaries with higher needs, many of whom are dually eligible. MLTSS programs are a pathway for states to integrate care across Medicare and Medicaid. In some states, health plans that operate a Medicaid MLTSS plan must also operate a Medicare Advantage (MA) dual eligible special needs plan (D-SNP).

Dually eligible individuals are more often choosing a Medicare managed care option. From 2006 to 2017, we saw a 24-point increase in the percentage of individuals choosing to enroll in Medicare Advantage, increasing from 11% to 35%.[3]

HMA anticipates continued growth in the integrated managed care market. The December 2018 Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter *Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare* (SMDL # 18-012) announced that CMS will be outlining new Medicare-Medicaid Financial Alignment Initiative-related opportunities for current demonstration states "and other states in the coming months." Additionally, Contract Year (CY) 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P) seeks to implement D-SNP provisions of the Bipartisan Budget Act of 2019 which permanently authorized Medicare Advantage Special Needs Plans, including D-SNPs.

Health plans are adapting business models and models of care to meet the diverse needs of dually eligible individuals. They are working to understand the diverse needs of the population, develop community-based approaches to locate and engage individuals to assess and serve them, and build care coordination systems and workflows to coordinate care across all services - primary, acute, behavioral health, LTSS and social services. Effectively serving dually eligible individuals includes thinking broadly about provider networks and building partnerships with community-based organizations. HMA outlined a list of key considerations for health plans in the January 8, 2019 webinar. These key considerations are informed by our work in the market with health plans, providers, community-based organizations and dually eligible individuals.

The webinar is also a useful resource for health plans that wish to better understand the key differences across state and federal programs and the different types of integrated health plans, including MA dual eligible special needs plans – D-SNP, a MA fully integrated special needs plan – FIDE SNPs, the proposed designation of a highly integrated dual eligible special needs plan – HIDE SNPs, and Medicare-Medicaid Plans (MMP). These are terms defined during the January 8th webinar. Link to Webinar

For more information, contact Sarah Barth at sbarth@healthmanagement.com and Ellen Breslin ebreslin@healthmanagement.com

[3] Data Analysis Brief: *Managed Care Enrollment Trends among Dually Eligible and Medicare-only Beneficiaries, 2006 through 2017*, CMS Medicare-Medicaid Coordination Office, December 2018.

HMA MEDICAID ROUNDUP

Arkansas

Provider-Led Entities Move Forward After PASSE Readiness Review. The Arkansas Department of Human Services (DHS) announced on February 12, 2019, that Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care have successfully passed their readiness reviews and will move ahead with full implementation of the state's Provider-led Arkansas Shared Savings Entity (PASSE) program. The reviews required organizations to demonstrate their ability to support Medicaid beneficiaries across the state and their ability to pay providers for services. PASSEs will begin accepting full risk effective March 1. Read More

Florida

House Reiterates Support for Loosening Certificate of Need Rules. *News4Jax.com/The News Service of Florida* reported on February 7, 2019, that the Florida House is again voicing support for loosening state certificate of need rules. Representative Cary Pigman (R-Avon Park), chair of the House Health Market Reform Subcommittee, said another certificate of need rollback proposal is likely during the 2019 legislative session. Meanwhile, Florida deputy secretary for Medicaid Molly McKinstry told House members that 25 new hospitals have gone through the existing certificate of need process in the last seven years with little regulatory issues. Read More

Medicaid Advocates Push for Expansion Ballot Initiative. *Politico* reported on February 6, 2019, that health care advocates are pushing for a Florida Medicaid expansion ballot initiative in 2020. Supporters must obtain at least 800,000 certified signatures from 14 of the state's 27 congressional districts by February 2020 to get the measure on the ballot. About 700,000 adults would be eligible. Read More

Georgia

Governor Seeks Support for Partial Medicaid Expansion Effort. *The Atlanta Journal-Constitution* reported on February 7, 2019, that Georgia Governor Brian Kemp will back proposed legislation to pursue partial Medicaid expansion through a federal waiver. The measure also seeks a waiver aimed at lowering premiums on the Affordable Care Act Exchanges. The expansion waiver, which is expected to be submitted and approved by 2020, could expand coverage to between 300,000 to 600,000 individuals in the state. Read More

Louisiana

Medicaid Expansion Enrollment Reaches 500,000, Outpacing Projections. *The Associated Press* reported on February 8, 2019, that more than 500,000 Louisiana residents have enrolled in the state's Medicaid expansion program, which continues to grow three years after coverage became effective in 2016 for adults ages 19 to 64 years with incomes up to 138 percent of the federal poverty level. Louisiana expects to enroll 560,000 individuals by June 2020. By June 2019, the state expects to have 1.7 million individuals enrolled in Medicaid through both expansion and non-expansion programs. Read More

Massachusetts

Massachusetts to Face Continued Federal Court Oversight of Mental Health Services for Children. *The Boston Globe* reported on February 9, 2019, that Massachusetts will face continued federal court oversight concerning the provision of mental health services to children on Medicaid. U.S. District Court Judge Michael Ponsor rejected the state's request to end court oversight in an 18-year-old case, ruling that continued delays can lead to violent outbursts, removal from homes, and unnecessary hospital stays. The state may appeal the ruling. Read More

Michigan

Governor Eyes Changes to Medicaid Work Requirements. *U.S. News and World Report* reported on February 8, 2019, that Michigan work requirements may cause between 61,000 and 183,000 adults to lose Medicaid coverage, according to a recent Manatt Health report. Governor Gretchen Whitmer has emphasized plans to work with lawmakers to modify the existing Healthy Michigan Plan so it "preserves coverage, promotes work, reduces red tape and minimizes administrative costs". Medicaid expansion beneficiaries in the state ages 18 to 62 must report a minimum of 80 hours of work, training, or volunteer activities. The state's Medicaid work requirements were approved in December by the Centers for Medicare & Medicaid Services (CMS). Read More

Missouri

Medicaid Overhaul Could Save $1 Billion Annually, Report Says. *The St. Louis Post-Dispatch* reported on February 11, 2019, that Missouri could potentially save up to $1 billion annually within the next four years by overhauling services and reimbursement rates for the state's Medicaid program, according to a report prepared for the state by McKinsey & Co. Among the recommendations are improving prescription management; altering reimbursement rates for hospitals, doctors, and nursing homes; and shifting more individuals to home care services. Tightening eligibility requirements weren't among the recommendations. Missouri has more than 900,000 Medicaid members at a cost of $10 billion annually. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Human Services Establishes Office of Medicaid Innovation. On February 6, 2019, the New Jersey Department of Human Services announced the launch of a new Office of Medicaid Innovation to "improve quality, delivery and cost of care within the state's Medicaid program." This office will take the lead on the Medicaid program's value-based purchasing developments and opportunities and explore a relationship between Medicare and Medicaid. It will also work with stakeholders to consider alternative payment models. The Office of Medicaid Innovation will be led by Gregory Woods who previously worked for the Centers for Medicare & Medicaid Services (CMS) overseeing payment and delivery system reforms within Medicare. Read More

Health Care Quality Institute Forms Medicaid Policy Center. On February 7, 2019, the New Jersey Health Care Quality Institute (Quality Institute) announced the formation of a new policy center that aims to advance quality, service delivery and cost effectiveness in New Jersey's Medicaid program. Close to 1.8 million New Jersey residents receive Medicaid benefits and are served by different state departments and divisions. The Medicaid Policy Center (MPC) will partner with the state agencies and other organizations with a stake in the New Jersey Medicaid program to work on areas of common interest, such as alternative payment models, to improve patient outcomes and innovate health care delivery. MPC will work closely with the recently formed Medicaid Innovation Office within the Department of Human Services. Read More

New Mexico

Governor Seeks to Reverse New Medicaid Premiums, Copays, Retroactive Eligibility Limits. New Mexico Governor Michelle Lujan Grisham announced on February 13, 2019, that her administration will seek federal approval to reverse several new Medicaid policies, including copays and limits on retroactive eligibility. The policies were approved as part of the New Mexico Centennial Care 2.0 demonstration waiver last year and are expected to impact approximately 700,000 individuals. If implemented, $8 copays for non-emergency visits to the E.R. and for use of non-preferred drugs would take effect in March, and $10 premiums for Medicaid adult expansion members would take effect in July. The state already reduced retroactive eligibility to one month from three effective January 1, 2019, and plans to eliminate retroactive eligibility entirely in 2020. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York State Office of Alcoholism and Substance Abuse Services Releases RFAs to Address Opioid Crisis. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) announced on February 06, 2019, that it has received a State Opioid Response Grant (SOR) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant opportunity aims to address the opioid crisis by increasing access to medication-assisted treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. OASAS has issued five requests for applications (RFAs), worth up to $7,575,000, that target specific components of its strategy for responding to the opioid crisis, including establishing medication-assisted treatment services, peer-driven recovery networks, Buprenorphine induction in hospitals, PAX good behavior games in classrooms, and delivering the Strengthening Families Program. Funding is made possible by the Year 1 State Opioid Response Grant through SAMHSA which ends on September 29, 2019 and is subject to a second year of funding based on federal appropriations. Read More

New York Holds Legislative Hearing on Health Budget. On February 5, 2019, the New York legislature held its Joint Legislative Budget Hearing on Health/Medicaid. The hearing is meant to provide the legislature the opportunity to ask questions about the governor's executive budget proposal, and to hear from stakeholders about their concerns with the budget. The 9-hour hearing began with a presentation from the Commissioner of the Department of Health, Dr. Howard Zucker, and the New York Medicaid Director and Director of New York State of Health, Donna Frescatore. A wide range of stakeholders provided testimony, including hospitals, nursing homes, physicians, nurses, community health centers, consumer groups, labor, pharmacists and pharmaceutical benefits managers, health plans, and disability advocates. A recording of the hearing can be found here

Assembly Reintroduces New York Health Act. *Crain's New York Business* reported on February 11, 2019, that New York Assembly member Richard Gottfried has re-introduced his New York Health Act, which would establish a single-payer system for New York state. The bill has been revised to include long-term care in addition to physician, hospital and pharmaceutical services for every state resident without premiums or cost-sharing payments. As in earlier versions of the bill, the specific tax structure to raise necessary revenue is not identified. State Senator Gustavo Rivera, chair of the Senate Committee on Health, has expressed support for the bill and is likely to introduce it in the Senate as well. Read More

Enrollment in Health Coverage Remains Strong. New York State of Health, the state's official health plan Marketplace, announced that more than 4.7 million New Yorkers had enrolled in health coverage through the Marketplace by the end of the open enrollment period on January 31. This represented an increase of more than 435,000 people from 2018. Among QHP enrollees, 22 percent were new enrollees and 78 percent were renewing coverage; for the Essential Plan (New York's Basic Health Program for individuals with incomes between 133 and 200 percent of the federal poverty level) 12 percent were new enrollees and 88 percent were renewing coverage.

Total enrollment: 4,767,624

- Medicaid: 3,287,846
- Non-Medicaid: 1,479,778
  - Qualified Health Plan: 271,873
  - Essential Plan: 790,152
  - Child Health Plus: 417,753. Read More

North Carolina

NC Faces Appeal from My Health Over Medicaid Managed Care Contract Awards. *The News & Observer* reported on February 12, 2019, that My Health by Health Providers has announced plans to appeal the North Carolina Medicaid managed care contract awards after failing to be named among the winners in the state's recent procurement. The North Carolina Department of Health and Human Services awarded statewide contracts to AmeriHealth Caritas, Blue Cross and Blue Shield, UnitedHealthcare, and WellCare, as well as one regional contract to Carolina Complete Health. The Medicaid managed care program will launch in a test region in November 2019, and all other regions will launch February 2020. Approximately 1.6 million people will be eligible. Read More

Governor Continues to Push for Medicaid Expansion. *The Charlotte Observer* reported on February 12, 2019, that North Carolina Governor Roy Cooper continues to push for Medicaid expansion, calling it "one of the most important life-saving decisions we can make." Democrats have introduced identical Medicaid expansion bills in the House and Senate, and some Republicans appear to be open to the idea. An estimated 500,000 residents would benefit from the expansion. Read More

Ohio

Ohio Medicaid Releases RFP for Actuarial Services for Medicaid Managed Care. On February 11, 2019, the Ohio Department of Medicaid (ODM) released a request for proposals (RFP) for actuarial services for Medicaid Managed Care. ODM is seeking a supplier to assist in gathering and analyzing data to develop program decisions and payment updates to achieve the goal of fiscal soundness and access to quality care. The scope of work includes providing ongoing technical support fiscal monitoring and cost containment, including determination of appropriate reinsurance levels, cost report reviews, single Preferred Drug List reviews, provider taxes, and review of financial performance measures. The inquiry period ends on February 29, 2019. The RFP opening date is March 15, 2019, with an estimated award date of April 3, 2019. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Attorney General Files Suit in Advance of UPMC-Highmark Agreement Expiration. *The Morning Call* reported on February 7, 2019, that Pennsylvania Attorney General Josh Shapiro filed suit against UPMC to prevent it ending its business relationship with Highmark Health. The petition aims to modify and indefinitely extend 5-year-old consent agreement to continue accepting each other's insurance subscribers at their hospitals and physician offices. The current agreement is set to expire June 30. The attorney general's office wants the court to impose a single, modified consent decree that would continue the business relationship between UPMC and Highmark. The petition filed specifically asks the Commonwealth Court to:

- Enable open and affordable access to UPMC's health care services and products through negotiated contracts with any health plan;
- Require last, best-offer arbitration when contract negotiations between insurers and providers fail; and
- Protect against UPMC's unjust enrichment by prohibiting excessive and unreasonable billing practices inconsistent with its status as a non-profit charity providing healthcare to the public. Read More

Pennsylvania To Expand LIFE Program in Multiple Counties. The Pennsylvania Department of Human Services (DHS) announced on February 9, 2019, that it is planning to expand the Living Independence for the Elderly (LIFE) Program, a program under the Federal Program of All-inclusive Care for the Elderly (PACE), to multiple counties. The Department will solicit information from organizations interested in serving one or more of 15 identified counties. The Department will not provide any grant dollars or other payment for the initial development of a LIFE Program. Read More

Rhode Island

Rhode Island NEMT Provider Receives Complaints for Inadequate Service. *McKnight's Long-Term Care News* reported on February 11, 2019, that Rhode Island's newly contracted Medicaid non-emergency medical transportation (NEMT) provider has received more than 1,000 complaints for inadequate service. The head of Medical Transportation Management (MTM), which took over the state's NEMT contract in January, apologized at a state House Oversight Committee hearing. Read More

South Carolina

Medicaid Spending, Enrollment Continues to Increase. *The Post and Courier* reported on February 10, 2019, that South Carolina has seen a 32 percent increase in Medicaid spending over the past eight years, even though the state hasn't expanded Medicaid. In fiscal 2019, Medicaid spending is projected to hit $7.7 billion for 1 million members. According to the South Carolina Department of Health and Human Services data, enrollment among children has risen from less than 500,000 children to more than 650,000 since 2011. Governor Henry McMaster has repeatedly stated that the state cannot afford to fund Medicaid expansion, even with a 90 percent federal match. Read More

Texas

Home Telemonitoring Providers Begin Receiving Medicaid Payments Following Court Order. *The Statesman* reported on February 6, 2019, that several home telemonitoring services are again being reimbursed for Medicaid services, following a court order. The Texas Health and Human Services Commission (HHSC) had stopped accepting telemonitoring claims following a coding change in November. HHSC was ordered by a Texas district judge to again start reimbursing providers. A settlement of the issue is likely, according to HHSC lawyers. Read More

Utah

Utah Passes Partial Medicaid Expansion, Per Capita Cap; CMS Waiver Approval Required. *Modern Healthcare* reported on February 11, 2019, that the Utah legislature has passed a bill to replace the state's voter-approved Medicaid expansion with a partial expansion plan and to institute a per capita cap on federal Medicaid payments to the state. The plan, which Governor Gary Herbert is expected to sign off on, will be submitted to the Centers for Medicare & Medicaid Services (CMS) for approval. Partial expansion would cover individuals up to 100 percent of the poverty level versus 150,000 for the full, voter-approved expansion. Coverage is expected to begin on April 1. Read More

Republicans Consider 'Fallback' in Effort to Replace Voter-Approved Medicaid Expansion. *The Salt Lake Tribune* reported on February 7, 2019, that Utah House Republicans are considering a fallback plan if they fail in their efforts to replace the state's voter-approved Medicaid expansion plan with a partial expansion. If federal regulators deny the waiver, Republicans are considering contingencies that might include full expansion with work requirements. Coverage is expected to begin on April 1. Read More

National

Medicare, Medicaid Control Spending Better Than Private Insurance, Study Finds. *Modern Healthcare* reported on February 11, 2019, that Medicare and Medicaid experienced much slower growth in spending per enrollee than private health insurance in 2016 and 2017, according to an Urban Institute study. The study found that Medicare spending rose 2.4 percent annually per enrollee, Medicaid rose 1.6 percent, and private health insurance rose 4.4 percent. John Holahan, an Urban Institute fellow, said public programs like Medicare and Medicaid have more leverage to keep down provider payment rates. Read More

CMS Releases Interoperability, Patient Access Proposed Rule. The Centers for Medicare & Medicaid Services (CMS) released on February 11, 2019, the Interoperability and Patient Access Proposed Rule, which is aimed at improving the use of electronic health information and data exchange. CMS has also released two Requests for Information (RFI): one on health IT interoperability across settings including long-term care, post acute care, behavioral health, dual eligibles, and home and community-based services; a second on leveraging its authority to improve patient identification and safety to improve care coordination. Read More

Blue States Are Poised to Seek Flexibility in Medicaid Program Design. *The Wall Street Journal* reported on February 10, 2019, that newly Democratic-controlled states are poised to ask federal regulators for flexibility to expand coverage through various initiatives, including single-payer and public health options. The Centers for Medicare & Medicaid Services (CMS) has stressed the notion of giving states additional control and flexibility when it signaled its intent to approve program design changes like work requirements and premiums in Republican-controlled states. "There is no monopoly on good ideas," said CMS administrator Seema Verma. Read More

Medicaid Retroactive Eligibility Waivers Are Expected to Shift Costs to Providers. *Modern Healthcare* reported on February 9, 2019, that federal waivers allowing states to reduce retroactive Medicaid coverage from 90 to 30 days are expected to shift costs to hospitals and other providers. In Florida, a reduction in retroactive eligibility is expected to save the state nearly $100 million. However, officials at Jackson Memorial Hospital in Miami estimate that the policy would have cost the hospital at least $4 million in uncompensated care had it been in effect last year. The Centers for Medicare & Medicaid Services (CMS) has approved waivers in Arizona, Arkansas, Florida, Iowa, and Kentucky and is considering a similar request from Ohio. Maine also received approval but the governor will not be implementing the policy. Read More

Medicare ACOs Opt for Low-Risk Contracts in Revamped Shared Saving Program. *Modern Healthcare* reported on February 2, 2019, that Affordable Care Organizations (ACOs) are opting for low-risk contracts in the revamped Medicare Shared Savings Program (MSSP). Most existing Medicare ACOs are expected to renew their MSSP participation; however, a tight renewal deadline of February 19 has many seeking contracts with less downside risk. After revamping the MSSP program in December, the Centers for Medicare & Medicaid Services (CMS) gave ACOs just two months to decide if they wanted to participate. The program, called Pathways to Success, takes effect July 1. Read More

Senate Bill Aims to Improve Care for Children With Complex Needs. *WeAreIowa.com* reported on February 5, 2019, that Senators Chuck Grassley (R-IA) and Michael Bennet (D-CO) have reintroduced the Advancing Care for Exceptional (ACE) Kids Act, aimed at improving outcomes and care coordination for children on Medicaid with complex medical conditions. About two million children on Medicaid have complex conditions, including cancer, congenital heart disease, cystic fibrosis, Down syndrome, and chronic health challenges from premature birth. Read More

States Approved For Medicaid Work Requirements Lack Plan to Track Impact on Beneficiaries. *The Los Angeles Times* reported on February 6, 2019, that none of the eight states approved to implement Medicaid work requirements have met federal requirements to develop a plan to track whether the program improves health or results in people finding a job. Meanwhile, nine of the 17 states seeking approval for work requirements are being allowed by federal regulators to move forward with their applications despite failing to calculate how many people might lose coverage. Obama-era rules require states to project and track the impact of changes to their Medicaid program prior to receiving federal approval. Read More

Democratic Legislators Introduce Bill Allowing Medicare to Negotiate Drug Prices. *The Hill* reported on February 7, 2019, that Senator Sherrod Brown (D-Ohio) and Representative Lloyd Doggett (D-Texas) unveiled a bill that would allow Medicare to negotiate drug prices in an effort to lower pharmaceutical costs. The legislation faces long odds in the Republican-controlled Senate. Meanwhile, House committees are already beginning to hold hearing on drug pricing, with several different bills under consideration. Read More

Missouri, Tennessee See Decline In Medicaid Enrollment, Raising Concerns Over Eligibility Verification Process. *Kaiser Health News* reported on February 8, 2019, that Medicaid enrollment in Missouri and Tennessee continues to decline as both states increase efforts to verify member eligibility. The efforts have raised concerns among health care advocates over wrongful disenrollment of certain members, especially children. The Missouri Department of Social Services cites a new automated eligibility system, low unemployment, and no federal tax penalty for those without insurance as reasons behind the decline in enrollment. Missouri and Tennessee are non-expansion states. Read More

Industry News

U.S. Renal Care to Be Acquired By Investor Group Including Bain Capital Private Equity. U.S Renal Care, Inc. announced on February 13, 2019, that it has entered into a definitive agreement to be acquired by a private investor group that includes Bain Capital Private Equity. Texas-based U.S. Renal Care operates outpatient treatment centers for individuals suffering from chronic kidney failure. U.S. Renal Care serves about 25,000 patients across 32 states. Financial terms were not disclosed. Read More

CVS to Forego Payment Cuts to 340B Providers. *Modern Healthcare* reported on February 11, 2019, that CVS Caremark has decided to forego previously planned payment cuts to 340B pharmacies. The cuts, which were set to take effect this spring, would have impacted manufacturer rebates and commercial pharmacy rates at 340B hospitals or clinics. Read More

BlueCross BlueShield Venture Partners Invests in Ideal Option. Opioid abuse treatment provider Ideal Option announced on February 6, 2019, that it had secured a minority investment from BlueCross BlueShield Venture Partners (BCBSVP). Kennewick, WA-based Ideal, which provides medication-assisted treatment and behavioral counseling, delivers medication to more than 20,000 patients through 60 office-based opioid treatment clinics in 10 states. Last year, Ideal received an investment from Varsity Healthcare Partners. BCBSVP, which invests in health care companies on behalf of 33 Blue Cross Blue Shield organizations, utilizes Sandbox Industries as its exclusive provider of investment management services. No financial terms were discussed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Massachusetts One Care (Duals Demo)	RFP Release	150,000
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
2019	Louisiana	RFP Release	1,500,000
April 1, 2019	Idaho Medicaid Plus (Dual) - Bonneville, Bingham, Bannock Counties	Implementation	3,329
April 22, 2019	Oregon CCO 2.0	Applications Due	840,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
July 9, 2019	Oregon CCO 2.0	Awards	840,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
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	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

HMA News

Upcoming Webinars:
February 20, 2019 - The Future of Medicaid Expansion: States to Watch for Potential Ballot Initiatives, Other Expansion Efforts. Register here

February 28, 2019 - Military Competency Among Health Care Providers: Best Practices for Screening, Treating and Coordinating Care of Veterans. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Special Needs Plans (SNP) Enrollment by State and Plan, Nov-18 Data
- U.S. Medicaid, CHIP Enrollment at 73 Million, Oct-18 Data
- District of Columbia Medicaid Managed Care Enrollment is Down 3.6%, Sep-18 Data
- District of Columbia SNP Membership at 16,795, Nov-18 Data
- Hawaii SNP Membership at 22,616, Nov-18 Data
- Iowa SNP Membership at 4,069, Nov-18 Data
- Mississippi SNP Membership at 21,581, Nov-18 Data
- Oregon SNP Membership at 24,042, Nov-18 Data
- Puerto Rico SNP Membership at 293,503, Nov-18 Data
- South Carolina SNP Membership at 7,245, Nov-18 Data
- Utah SNP Membership at 7,638, Nov-18 Data
- Virginia SNP Membership at 42,815, Nov-18 Data
- Wisconsin SNP Membership at 39,084, Nov-18 Data
- Georgia Medicaid Management Care Enrollment is Up 1.3%, Feb-19
- Michigan Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- Minnesota Medicaid Managed Care Enrollment is Down 5.8%, Jan-19 Data
- North Carolina Medicaid Enrollment by Aid Category, Feb-19
- New York Dual Demo Enrollment is Down 20.8%, 2018 Data
- New York Dual Demo Enrollment is Down 10.1%, Jan-19 Data
- New York Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- Texas Medicaid Managed Care Enrollment is Flat, Nov-18 Data
- Virginia Medicaid Managed Care Enrollment is Up 22.1%, Jan-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- District of Columbia Medicaid Managed Care RFP, Data Books, and Related Documents, 2018
- Louisiana A Preferred Drug List & Drug Rebate Processing RFP, Feb-19
- Ohio Medicaid Managed Care Actuarial Services RFP, Feb-19
- Oregon Final CCO 2.0 RFA, Attachments, and Letters of Intent, Feb-19
- Virginia Commonwealth Coordinated Care Plus MLTSS MCO Contracts, 2017-19
- West Virginia Medicaid Preferred Drug/Product List & State Maximum Allowable Cost Services RFQ, Feb-19

Medicaid Program Reports, Data and Updates:

- Alaska Governor's Proposed Budget, FY 2020
- Arizona AHCCCS Population Demographics, Feb-19
- Arizona Governor's Proposed Budget, FY 2020
- DC Medicaid MCO External Quality Review Annual Technical Reports, 2014-17
- Delaware Governor's Recommended Budget, FY 2020
- Idaho HCBS Statewide Transition Plan CMS Final Approval, Oct-18
- Illinois Governor's Healthy Children and Families Committee Transition Report, Feb-19
- MassHealth Snapshot Enrollment Summary, 2012-18
- Maryland Hepatitis C Strategic Plan Report, Jan-19
- Minnesota DHS EQR Annual Technical Report, 2016
- Minnesota Managed Care Satisfaction Survey Results, 2015-17
- Minnesota Medicaid Managed Care Comprehensive Quality Strategy, Jun-18
- Missouri Rapid Response Review Assessment of Missouri Medicaid Program, Feb-19
- Mississippi Governor's Executive Budget Recommendation, FY 2020
- Mississippi Home and Community Based Services and Long-Term Care Waivers, 2015-18
- New Mexico Medicaid Rate Certifications and Rate Sheets, CY 2015-18
- Texas HHS Medicaid Budget Overview Presentation, Feb-19
- Texas HHS State Hospital Redesign Presentation, Feb-19
- Utah 1115 Primary Care Network Demonstration Waiver Documents, 2016-19
- West Virginia Governor's Recommended Budget, FY 2020

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