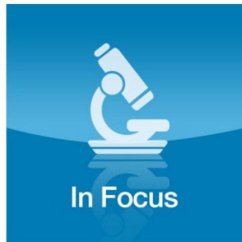
Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

March 20, 2019



RFP Calendar

HMA News

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This Week

- In Focus: Analysis of Key Medicare Proposals in the President's FY 2020 Budget
- In Focus: Patient Protection and Affordable Care Act; 2020 Proposed Notice of Benefit and Payment Parameters
- Florida House Panel Votes to Make 30-Day Retroactive Medicaid Eligibility Permanent
- Illinois Governor Proposes Medicaid MCO Tax to Improve Care, Reduce Cost to Taxpayer
- Kansas Senate, House Committees Remove Medicaid Expansion Funding From Proposed Budget
- Pennsylvania Experiences Bumpy Transition to Community HealthChoices Dual Eligible Program
- Texas Releases Outline of IDD Strategic Plan
- Medicaid Drug Spending Grows 14.8 Percent from 2013-17
- Not-For-Profit Health Systems Post Significant 2018 Investment Losses
- HMA Welcomes: Katie Rogers (Seattle, WA) and John Volpe (New York, NY)
- Will Hospitals Serving Racial and Ethnic Minorities Lose Out in a Value-Based Payment World?
- New This Week on HMAIS

Registration Is Now Open for HMA's 2019 Conference on The Next Wave of Medicaid Growth and Opportunity

Register now for HMA's fourth annual conference on *Trends in Publicly Sponsored Healthcare*, September 9-10 at the Chicago Marriott Downtown Magnificent Mile. Register here: https://conference.healthmanagement.com/

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*.

Last year's conference brought together 460 high-level executives from health plans, providers, state and federal government, community-based organizations and others serving Medicaid, including 45 industry leading speakers. Similar attendance is expected for the 2019 event.

And don't forget to sign up for our pre-conference workshop on Sunday, September 8, on the *Inner Workings of Medicaid: State-by-State Program Basics and Key Variations*, an introductory session on the basic building blocks of Medicaid.

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

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

State Medicaid Speakers to Date (In alphabetical order)

- Mari Cantwell, Chief Deputy Director, Health Care Programs, California Dept. of Health Care Services
- Mandy Cohen, MD, Secretary, North Carolina Department of Health and Human Services
- Doug Elwell, Medicaid Director, Illinois Department of Healthcare and Family Services
- Karen Kimsey, Chief Deputy, Virginia Department of Medical Assistance Services
- Dennis Smith, Senior Advisor, Medicaid and Health Care Reform, Arkansas Department of Human Services
- Jami Snyder, Director, Arizona Health Care Cost Containment System
- Betsey Tilson, MD, State Health Director, Chief Medical Officer, North Carolina Department of Health and Human Services
- Carol Steckel, Commissioner, Kentucky Division of Medicaid Services

Medicaid Managed Care Speakers to Date (In alphabetical order)

- Heidi Garwood, President Medicaid, Health Care Service Corp.
- Janet Grant, Regional Vice President, Great Plains Region, Aetna Medicaid
- Brad Lucas, MD, Senior Medical Director, Buckeye Health Plan
- Joanne McFall, Market President, Keystone First Health Plan
- Kevin Moore, VP, Policy, Health & Human Services, UnitedHealthcare Community & State
- Dennis Mouras, CEO, UnitedHealthcare Community Plan of Michigan
- Lois Simon, EVP, Policy and Programs, Seniorlink
- Patrick Sturdivant, President, Virginia Medicaid Health Plan, Anthem, Inc.
- Paul Tufano, Chairman, CEO, AmeriHealth Caritas

Provider Speakers to Date (In alphabetical order)

- Alan Cohn, CEO, President, AbsoluteCARE Inc.
- Deepu George, Division Chief - Behavioral Medicine, Dept. of Family & Preventive Medicine, UTHealth
- Mitchell Katz, MD, President and CEO, NYC Health + Hospitals
- Rebecca Kavoussi, President, West, Landmark Health
- Sharon Raggio, President, CEO, Mind Springs Health
- René Santiago, Deputy County Executive, County of Santa Clara, CA

Other Speakers to Date (In alphabetical order)

- Jonathan Blum, Managing Principal, HMA; former CMS Deputy Administrator for Medicare
- Corey Waller, Principal, HMA (Lansing, MI)
- Tracy Wareing Evans, Executive Director, American Public Human Services Association

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IN FOCUS

ANALYSIS OF KEY MEDICARE PROPOSALS IN THE PRESIDENT'S FY 2020 BUDGET

This week, our *In Focus* comes to us from HMA Senior Consultant Narda Ipakchi. On March 11, 2019, the White House released President Trump's budget for fiscal year (FY) 2020, which includes a number of legislative and administrative proposals related to Medicare that would reduce net Medicare spending by $811 billion over the next ten years. It is important to note that the legislative proposals included in the President's budget are non-binding and serve as recommendations to Congress where they may or may not be advanced. Under a Democratic-majority House of Representatives, many of the legislative proposals outlined in the FY 2020 budget are unlikely to advance. Several of the policies, however, such as reductions to Medicare bad debt and implementing site neutral payment systems were also proposed by the previous administration. Administrative proposals are more likely to move forward, as the administration can implement these policies through its regulatory channels.

Overall, the Medicare proposals in the President's budget are consistent with this administration's stated goals of lowering the cost of prescription drugs, expanding value-based payment programs, reducing administrative burden, and improving price transparency. Key Medicare provisions of the President's FY 2020 budget are highlighted below:

Legislative Proposals

- **Reducing Part D out-of-pocket spending** by: 1) ending the practice allowing manufacturer discounts to count toward a beneficiary's out-of-pocket costs in the coverage gap, 2) eliminating cost-sharing for generics for low-income beneficiaries, and 3) increasing Part D private plan liability in the catastrophic phase from 15 percent to 80 percent while eliminating beneficiary coinsurance and decreasing Medicare program's liability from 80 percent to 20 percent.
- **Increasing drug price transparency and strengthening negotiating power** with drug manufacturers by: 1) consolidating certain Part B drugs into Part D to leverage private plan negotiations, 2) penalizing manufacturers that do not report required average sales price (ASP) data necessary for payment accuracy, 3) reducing the payment rate for single source drugs, biologics and biosimilars, and 4) imposing penalties on manufacturers that pay competitors to delay release of generic/biosimilar products when a drug is about to lose market exclusivity.
- **Continuing to combat the opioid crisis** by requiring the Centers for Medicare & Medicaid Services (CMS) to report to the Drug Enforcement Agency (DEA) providers revoked from Medicare or placed on preclusion lists for patterns of abusive prescribing of controlled substances.

- **Increasing participation in alternative payment models (APMs)** by establishing an exception to the Physician Self-Referral Law (Stark Law) for APM participants, revising the ACO beneficiary assignment process to allow non-physician primary care providers to align beneficiaries to their ACO, and simplifying reporting requirements for the Merit-based Incentive Payment System (MIPS)
- **Reducing overall payments to hospitals for uncompensated care and graduate medical education (GME)** by placing new caps on the total amounts of funds and limiting annual funding growth. The total amount of uncompensated care funds available will be capped at FY2019 funding levels and grown annually by the Consumer Price Index for All Urban Consumers (CPI-U). The budget also proposes to distribute payments based on share of charity care and non-Medicare bad debt. Under the GME proposal, medical education payments would be consolidated into a single grant program. Total available funds would be capped at 2017 payments, adjusted for inflation, and would grow at CPI-U minus one percentage point annually. Funding would be distributed based on the number of residents and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients.
- **Reforming hospital value-based purchasing (VBP) programs** to consolidate existing hospital quality reporting programs and implementing a new VBP program for outpatient hospitals and ambulatory surgical centers (ASCs). The budget also proposes redesigning outpatient hospital and ASC payment systems to adjust for the severity of patient diagnoses.
- **Advancing site neutrality** through: 1) creation of a unified post-acute care payment system, 2) aligning reimbursement for on-campus hospital outpatient departments and physician services, 3) requiring hospital-owned physician offices located offsite to be reimbursed under the Physician Fee Schedule, and 4) increasing the eligibility threshold for long term care hospitals from three days in an intensive care unit to eight days.
- **Reducing Medicare coverage of bad debts** from 65 percent to 25 percent over three years, with exceptions for certain rural settings, Federally Qualified Health Centers, and Critical Access Hospitals.
- **Increasing competition for Durable Medical Equipment (DME)** by reimbursing suppliers based on their own bid amounts as opposed to the maximum bid in a given area as well as expanding coverage to non-durable alternatives to DME.
- **Reducing fraud, waste, and abuse** through a number of program integrity proposals that would: 1) impose penalties on providers for ordering high-risk, high-cost items or services without proper documentation, 2) expand prior authorization to additional fee-for-service items at high risk for fraud an abuse, and 3) require confirmation of diagnoses submitted by Medicare Advantage (MA) plans prior to CMS making risk-adjusted payments.

Administrative Proposals

- **Encouraging adoption of high-value technologies and devices** through bundled payment demonstrations.
- **Improving MA payment accuracy** by expanding risk adjustment data validation audits and transitioning to risk score calculations weighted more heavily toward encounter-based data than fee-for-service data: 75 percent in 2021 and 100 percent in 2022. This proposal aligns with CMS' goals to transition to 100 percent encounter data in 2022 as stated in the 2020 Advance Notice and Draft Call Letter.
- **Reducing utilization of low-value services paid by Traditional Medicare** through new prior authorization demonstrations.

HMA Next Steps

HMA continues to analyze these proposals and others included in the President's budget. For more information or questions about the President's budget or other legislative or regulatory proposals, please contact Narda Ipakchi.

Patient Protection and Affordable Care Act; 2020 Proposed Notice of Benefit and Payment Parameters

This week, our *In Focus* reviews the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020. The new proposed rule does not contain as many major changes as the 2019 rule, but there are requests for comment on potentially important rulemaking starting in 2021 and guidance on important policy, such as:

- Streamlining of Direct Enrollment regulations for and new definitions of entities participating in Direct Enrollment
- New rules related to plan formularies and Essential Health benefits
- A decrease in Federally-Facilitated Exchange (FFE) and State-Based Exchange on the Federal Platform (SBE-FP) user fees
- The practice of "silver-loading" was not prohibited, but rulemaking could be forthcoming in the absence of Congressional action to appropriate funds for cost-sharing reductions
- A new methodology for calculating Premium Adjustment Percentage that reflects a faster premium growth rate, which could have significant effects on premiums and enrollment
- A new Special Enrollment Period for off-Exchange individual market enrollees who experience a decrease in household income and receive a new determination of eligibility for advanced payment of the premium tax credit by an Exchange
- An admonition against discrimination related to Medication-Assisted Treatment
- Creation of "mirror Qualified Health Plans" to encourage enrollment by consumers who wish to enroll in a QHP but object to having non-Hyde abortion benefits included in their coverage.

1. Automatic Re-Enrollment

The Centers for Medicare & Medicaid Services (CMS) expresses concerns related to automatic re-enrollment of enrollees in Qualified Health Plans (QHPs). The agency states that automatic re-enrollment might prevent QHP enrollees from updating their coverage and premium tax credit eligibility as their personal circumstances change, potentially leading to less than adequate coverage, eligibility errors, tax credit miscalculations, and unrecoverable federal spending on such credits. CMS seeks comment on the automatic re-enrollment processes and capabilities for potential future rulemaking no sooner than plan year 2021.

2. Guaranteed Renewability and Formularies

The rule proposes to allow issuers to update their prescription drug formularies by allowing certain mid-year formulary changes, subject to applicable state law, to optimize the use of new generic drugs as they become available. An issuer must provide affected enrollees with at least 60 days' notice before removing or moving a drug to a higher-cost tier. Issuers also must provide a coverage appeal process for affected enrollees. This change would apply to the individual, small group, and large group markets.

3. Risk Adjustment

The rule proposes to recalibrate the risk adjustment models consistent with the methodology finalized for the 2019 plan year and the incorporation of blended plan years of MarketScan (2017) and enrollee-level EDGE (2016 and 2017) data that are available. The rule maintains the risk adjustment model categories used for the 2019 plan year and retains, for high-cost risk pooling, the same $1 million exclusion threshold and 60 percent coinsurance rate for all state individual and small group markets.

4. Navigators

CMS proposes to provide more flexibility to Navigators by streamlining training requirements and making permissive, not required, certain types of post-enrollment assistance unless required by an SBE or an SBE-FP. The rule also proposes to give Exchanges increased flexibility related to Navigator training to insure coverage of the most important topics related to the operation of that exchange.

5. Direct Enrollment

To better describe functions and responsibilities of entities participating in direct enrollment, the proposed rule provides definitions of "direct enrollment entities," "web-brokers," and "direct enrollment technology providers."

The proposed rule includes new provisions to require that web-broker websites used to complete QHP selection comply with applicable federal requirements and prohibits websites from displaying recommendations for QHPs based on compensation that the web-broker, agent, or broker receives from QHP issuers. Additionally, the proposed rule allows the Department of Health and Human Services (HHS) immediately to suspend an agent's or broker's ability to transact business with The Exchange if that entity's actions create an unacceptable risk to Exchange operations. HHS also would be able to terminate the entity's Exchange agreement if that entity is not licensed in every state within which the entity actively assists Exchange consumers to select or enroll in QHPs.

The rule proposes to revise 45 CFR 155.221 to apply to all types of direct enrollment entities, expanding the requirements included in that regulation beyond only audits of direct enrollment entities. The rule proposes that third-party auditors of direct enrollment entities must demonstrate operational readiness and must be independent of the entities they are auditing. The rule also proposes to require direct enrollment entities to display and market QHPs and non-QHPs on separate website pages on their non-Exchange websites.

6. Special Enrollment Periods

The rule proposes to authorize Exchanges to provide an optional special enrollment period (SEP) to enroll in Exchange coverage for off-Exchange individual market enrollees who experience a decrease in household income and receive a new determination of eligibility for advanced payment of the premium tax credit (APTC) by an Exchange. This SEP would apply to qualified individuals (QIs) and their dependents whose household income decreases and the QI or his or her dependent are both newly determined eligible for APTC by an Exchange and had coverage (pregnancy Medicaid, CHIP unborn child, Medically-Needy Medicaid, and minimum essential coverage as described at 26 CFR 1.5000A-1(b)), in which they were enrolled and under which they were entitled to receive benefits for one or more days during the 60 days preceding the change in circumstances. QIs or their dependents must verify the attested change in household income and health prior coverage.

7. User Fees

The rule proposes to lower for the 2020 plan year user fees for participating FFE issuers to 3.0 percent of total monthly premiums (from 3.5 percent) and the fee for issuers offering QHPs through an SBE-FP to 2.5 percent of total monthly premiums (from 3.0 percent). CMS notes that this fee decrease reflects their expectation for premium increases and enrollment decreases for the 2020 plan year.

8. Exemptions

For tax year 2018 only, the rule proposes to allow individuals to claim hardship exemptions through the IRS tax filing process alone, with no need to obtain an exemption certificate from the Exchange.

9. Silver-Loading

The proposed rule does not prohibit “silver-loading,” the practice of increasing premiums on silver plans in order to increase premium assistance, in the form of premium tax credits, to offset the loss of cost-sharing reduction (CSR) payments. Increasing the premium on silver plans, the benchmark for the calculation of premium tax credits, has increased federal expenditures and the practice might be the subject of future rulemaking (in the absence of the Trump Administration’s preferred alternative, the appropriation of funds by Congress for the resumption of CSR payments) occurring no earlier than 2021.

10. Essential Health Benefits

CMS proposes to require that QHP issuers who made a mid-year formulary change during the prior plan year under the proposed amendment to 45 CFR 147.106(e) submit notice to CMS, including information such as (but not limited to) the name of the drug being removed from the formulary, the dosage, and the generic equivalent. The rule seeks comment on whether such generic substitution policies, along with therapeutic substitution, should be pursued together in order to offset any premium impact of either strategy. The rule also seeks comment on whether certain drug categories and classes are better suited to therapeutic substitution than others and on existing standards of practice for therapeutic substitution, including whether those standards are nationally recognized and readily available for providers to use. Finally, the rule seeks comment on the opportunities and risks of implementing or incentivizing reference-based pricing for prescription drugs.

CMS also discusses potential discrimination related to Medication-Assisted Treatment (MAT), noting that some issuers utilize plan designs which exclude coverage of certain drugs when used for MAT although the same drugs are covered for other medically-necessary purposes, such as analgesia or alcohol use disorder. CMS reminds QHP issuers that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. CMS also states that indication of a reduction in the generosity of a benefit for certain individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory. If a plan excludes certain treatment of opioid use disorder but covers the same treatment for other medically necessary purposes, the issuer must be able to justify such an exclusion with supporting documentation explaining how such a plan design is not discriminatory.

11. Premium Adjustment Percentage

CMS proposes an alternative premium measure that captures increases in individual market premiums, both on and off Exchanges, in addition to increases in employer-sponsored insurance premiums for purposes of calculating the premium adjustment percentage for the 2020 plan year and beyond. CMS foresees that the proposed premium adjustment percentage calculation could result in a faster premium growth rate for the foreseeable future than if it continued to use only employer-sponsored insurance premiums as in prior plan years.

Such a measure of premium growth reflecting a faster premium growth rate probably would increase the portion of the premium the consumer is responsible for paying, decreasing the amount of premium tax credit for which consumers qualify. It also might cause more individuals with an offer of employer-sponsored insurance to be ineligible for the premium tax credit and would give rise to higher employer shared responsibility payment amounts. CMS notes that the purpose of this policy change is to counteract the effects of "silver-loading" in 2018, which resulted in a significant increase in tax credit expenditures. This new methodology would help to slow the increase in premium tax credit expenditures that results from "silver-loading," reducing taxpayer burden but possibly contributing to a decline in Exchange enrollment among premium tax credit-eligible consumers, resulting in net premium increases for enrollees that remain in the individual market, both on and off the Exchanges, as healthier enrollees elect not to purchase Exchange coverage.

12. Cost-Sharing

CMS proposes, subject to applicable state law, to allow a plan that covers both a brand prescription drug and its generic equivalent, for plan years beginning on or after January 1, 2020, to consider the brand drug to not be EHB, if the generic drug is available and medically appropriate for the enrollee, unless coverage of the brand drug is determined to be required under an exception process. CMS also is considering allowing an issuer to except from the annual limitation on cost-sharing the entire amount paid by a patient for a brand drug for which there is a medically appropriate generic alternative. These proposed alternatives would apply to group health plans, group health insurance coverage, and individual market coverage, regardless of whether they are required to cover EHBs. If either option is finalized, the change would permit all group health plans and group health insurance issuers to impose lifetime and annual dollar limits on such brand drugs because they would no longer be considered EHB subject to the prohibition on such limits. Additionally, neither the premium tax credit nor APTC could be applied to any portion of the premium attributable to coverage of brand name drugs not covered as EHB, so QHP issuers would be required to calculate that portion of premium and report it to the applicable Exchange.

CMS also proposes that amounts paid toward cost-sharing using any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent are not required to be counted toward the annual limitation on cost-sharing.

13. Segregation of Funds for Non-Hyde Abortion Services

CMS expresses concern that some consumers who wish to enroll in a QHP may object, based on religious or moral beliefs, to having non-Hyde abortion benefits included in their health insurance coverage. CMS proposes that, to the extent permissible under state law, if a QHP issuer provides coverage of non-Hyde abortion services in one or more QHPs, the QHP issuer also must offer, in each applicable service area, at least one "mirror QHP" that provides benefit coverage identical to one of the QHPs with non-Hyde abortion coverage, omitting coverage of non-Hyde abortion services. The QHP issuer would determine at which metal level the "mirror QHP" is offered.

Link to Proposed Rule
For more information, please contact Ryan Mooney.

HMA MEDICAID ROUNDUP

Alaska

Alaska Proposes $95 Million in Medicaid Spending Cuts for Fiscal 2020. *The Anchorage Daily News/Associated Press* reported on March 19, 2019, that Alaska Governor Mike Dunleavy is seeking a $95 million reduction in state Medicaid spending for the upcoming fiscal year as part of first phase of a spending reduction plan. Cuts would total $225 million in the second phase. The initial cuts include Medicaid provider rate reductions and limits on the number of annual adult Medicaid visits for physical, occupational, or speech therapy. Read More

Arkansas

Arkansas Says Another 13,000 Medicaid Beneficiaries Failed to Meet Work Requirement. *CQ Health* reported on March 15, 2019, that another 13,373 individuals failed to meet Arkansas' Medicaid work requirements in February 2019. Individuals who don't meet the requirements for three months lose coverage for the year. More than 18,000 beneficiaries lost Medicaid coverage in 2018. The requirement is being challenged in federal court, with a ruling expected by April 1. Read More

Florida

House Panel Votes to Make 30-Day Retroactive Medicaid Eligibility Permanent. *New4Jax/The News Service of Florida* reported on March 19, 2019, that the Florida House Health Care Appropriations Subcommittee advanced a bill that would cut $103 million from Medicaid by permanently reducing retroactive Medicaid eligibility from 90 to 30 days. An accompanying bill would also require the state to remodel its existing Medicaid waiver program for individuals with developmental disabilities if the program runs a deficit in fiscal 2019. Read More

House Subcommittee Advances Medicaid Work Requirements Bill. *WFSU Public Media* reported on March 13, 2019, that the Florida House Health Market Reform Subcommittee cleared a Medicaid work requirements bill. The measure, sponsored by Representative Daniel Perez (R-Miami), would require individuals with children over three months old and adults age 19 to 20 to work, participate in community engagement, or receive vocational or educational training for no more than 40 hours a week to maintain coverage. If passed, the measure would require federal approval before going into effect. Read More

Georgia

Senate Committee Votes In Favor Of Behavioral Health Commission. *Georgia Health News* reported on March 13, 2019, that a Georgia Senate Committee approved a bill to create a 23-member behavioral health commission to study the state's mental health system and make recommendations for improvement. The measure, sponsored by Representative Kevin Tanner (R-Dawsonville), has already been approved by the Georgia House. Read More

Idaho

House Lawmaker Reintroduces Bill To Limit Voter-Approved Medicaid Expansion. *The State/Associated Press* reported on March 18, 2019, that Idaho Representative John Vander Woude (R-Nampa) reintroduced a bill to limit the state's voter-approved Medicaid expansion program. The bill, introduced in the House Health and Welfare Committee, would require individuals at 100 to 138 percent of the federal poverty level to continue to purchase Exchange coverage. It would also implement Medicaid work requirements. The House committee previously delayed a vote on the bill after lawmakers heard testimonies in opposition. A hearing on the measure is set for March 20, 2019. Read More

Illinois

Governor Proposes Medicaid MCO Tax to Improve Care, Reduce Cost to Taxpayer. *The State Journal-Register* reported on March 19, 2019, that Illinois Governor J.B. Pritzker has proposed new taxes on Medicaid managed care plans in an effort to improve patient care while reducing the cost to taxpayers. Pritzker's has proposed a $25.1 billion budget for the state Department of Healthcare and Family Services (DHFS) for fiscal 2020, most of which goes to Medicaid. New managed care taxes would go toward a special fund for provider reimbursements. Read More

House Committee Advances Bill Requiring Medicaid Plans to Expand Autism Coverage. *The Herald & Review/Capitol News Illinois* reported on March 14, 2019, that the Illinois House Mental Health Committee advanced a bill which would require Medicaid managed care plans to cover autism diagnosis and treatment, including applied behavioral analysis, for individuals under 21 years. The bill, sponsored by Representative Deb Conroy (D-Villa Park), now moves to the full House for review. Read More

Iowa

Senate Approves Medicaid Work Requirements. *The Des Moines Register* reported on March 19, 2019, that the Iowa Senate has approved a Medicaid work requirements bill. The measure, which may affect about 70,000 beneficiaries, would require beneficiaries to work or participate in volunteer programs at least 20 hours a week to maintain coverage. If approved, the law would need federal approval before being implemented. The legislation now heads to the House for a vote. Read More

Kansas

Kansas Names Lee Norman Health Secretary. The Kansas Senate voted on March 14, 2019, to unanimously confirm the appointment of Lee Norman, MD, to serve as Secretary of the Kansas Department of Health and Environment (KDHE), which oversees Medicaid. Norman also serves as chief health officer of Kansas and most recently was with the University of Kansas Health System. Read More

Senate, House Committees Remove Medicaid Expansion Funding From Proposed Budget. *KFDI/Associated Press* reported on March 14, 2019, that two Republican-led committees have removed Medicaid expansion funding from Democratic Governor Laura Kelly's proposed fiscal year 2020 budget. Both the Senate Ways and Means Committee as well as the House Appropriations Committee voted to remove funds earmarked for expansion, which has bipartisan support. Read More

Montana

Lawmakers Hear Public Testimony Over Dueling Medicaid Expansion Bills. *The News & Observer/Associated Press* reported on March 16, 2019, that Montana lawmakers on the House Health and Human Services Committee heard public testimony over dueling bills with different visions on continuing Medicaid expansion in the state. A bill from Representative Mary Caferro (D-Helena) would maintain the provisions of the original program and increase funding for voluntary workforce training. A competing bill from Representative Ed Buttrey (R-Great Falls) would add Medicaid work requirements requiring 20 hours of community engagement activities each week for able-bodied adults. Medicaid expansion in Montana serves 96,000 individuals and is expected to end in June 2019 if lawmakers don't come to an agreement. Read More

New Hampshire

Senate Passes Bill that Could End Medicaid Work Requirements. *The New Hampshire Union Leader* reported on March 14, 2019, that the New Hampshire Senate passed a bill that would end Medicaid work requirements for expansion enrollees if over 500 individuals are kicked off the program. The bill would also ease restrictions on which individuals are exempt from the requirement. Last year, the legislature voted to extend the state's Medicaid expansion program, which covers 50,000 individuals, for an additional five years. Read More

New Jersey

New Jersey Eases Rules on Shared Clinical Space for Behavioral Health, Substance Abuse Treatment. The New Jersey Department of Health announced on March 18, 2019, new guidance permitting health care facilities that provide both mental health and substance use disorder services to share clinical space. The guidance also permits deemed status for accredited substance use disorder facilities in place of required periodic inspections. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Hospital Revenue, Medicaid Funding Increased between 2012-16, Report Finds. A recent report released by the Empire Center found that total New York hospital revenue and Medicaid funding increased between 2012 and 2016, at rates higher than national averages, although inpatients served declined slightly. The report reviews which hospitals benefited from the increase in funding. Approximately one-quarter of the state's hospitals experienced growth in the number of inpatients treated and a positive bottom line. Alternatively, three-quarters of hospitals experienced declining demand, and over half were in deficit. The report raises concerns about hospitals with dominant market position generating higher prices, as well as potentially driving smaller hospitals out of business, with implications for access to care. Read More

New York Budget Negotiations Underway. New York Governor Andrew Cuomo introduced his Executive Budget for fiscal year 2019 on January 15, 2019. The Assembly and Senate introduced their one-house budget bills on March 12. For the first time since the Medicaid Redesign Team introduced a Global Spending Cap for New York's Medicaid program, the governor proposed increasing Medicaid spending by 3.6 percent, above the 3.1 percent allowed under the global cap. During the 30-day budget amendments, he rescinded that increase, keeping the growth in Medicaid spending to the limit allowed under the Global Spending Cap. After both houses of the legislature rejected the cut, as well as massive protest from the hospital industry, he backed down from the cut, going back to his original proposal. The state Budget Director Robert Mujica has indicated that the state must find equivalent savings, totaling $550 million, elsewhere in the budget. Budget negotiations are on-going with the goal of passing a budget in time for the April 1 start of the new state fiscal year. Below are some budget highlights and a discussion of differences between the three parties.

Universal Access to Health Care

One of the most significant pieces of health care legislation likely to be considered early in the legislative session (which began on January 9) is a single-payor proposal called the New York Health Act. The New York Health Act, drafted by Assembly member Richard Gottfried, has passed the Assembly in each of the last four years, and the bill has already been passed by the Assembly Health Committee. The newly named Chair of the Senate Committee on Health, Senator Gustavo Rivera, has indicated his support for the proposal, and will be holding hearings soon. Governor Cuomo has indicated that while he supports a single payer concept, he has concerns about the feasibility of such a plan being implemented on a state level. His budget proposal does not directly address the single payor question; instead it proposes establishing a Commission on Universal Access to Health Care. The Commission, made up of "independent health policy and insurance experts," would review options for achieving universal access to care. The commission would report back to the governor in December 2019.

Both the Assembly and the Senate reject the governor's proposal to establish a Universal Access Commission, arguing that it just delays the issue of single payor.

Pharmacy Costs

The executive budget proposes requiring pharmacy benefit managers to be licensed and registered, with mandatory reporting of any financial incentives or benefits they might have. The Senate budget would increase penalties for violations, increasing transparency requirements, and prohibiting PBM's requiring substitution of a prescribed drug without the approval of the prescriber. The Assembly makes no change to the executive proposal.

Fiscal Intermediaries for Consumer-Directed Program

The executive budget proposes changing the way that fiscal intermediaries (FI) are reimbursed from a percentage of fees to a set PMPM. The state believes that the administrative functions performed by FIs does not vary based on the intensity of services provided, and that those fees should be standardized. Last year's budget capped the number of fiscal intermediaries that health plans could contract with. This year the budget proposes further consolidation, reducing the 600 currently practicing FIs by 90 percent. Both the Assembly and the Senate reject the executive proposal, concerned about ensuring access to care is not interrupted.

Managed Long-Term Care

The executive budget did not address on-going concerns about the managed long-term care rate setting process, and the adequacy of rates to meet the cost of care for the highest-need members. The Assembly budget again includes a proposal to establish a separate rate for high need enrollees, something that had been included in both the Assembly and Senate budget proposals last year. The Senate proposal also includes language to ensure rate adequacy for MLTCs.

Capital Funding

The proposed budget does not include new capital funding for health care facilities, as $725 million in prior funding has not yet been awarded. The budget would allow the Department of Health to award $300 million of last year's $525 million allocation to entities that had submitted an application but were denied in prior rounds of funding. The Assembly would add an additional $25 million in funding to children's residential treatment facilities, mental hygiene clinics, hospices, and community-based health care providers. The Senate proposes requiring that a minimum of $20 million be attributed to Assisted Living Programs.

DSRIP and System Transformation

Over the first 3 years of New York's Delivery System Reform Incentive Payment program, the state has seen a 17 percent reduction in avoidable hospitalizations. To further encourage efforts to reduce avoidable hospitalizations, and to continue efforts to strengthen the primary care delivery system, the budget proposes reducing inpatient payments to hospitals that have not reduced their avoidable hospitalization rates, and invest those dollars into higher fees paid to primary care and maternity providers. Both the Assembly and the Senate rejected that proposal.

Nurse Staffing Requirements

The Senate budget resolution includes a request that the Department of Health launch a stakeholder process examining "how staffing enhancements can improve patient safety and the quality of healthcare service delivery, including the fiscal impact of these staffing enhancements on healthcare providers." The New York State Nurses Association has championed a nurse staffing ratio bill for several years, a proposal that is strongly opposed by the hospital industry.

Indigent Care

In the 30-day amendments the governor proposed a cut to the state's indigent care pool of $275 million. This was in part as a response to the work of the Indigent Care Pool Task Force, established in last year's budget, which recently released a report on its findings. There is widespread consensus that the current allocation formula does not adequately support those hospitals that provide the bulk of care to the uninsured, but there is little agreement on how to revise the formula. Both houses reject the governor's proposed cut. The Assembly budget does not address the Indigent Care formula at all; the Senate supports changes to the formula that "will adequately reimburse hospitals that provide a higher percentage of uncompensated care," but provided no additional detail.

Ohio

Medicaid Work Requirements Approved. On March 15, 2019, the Ohio Department of Medicaid released a report detailing the approval of Ohio's work requirement and community engagement waiver for able-bodied Ohioans in the Medicaid expansion population. The Centers for Medicare & Medicaid Services (CMS) approved the waiver that states Ohio expansion enrollees will need to demonstrate 20 hours of work per week. Allowable work includes activities such as job search, education and training, or community service. The waiver is meant to promote economic self-sufficiency. Read More

Ohio Files Lawsuit to Recover $16 Million From Workers Comp PBM. *The Columbus Dispatch* reported on March 18, 2019, that Ohio Attorney General Dave Yost filed a state lawsuit seeking to recover $16 million from the company that manages pharmacy benefits for the state Bureau of Workers' Compensation (BWC). According to Yost, the overcharges were attributable to a failure to adhere to agreed discounts on generic drugs for almost three years. OptumRx handles PBM services for BWC. Read More

Oklahoma

House Approves Medicaid Expansion Based on Local Tax Plan. *The Tulsa World* reported on March 13, 2019, that the Oklahoma House approved a Medicaid expansion bill in which newly created local hospital and health care districts would levy taxes aimed at drawing federal matching funds. The measure, which was sponsored by House Speaker Charles McCall (R-Atoka), now heads to the Senate for review. If passed, the bill would require a federal waiver to implement. Read More

Oregon

Oregon Enacts Hospital, Insurance Tax to Fund Medicaid Shortfall. *The Associated Press* reported on March 13, 2019, that Oregon has enacted a six-year tax on hospitals and insurance plans to help fund the state's $950 million Medicaid shortfall. The measure is expected to raise more than $430 million. Possible taxes on tobacco, e-cigarettes, and employers that don't provide adequate, affordable health coverage could make up the rest. Read More

Pennsylvania

Pennsylvania Experiences Bumpy Transition to Community HealthChoices Dual Eligible Program. *The Inquirer* reported on March 19, 2019, that Pennsylvania patients and providers have experienced confusion over the rollout of the state's Community HealthChoices (CHC) dual eligible managed care program. Effective January 1, 2019, CHC required dual members to belong to one of three managed care plans: Keystone First, UPMC Community HealthChoices, or Pennsylvania Health and Wellness. Some 60 percent of the state's dual-eligible population were assigned to a plan because they didn't choose one. Read More

Rhode Island

Lawmakers Review Plan to Tax Large Companies for Having Employees on Medicaid. *The Providence Journal* reported on March 18, 2019, that nearly 200 Rhode Island employers have at least 50 employees on Medicaid and at least 10 have more than 300 employees on Medicaid, according to a report released by the Rhode Island Executive Office of Health and Human Services (EOHHS). Governor Gina Raimondo has proposed taxing large companies 10-percent of wages (up to $1,500 per individual) for each employee on Medicaid. The House Finance Committee is expected to hold a hearing on the tax on March 19, 2019. Read More

Tennessee

Tennessee Launches Medicaid Eligibility Determination System. *The Tennessean* reported on March 18, 2019, that Tennessee has launched a $400 million Medicaid application processing system, including a web portal, call center, and internal computer system for eligibility determinations. The system release was delayed by five years. Read More

Bill Would Help Families Pay for Care of Children With Disabilities. *The Tennessean* reported on March 13, 2019, that Tennessee lawmakers have proposed a bill to help ease the financial burden on families of children with long-term disabilities or complex medical needs. The bill is aimed at families with incomes too high to qualify for Medicaid. The two-part plan would include: 1. a pathway to Medicaid services and wraparound home and community-based services for children with disabilities; 2. a Medicaid diversion plan in which the Tennessee Department of Intellectual and Developmental Disabilities offers a capped package of services on a sliding fee scale. If the bill passes, an additional budget amendment would be needed to fund the measure. Read More

Texas

Texas Releases Outline of IDD Strategic Plan. The Texas Health and Human Services Commission (HHSC) released on March 20, 2019, the outline for the state's first Intellectual and Developmental Disability strategic plan. The plan is intended to guide the state as it develops new interventions, models of care and best practices for individuals with developmental disabilities. The outline is the first phase in the development of a full plan, which is expected to be released in the late summer of 2019. Read More

Utah

Utah Alliance Led by Intermountain Selects Social Determinants of Health Software. *HealthData Management* reported on March 18, 2019, that an alliance led by Intermountain Healthcare will use software from Unite Us to coordinate patient care among clinical providers and organizations that address social determinants of health. The Utah Alliance for the Determinants of Health helps track patients' social determinants of health, including food insecurity, housing instability, interpersonal violence and transportation. The Alliance will join with Medicaid plan SelectHealth to launch demonstration pilots in Washington and Weber counties. Read More

Wisconsin

Health Secretary Says Medicaid Expansion Will Free Up Funds for Other Health Care Services. *Wisconsin Public Radio* reported on March 15, 2019, that full Medicaid expansion in Wisconsin would free up funds for additional spending on mental health, dental, and long-term care services, according to Department of Health Services Secretary Andrea Palm. The Medicaid expansion plan included in Governor Tony Evers proposed budget would cover a projected 82,000 individuals up to 138 percent of the federal poverty level. Read More

National

MACPAC Says Congress Should Begin DSH Cuts in States With Unspent Funds From Prior Years. *Modern Healthcare* reported on March 15, 2019, that the Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that lawmakers adjust the planned rollout of disproportionate share hospital (DSH) payment cuts by applying them first to states with leftover, unspent funds from the previous years, according to the March 2019 MACPAC report. MACPAC also recommended starting with $2 billion in cuts in the fiscal year starting October 1, 2019, instead of the $4 billion that is scheduled. Read More

CMS Releases Integrated Care for Kids (InCK) Model RFI. On March 14, 2019, the Centers for Medicare & Medicaid Services (CMS) released a request for information (RFI) for the Integrated Care for Kids (InCK) Model, which provides funding for states to test whether integrated physical-behavioral payments improve care and reduce costs for children in Medicaid and CHIP. The program will assist states in addressing high-priority health concerns for children, including behavioral health, opioid use, and the impact of opioids on families. The program aims to improve child health, reduce avoidable inpatient stays and out of home placement, and create sustainable Alternative Payment Models (APMs). CMS will award up to eight contracts for implementation from January 1, 2020, through December 31, 2026. The contracts are worth $128 million. Read More

CMS Releases Medicaid Section 1115 Waiver Guidance. *Modern Healthcare* reported on March 14, 2019, that the Centers for Medicare & Medicaid Services (CMS) released new monitoring and evaluation resources to help states obtain Medicaid Section 1115 waiver approval. The tools include templates to implement, monitor, and utilize data evaluation methods to determine the impact of the changes, including Medicaid work requirements. Read More

HHS Is In Talks With States Interested In Medicaid Block Grants. *The Hill* reported on March 14, 2019, that federal regulators are in talks with states interested in implementing Medicaid block grants without congressional approval. Health and Human Services (HHS) Secretary Alex Azar said he didn't know how many states were involved in the conversation. States may attempt to implement block grants through a federal waiver. Read More

Nursing Homes Pay Less in Fines Under Trump Administration. *Kaiser Health News* reported on March 15, 2019, that nursing home fines have dropped to an average of $25,405 under the Trump administration, down from $41,260 in 2016. While the number of fines has risen, the amount collected declined 10 percent to $114 million under the Trump administration in one year, compared to $127 million in Obama's last year. Read More

Federal Judge to Rule on AR, KY Work Requirements by April 1. *Kaiser Health News* reported on March 14, 2019, that U.S. District Judge James Boasberg will rule by April 1 on whether Medicaid work requirements in Arkansas and Kentucky achieve the program's goal of promoting health coverage. In a previous ruling, Boasberg found that Medicaid work requirements in Kentucky failed to promote the objectives of Medicaid. Read More

Medicaid Drug Spending Grows 14.8 Percent from 2013-17. The Centers for Medicare & Medicaid Services (CMS) reported on March 14, 2019, that gross spending on prescription drugs was $67.6 billion for Medicaid, $154.9 billion for Medicare Part D, and $30.4 billion for Medicare Part B in 2017. The data, which comes from the CMS Drug Dashboards, shows that Medicaid drug spending grew 14.8 percent from 2013 to 2017, Part D spending grew 10.6 percent, and Part B spending grew 10 percent. Read More

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Complex Care Among Medicaid Beneficiaries with Comorbid SUD and Other Chronic Conditions. The Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program's (IAP) Reducing Substance Use Disorder (SUD) program area is hosting a national learning webinar on Wednesday, April 3, 2019 from 3:00 PM-4:00 PM EST about the critical importance of identifying and treating individuals with comorbid SUD and other chronic conditions. Participants will learn about (1) identifying and treating complex conditions, (2) the unique challenges and needs of the SUD population with these conditions, and (3) reasons that customizing approaches for this population is necessary. Additionally, participants will hear about one state's health home approach to treating Medicaid beneficiaries with comorbid SUD and other chronic conditions.

HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates. To participate in this webinar, register here.

Industry News

Not-For-Profit Health Systems Post Significant 2018 Investment Losses. *Modern Healthcare* reported on March 19, 2019, that twelve of the largest not-for-profit health systems in the country saw $3.7 billion in collective investment losses in 2018. Kaiser Permanente posted a $1.2 billion loss compared to a $3.6 billion gain in 2017. Other systems reporting 2018 losses included Ascension, Providence St. Joseph Health, Cleveland Clinic, and Catholic Health Initiatives. Read More

Banner Health, IHMS To Help Uninsured Find Health Care Coverage. Phoenix-based Banner Health announced on March 8, 2019, that it will work with Integrated Health Management Services (IHMS) to assist uninsured patients in six states to connect with health insurance coverage opportunities. The services will be available at McKee Medical Center, North Colorado Medical Center, Banner Fort Collins Medical Center and 19 other hospitals in Arizona, California, Colorado, Nebraska, Nevada, and Wyoming. Read More

Signify Health Acquires TAVHealth. Signify Health announced on March 15, 2019, that it has acquired TAVHealth, a technology platform aimed at helping communities address social determinants. Signify, which provides in-home and complex care management services, manages a network of 4,000 healthcare providers. Financial terms were not disclosed. Read More

Audax Acquires Autism Behavioral Health Services Provider Proud Moments. *Behavioral Healthcare Executive* reported on March 15, 2019, that Proud Moments, which provides autism behavioral health services, has been acquired by Audax Private Equity. Proud Moments services children and adults affected by autism spectrum disorder in New York, New Jersey, Maryland, Tennessee, and Nevada. Read More

CHS Is Accused of Filing False Claims Related to Meaningful EHR Use. *Modern Healthcare* reported on March 15, 2019, that a whistleblower lawsuit alleges that Tennessee-based hospital chain Community Health Systems (CHS) filed false claims and received more than $450 million in incentive payments related to meaningful use of electronic health records (EHR) between 2012 and 2015. The lawsuit alleges that CHS shouldn't have qualified for the payments because of flaws in the EHR technology it had implemented. Read More

HCA Healthcare To Acquire Majority Stake in Galen College of Nursing. HCA Healthcare announced on March 14, 2019, that it will acquire a majority stake in Galen College of Nursing. Financial terms were not disclosed. HCA employs 94,000 registered nurses. Read More

Gryphon to Acquire LEARN Behavioral from LLR Partners. Gryphon Investors announced on March 13, 2019, that it has struck a deal to acquire LEARN Behavioral from LLR Partners. LEARN provides applied behavioral analysis, speech-language therapy, occupational therapy, counseling to individuals with autism. Financial terms were not disclosed. Read More

DentaQuest to Acquire Dental Care Plus Group Companies. DentaQuest, LLC, announced on March 14, 2019, a definitive merger to acquire the Dental Care Plus Group (DCPG) companies of DCP Holding Company for $41.5 million in cash. The DCPG companies, which will become wholly-owned subsidiaries of DentaQuest, have 380,000 Midwest members and a network of 246,000 provider locations. The transaction is expected to close in the second or third quarter of 2019. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
April 1, 2019	Idaho Medicaid Plus (Dual) - Bonneville, Bingham, Bannock Counties	Implementation	3,329
April 12, 2019	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Proposals Due	
April 22, 2019	Oregon CCO 2.0	Applications Due	840,000
April 29, 2019	Louisiana	Proposals Due	1,500,000
May 17, 2019	Minnesota MA Families and Children; MinnesotaCare	Proposals Due	679,000
May 17, 2019	Minnesota Senior Health Options; Senior Care Plus	Proposals Due	55,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
June 28, 2019	Louisiana	Awards	1,500,000
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
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	1,500,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	3,000,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	1,400,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	950,000
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
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
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	1,500,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	3,000,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	1,400,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	950,000
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

COMPANY ANNOUNCEMENTS

Sharp Transitions Awarded $100,000 2019 Hearst Health Prize For Its Outstanding Home-Based Palliative Care Program

MCG Health's Dr. Sabitha Rajan to Speak at 2019 Society of Hospital Medicine Conference

HMA WELCOMES

John Volpe – Principal

John Volpe is an experienced senior health official with a demonstrated record of success at the intersection of health, social service, public safety and the criminal justice system.

Prior to joining HMA, John served as special advisor on criminal justice for the New York City (NYC) Department of Health and Mental Hygiene, founding the Office of Criminal Justice. The office was designed to lead in the areas of policy, system design, cross-sector collaboration and developing and improving service delivery where health and social services intersect with crisis systems, law enforcement, the courts, probation and parole, as well as jails and prisons.

John's key accomplishments in support of a strong public safety and public health paradigm include work with the New York Police Department (NYPD) intervention training program, police/mental health co-response teams, crisis centers for NYPD drop off, Academy for Justice Informed Practice, NYC Crisis System Task force, and probation and health homes.

Prior to joining city government, John served at the NYC Legal Aid Society as a founding member of an interdisciplinary criminal defense project. Later, in an administrative role, John designed and secured grant funding to spearhead new efforts for at-risk populations, including frontline clinical court services to divert people from jail, immigrants facing deportation, and victims of human trafficking.

John has a bachelor's degree from Georgetown University and a Master of Social Work from Hunter College School of Social Work.

Katie Rogers – Principal

A senior executive with more than 20 years of regulatory operations, compliance and oversight experience, Katie Rogers is adept at leading and implementing Medicaid and Medicare contracts, regulations and programs at the highest levels.

Katie worked as a vice president of compliance with Centene Corporation for seven years and spent six years at Coordinated Care Health Plan in Washington state, including one year traveling to health plans in need of interim executive compliance expertise.

In her role with Centene and as the director of government programs at Community Health Plan of Washington, Katie created compliance programs for Medicaid and the health insurance Marketplace, including regulatory operations oversight, risk assessment, contract oversight, fraud/waste/abuse, privacy and security. She improved Medicaid audit scores and reduced costs while directing government contracts for Community Health Plan of Washington.

She has a bachelor's degree from the University of Washington and a certification in healthcare compliance from the Health Care Compliance Association.

HMA NEWS

Will Hospitals Serving Racial and Ethnic Minorities Lose Out in a Value-Based Payment World? HMA Principal Madeleine Shea, with her partners from the National Committee for Quality Assurance and American Hospital Association, recently authored the *Health Equity* article, *Explaining the Relationship between Minority Group Status and Health Disparities.* While federal policy has moved in the direction of adjusting for poverty and disability as proxies for social risks, this article keeps the focus on race and ethnicity as a major explanation for health disparities in the United States. Read more

Upcoming Webinar: March 28, 2019 - Overcoming Stigma of Opioid Use Disorder: Lessons for Providers, Payers, Policymakers, and the Healthcare Community at Large. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- California Medicaid Eligibles 65+ by County and Aid Group, Sep-18 Data
- Colorado RAE Enrollment is 1.2 Million, Feb-19 Data
- Florida Medicaid Managed Care Enrollment is Down 1.3%, Feb-19 Data
- Florida Medicaid Eligibility by County, Age, Sex, Feb-19 Data
- Illinois Medicaid Managed Care Enrollment is Down 2.2%, Feb-19 Data
- Iowa Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Maine Medicaid Expansion Enrollment by County, Mar-19 Data
- Ohio Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Oklahoma Medicaid Enrollment by Age, Race, and County, Feb-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- South Carolina Medicaid Managed Care Enrollment is Up 1.5%, Mar-19 Data
- Utah Medicaid Managed Care Enrollment is Down 0.9%, Mar-19 Data
- Virginia Medicaid MLTSS Enrollment is Over 240,000, Feb-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- CMS Integrated Care for Kids (InCK) Model RFI, Mar-19
- North Carolina Prepaid Health Plan Services RFP Protests, Mar-19
- Rhode Island DHS Employment and Income Verification Services RFP, Jan-19
- Rhode Island Medicaid Managed Care Services Model Contract, 2017
- Utah Medicaid Pharmacy Maximum Allowable Cost (MAC) Containment RFP, Mar-19

Medicaid Program Reports, Data and Updates:

- California Medi-Cal Managed Care Rate Ranges, SFY 2017-18
- OneCare Kansas (OCK) Planning Council Meeting Materials, 2018-19
- Louisiana Medicaid Financial Forecast Reports, SFY 2018-19, Feb-19
- Maryland Medicaid Advisory Committee Meeting Materials, Feb-19
- Massachusetts CHIP Annual Reports, 2010-18
- Mississippi House Medicaid Committee Update, Jan-19
- Mississippi Medicaid Legislative Fact Sheet, 2019
- Missouri HealthNet Monthly Management Reports, 2014-18, Jan-19
- Nebraska Governor's Biennium Proposed Budget, FY 2019-21
- Ohio Governor's Budget Recommendations, FY 2020-21
- Oklahoma Provider Fast Facts by County, Feb-19
- Oklahoma Medical Advisory Meeting Materials, Jan-19
- Pennsylvania Proposed Medicaid Work Requirements Report, Oct-18
- Pennsylvania Medicaid Expansion Update Report, 2019
- Virginia Medicaid Expansion Enrollment Dashboard, Mar-19
- West Virginia BMS Medicaid Pharmacy Savings Report, Feb-19

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