HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 27, 2019

RFP CALENDAR

HMA News

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

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IN FOCUS

CMS INCREASES MONITORING AND EVALUATION REQUIREMENTS FOR SECTION 1115(A) MEDICAID DEMONSTRATIONS

This week, our *In Focus* reviews the implications of the new federal guidance for state waivers with community engagement, premiums, non-eligibility periods, and other personal responsibility provisions.

BACKGROUND

On March 14, 2019, the Centers for Medicare & Medicaid Services (CMS) issued several new guidance documents that significantly increase the level of monitoring and evaluation required for Section 1115(a) Medicaid Demonstrations. These new requirements apply to community engagement, premiums, and other waiver provisions that impact eligibility and enrollment, and affect states currently with such waivers as well as any states proposing these ideas. Changes in reporting, data collection, and waiver monitoring processes will be necessary, and soon—as the materials detail compliance dates for these significant new requirements.

These guidance materials fall into five broad categories:

1. **Implementation Plan Template:** A 27-page document issued for states to describe their approach for implementing community engagement policies.
2. **Monitoring Report Template:** A 28-page outline for quarterly and annual monitoring reports that are required by Section 1115(a) Medicaid Demonstration Special Terms and Conditions (STCs).
3. **Monitoring Metrics:** An extensive list of quantitative metrics on which states will be required to report to CMS monthly, as well as within the aforementioned quarterly and annual monitoring reports. The metrics are divided into six separate modules:
    - Module 1 (45 metrics): "Overview of eligibility and coverage metrics standard across any demonstration with premiums, Marketplace-focused premium assistance, health behavior incentives, community engagement, or retroactive eligibility waiver policies"
    - Module 2 (21 metrics): "Additional metrics relevant for states that require premiums or other monthly payments"
    - Module 3 (3 metrics): "Additional metrics relevant for states with Marketplace-focused premium assistance programs"
    - Module 4 (7 metrics): "Additional metrics relevant for states with programs that incentivize particular health behaviors"
    - Module 5 (46 metrics): "Metrics relevant for states with community engagement requirements"
    - Module 6 (3 metrics): "Monitoring metrics for states with retroactive eligibility waivers"
4. **Evaluation Design Master Narrative:** A blueprint for states to use in submitting their Evaluation Design to CMS. This document includes the preferred methodologies, target and comparison groups, and analytic approaches.
5. **Evaluation Design Appendices:** In addition to the Evaluation Design Master Narrative, CMS has issued five separate appendices which outline the recommended approaches for assessing the impact of the following five Demonstration policies:
    i. Community Engagement
    ii. Non-eligibility Periods
    iii. Premium/Account Payments
    iv. Retroactive Coverage
    v. Demonstration Sustainability

IMPLICATIONS FOR STATES

The release of these guidance documents is likely to have significant implications for states' evaluation and monitoring activities, and in some instances, may require a significant investment of resources. This new requirement applies to states currently operating these waivers as well as all upcoming waiver applicants. The communications from CMS suggest that adherence to the letter of the guidance is compulsory rather than optional. For example, CMS indicated that states with approved Section 1115(a) Medicaid Demonstrations that contain one or more of the provisions covered by the guidance documents will be required to submit both an **Implementation Plan Template** and **Monitoring Report Template** at a date to be determined in consultation with CMS, while future Demonstrations will have the due dates for these documents outlined within the STCs (as demonstrated by Ohio's Demonstration).[1] Therefore, states with current personal responsibility waivers should begin preparing to submit both documents, while states that are considering personal responsibility waivers (or that have waivers pending with CMS) should be prepared to submit these documents during the first several months after waiver approval. Additionally, CMS has indicated that states without approved Evaluation Designs will be expected to adhere to the **Evaluation Design Master Narrative** and the associated **Evaluation Design Appendices** in their evaluation plan submissions.

System changes may also be required to comply with these new requirements. This may require significant operational changes and/or capacity enhancements to ensure compliance. For example, in order to track and report on the 125 metrics contained in the Monitoring Report Template, states may need to increase capacity to handle this process internally, delegate the responsibility to the STC-required independent third-party evaluator, or some combination of both of these. Similarly, states may need to adopt system changes to capture information which may have not been monitored previously, such as the number of beneficiaries who lost Medicaid and transitioned to a qualified health plan offered in the Marketplace. Although states may have reported this type information during annual or summative evaluation reports previously, the current guidance calls for each of these metrics—and over 100 others—to be measured monthly and reported at a level of granularity and specificity outside of current experience.

NEXT STEPS

This recent guidance from CMS fundamentally changes the monitoring and evaluation requirements for Section 1115(a) Medicaid Demonstrations. States will need to increase the level of effort and rigor within their evaluation plans and will also need to incorporate ongoing standardized monitoring of a large number of metrics related to their demonstrations.

HMA's Medicaid Market Solutions division has conducted an extensive review of each of the guidance documents and is prepared to assist states and stakeholders in navigating the new requirements.

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[1] Within the STCs for Ohio's Group VIII Work Requirement and Community Engagement Section 1115 Demonstration, it states, "The state must submit a Community Engagement Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration" (page 33), and "The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration."

HMA Medicaid Roundup

Alabama

Lawmakers Are Open to Medicaid Expansion, But Not Without Funding Source. *The News & Observer/Associated Press* reported on March 23, 2019, that some Alabama Republican lawmakers are open to Medicaid expansion, but say it won't be possible without first identifying a funding source. Republican Governor Kay Ivey has agreed to discuss Medicaid expansion with Democratic leaders, who are looking at funding sources including a lottery and legalized sports betting. An estimated 340,000 people would qualify for health insurance through expansion. Read More

Arizona

Arizona Announces DDD Health Plan Awards. The Arizona Department of Economic Security (ADES), Division of Developmental Disabilities (DDD) announced on March 21, 2019, that it has awarded contracts to UnitedHealthcare and Mercy Care for its managed Long-Term Care System/Developmental Disabilities program – DDD Health Plans – which will serve people who are eligible for both long-term care and DDD services. This program will integrate physical, behavioral, and long-term services and supports. Centene and Magellan Health also bid. The contract will be effective October 1, 2019, through September 30, 2022, with an additional seven, one-year extensions. Read More

Arkansas

Most Arkansas Medicaid Beneficiaries Who Fail to Meet Work Requirements Have Not Found Employment, Analysis Finds. *The Hill* reported on March 20, 2019, that only 1,981 of the 18,000 Arkansas residents who reportedly lost Medicaid coverage as a result of work requirements have found employment, according to an analysis by the Center on Budget and Policy Priorities. The data also showed that most individuals who were unemployed were also still uninsured, contradicting federal and state health officials' claims. Adults are required to report they are working, looking for a job, or going to school for 80 hours per month for three straight months to maintain Medicaid coverage. Read More

Colorado

Hospital Prices Haven't Declined Despite Medicaid Expansion, Report Finds. *Kaiser Health News* reported on March 27, 2019, that Medicaid expansion hasn't resulted in lower prices or a reduction in cost-shifting to commercial payers by Colorado hospitals, despite improvements in hospital margins, lower bad debt and charity care write-offs, and increased Medicaid revenues, according to a state report. The Cost Shift Analysis Report, released by the Colorado Healthcare Affordability and Sustainability Enterprise, found that average hospital profit per patient discharge doubled to $1,359 between 2009 and 2017. Hospital uncompensated care has dropped 60 percent. Read More

Florida

Senate Committee Advances Bill to Import Prescription Drugs from Canada. *Health News Florida* reported on March 26, 2019, that the Florida Senate Health Policy Committee cleared a bill, supported by Governor Ron DeSantis, that would allow the import of prescription drugs from Canada for Medicaid patients. Under the bill, sponsored by Senator Aaron Bean (R-Fernandina Beach), a vendor would be selected to administer the Canadian drug import program in the state. The measure would require federal approval. Read More

Lawmakers to Consider Extending Medicaid Managed Care Contracts. *Florida Politics/The News Service of Florida* reported on March 25, 2019, that Florida lawmakers are seeking to extend the terms of the state's $90 billion Medicaid managed care contracts from five years to possibly seven or eight. The extension, which would be aimed at improving continuity of patient care, would require legislative approval. Read More

Georgia

Legislature Passes Medicaid Expansion Waiver Proposal. *The Atlanta Journal-Constitution* reported on March 25, 2019, that the Georgia House joined the state Senate in passing a bill that would give Governor Brian Kemp leeway to pursue various waiver programs to expand Medicaid. The measure, which now heads to Kemp's desk for signature, would allow the governor to pursue two separate Medicaid waivers: 1. a waiver to lower premiums on the Affordable Care Act Exchanges; 2. a waiver to cap eligibility for Medicaid expansion up to the federal poverty level. Kemp has indicated that the state will not pursue full expansion, which would have added a projected 500,000 individuals to the state's Medicaid program. Read More

Governor Backs Renewed Effort to Overhaul Certificate of Need Rules. *Georgia Health News* reported on March 20, 2019, that Georgia Governor Brian Kemp is supporting a renewed effort to revamp the state's health care certificate-of-need (CON) rules. Earlier this month, the House voted against a measure that would overhaul CON laws, but the measure was attached to other House legislation and adopted by the Senate Finance Committee. Kemp stated that he would explore executive action if the CON overhaul is stalled. Read More

Idaho

Limited Medicaid Expansion Could Cost State More Than Full Expansion, Report Says. *The Post Register* reported on March 26, 2019, that an Idaho House bill aimed at limiting the state's voter-approved Medicaid expansion program could cost the state at least $32 million more than full expansion, according to a report from the Idaho Center for Fiscal Policy. By excluding 32,000 individuals at 100 to 138 percent of poverty, the limited expansion could result in a reduced federal funding match of 70 percent, instead of 90 percent under full expansion. Read More

House Committee Advances Bill to Limit Voter-Approved Medicaid Expansion. *The Idaho Statesman* reported on March 21, 2019, that the Idaho House Health and Welfare Committee advanced a bill to limit the state's voter-approved Medicaid expansion program. The bill, by Representative John Vander Woude (R-Nampa), would require individuals with incomes at 100 to 138 percent of the federal poverty level to continue to purchase Exchange coverage as well as implement Medicaid work requirements. The legislation now heads to House floor without a recommendation to pass it. Read More

Iowa

House Passes Children's Mental Health Services Bill. *The Des Moines Register* reported on March 21, 2019, that the Iowa House voted in favor of a bill that would create a behavioral health system providing services for children with a mental, behavioral, or emotional disorder. The bill also addressed potential funding gaps, with Medicaid and private insurance plans expected to reimburse the cost of some services. The legislation now heads to the Senate for review. Read More

Kansas

Medicaid Expansion Is in the Hands of GOP-Controlled State Senate. *The Wichita Eagle* reported on March 24, 2019, that the Republican-controlled Kansas Senate will decide the fate of Medicaid expansion after the House advanced an expansion plan last week. Medicaid expansion has been a priority of Democratic Governor Laura Kelly; however, it is expected to face resistance in the state Senate. If the measure passes, more than 150,000 additional people would qualify for Medicaid. Read More

House Advances Medicaid Expansion Plan. *The Connecticut Post* reported on March 20, 2019, that the Kansas House advanced a modified version of Governor Laura Kelly's Medicaid expansion plan in a first-round vote, with a final vote to send the bill to the Senate expected soon. If the measure passes, more than 150,000 additional people would qualify for Medicaid. Read More

Kentucky

Attorney General Launches Investigation into PBM Practices. *The New York Times/Reuters* reported on March 21, 2019, that Kentucky Attorney General Andy Beshear launched an investigation into whether pharmacy benefit managers (PBMs) overcharged the state's Medicaid program for prescription drugs. According to a recent state report, two PBMs earned at least $123 million from Medicaid in 2018 by paying pharmacies at a lower rate than what the state was charged for the same drugs. Read More

Proposed Medicaid Rate Increase Higher Than Expected, Passport Health Plan Says. *The Insider Louisville* reported on March 21, 2019, that Kentucky's new proposed Medicaid disbursement rates for April 1 are higher than expected, according to Medicaid managed care organization Passport Health Plan. Passport continues to lose an estimated $1.25 million per week despite deep cutbacks. The plan will assess the rate increase to determine whether it is enough to avoid going out of business. Read More

Louisiana

Louisiana Awards Medicaid, Inmate Hepatitis C Treatment Contract to Asegua Therapeutics. *U.S. News & World Report/Associated Press* reported on March 26, 2019, that the Louisiana Department of Health has awarded Asegua Therapeutics LLC, a Gilead Sciences subsidiary, a contract to provide an unlimited amount of hepatitis C medication to Medicaid members and inmates for a flat rate over five years. The state expects to treat 10,000 individuals with hepatitis C in its Medicaid and prison populations by 2020. Read More

New Hampshire

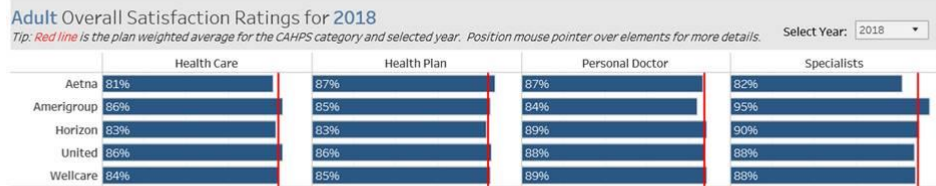
Medicaid Beneficiaries File Federal Lawsuit to Block Work Requirements. *CQ Health* reported on March 20, 2019, that four Medicaid beneficiaries in New Hampshire have filed a federal lawsuit seeking to block the state's Medicaid work requirements. The lawsuit, filed in U.S. District Court for the District of Columbia, argues that the requirements will result in substantial coverage losses. The National Health Law Program, New Hampshire Legal Assistance, and National Center for Law and Economic Justice will be representing the four individuals. New Hampshire joins Kentucky and Arkansas in facing similar legal challenges. Read More

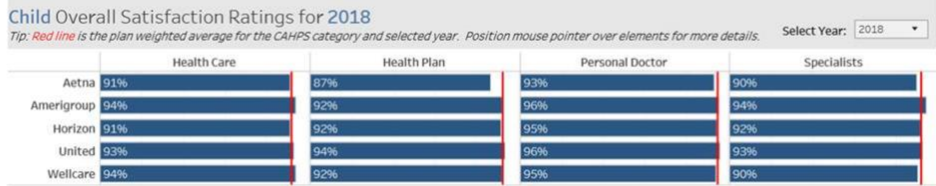
New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

State Parity Legislation Passes Both Houses. On March 25, 2019, the New Jersey Association of Mental Health and Addiction Agencies reported on the passage of state legislation (S1339/A2031) that calls for enhanced enforcement and oversight of mental health and substance use disorder parity laws. If signed into law, mental health conditions and substance use disorders parity with any other covered sickness must meet the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008. Read More

New Jersey Releases 2018 CAHPS Results for Medicaid Managed Care Plans. The New Jersey Medicaid agency has released the 2018 CAHPS results for its five contracted Medicaid managed care organizations. Overall satisfaction of adults and children were rated for Health Care, Health Plan, Personal Doctor and Specialists, and for adults in FIDE SNP plans.





In review of this data we highlight some of the findings for Medicaid managed care plans and FIDE SNPs:

MEDICAID MANAGED CARE ORGANIZATIONS

- Amerigroup had the highest health care satisfaction rating from adults and children (it shared the health care rating with United for adults).
- United received the highest health plan satisfaction rating among plans for children and was rated second among plans for health care by adults.
- Aetna received the highest health plan satisfaction rating from adults but received the lowest satisfaction rating for satisfaction with health care and specialists. Aetna had among the lowest ratings in child satisfaction in all four CAHPS categories.
- Horizon, the dominant plan by enrollment received the lowest health plan satisfaction rating from adults and shared the lowest health plan satisfaction rating with two other plans for children.

FIDE SNPs

- United's FIDE SNP had by far the highest CAHPS rating for health plan satisfaction, and the highest rating among FIDE SNPs for personal doctor satisfaction.
- WellCare had the lowest FIDE SNP CAHPS ratings for health care and health plan but demonstrated strengths in their members' satisfaction with their personal doctor and specialists.

CAHPS health plan results for 2015 through 2018 are available on the New Jersey Division of Medical Assistance and Health Services website through the NJ FamilyCare Data Dashboards link.

New Jersey to Pursue State-Based Health Exchange for 2021. On March 22, 2019, New Jersey Governor Phil Murphy announced plans for New Jersey to pursue its own state-based health insurance Exchange in 2021. The move intends to give the state greater control over its health insurance market and strengthen the protections for access to affordable health care in the Affordable Care Act (ACA) that are at risk under the current national environment. The transition will give the state more control over the open enrollment period, access to data to better regulate the market, and targeted outreach. User fees will fund state health Exchange operations, consumer assistance, outreach and advertising. The state plans to redirect the 3.5% of premium assessments currently paid to the federal government to fund the State-Based Health Exchange. The fee generates over $50 million annually which can be applied to consumer outreach and enrollment efforts previously reduced at the federal level.

New Jersey sent a Declaration Letter today to the Centers for Medicare & Medicaid Services (CMS) to initiate the transition and initiate legislation to transfer the current federal Exchange user fee to a State-Based Exchange for plan year 2021. This action includes plans to codify many of the primary ACA consumer insurance protections:

- Prohibiting preexisting conditions exclusions
- Requiring dependent coverage to age 26
- Requiring coverage of Essential Health Benefits
- Prohibiting lifetime and annual limits
- Requiring coverage without cost sharing for preventative services. Read More

New Mexico

New Mexico to Develop Medicaid Home and Community Supports Waiver Program. New Mexico Governor Michelle Lujan Grisham announced on March 25, 2019, that she has instructed state regulators to develop a Medicaid home and community supports waiver program to assist people with disabilities currently on the wait list for services under the Development Disabilities Waiver. New Mexico operates three waiver programs serving individuals with special needs: The traditional Developmental Disabilities Waiver for services and supports provided to eligible adults and children; the Mi Via Waiver for self-directed home and community-based services provided to individuals with developmental disabilities; and the Medically Fragile Waiver to assist individuals with both a medically fragile condition and a development disability to live in their homes. There are approximately 5,000 people currently wait listed for these waiver services, 53 percent of whom are under the age of 21, and the average wait time is approximately 13.5 years. The New Mexico Department of Health and the Human Services Department will review best practices related to administrative design, populations served, and funding allotments for service plans in the more than 20 states with supports waivers as they develop the program. Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

Nurses Back Away from Strike Threat. *Crain's New York Business* reported on March 25, 2019, that the New York State Nurses Association (NYSNA) has withdrawn its strike notice, citing significant progress in negotiations with three of New York City's largest hospital systems: Mount Sinai Health System, NewYork-Presbyterian, and Montefiore Health System. The strike would affect more than 10,000 registered nurses. The strike was threatened due to concerns about inadequate numbers of qualified staff, caseloads too high to provide safe care and patient acuity higher than normal. NYSNA has long advocated for a safe staffing bill, legislation that would mandate nurse to patient ratios in hospitals, as well as minimum care hours per resident, per day for RNs, LPNs and CNAs in nursing homes. NYSNA indicates that their talks with the hospital systems have included significant movement in safe staffing. Read More

New York City to Develop Alternative Facilities for Inmates with Mental Health Issues. *New York Magazine* reported on March 21, 2019, that New York City intends to develop facilities, located outside of the city's jails, that offer specialty care for inmates with mental-health issues, drug-related problems and complex medical needs. The city's Correctional Health Services recently put out a call for prospective contractors to study the design and cost of creating what it calls "therapeutic housing units" to be located in or near existing city hospitals. The specialized housing units would likely be operated by Correctional Health Services and the Department of Correction. Correctional Health Services is a division of the NYC Health + Hospitals, the city's public hospital system. The article notes that approximately 1,100 incarcerated people — 16 percent of the entire jail population — have been diagnosed with serious mental illness, and that share has risen in recent years even as the overall jail population has declined. Read More

NYC Health + Hospitals Is Making 'Great Progress,' Katz Says. *Modern Healthcare* reported on March 26, 2019, that NYC Health + Hospitals Corp. is making "great progress" and is on track to achieve $430 million in expense reductions and report $757 million in annual revenues, according to president and chief executive Mitchell Katz, MD. In testimony before the City Council Committee on Hospitals, Katz added that expenses are just $25 million or one percent over budget, in part from the hiring of 340 nurses and staff to bill and collect money from payers. Katz said there is more work ahead and raised concerns over the impact of scheduled federal disproportionate share payment cuts. Read More

North Carolina

Proposal Would Allow 2,000 More Adults into IDD Program In Lieu of Full Medicaid Expansion. *WRAL.com* reported on March 26, 2019, that North Carolina lawmakers proposed allowing an additional 2,000 adults into a Medicaid waiver program for individuals with intellectual and development disabilities as an alternative to full Medicaid expansion. The legislation, which would increase enrollment in the program from 12,000 to 14,000, would also remove state certificate of need requirements, eliminate state regulation of the Program of All-Inclusive Care for the Elderly, and enter North Carolina into the PsyPact interstate mental health compact. Read More

Ohio

County to Receive Funding Under BWC Drug Workplace Safety Program. *WorkersCompensation.com* reported on March 21, 2019, that the Ohio Bureau of Workers Compensation's (BWC) Substance Use Recovery and Workplace Safety Program is providing $139,088 to the Montgomery County Alcohol Drug Addiction and Mental Health Services (ADAMHS) board. This funding will support 61 local employers and 300 workers, and cover services such as reimbursement for pre-employment drug testing, training for managers, and a forum/venue that will allow employers to share success stories. Read More

Medicaid to Release Managed Care Procurement Request for Information. On March 20, 2019, Ohio Department of Medicaid (ODM) Director Maureen Corcoran provided testimony to the finance committee of the Ohio House of Representatives outlining agency priorities. In preparation for an upcoming managed care plan procurement, ODM will be releasing a request for information (RFI) in the next coming weeks to obtain input from interested parties. Additionally, ODM is working with the Department of Mental Health and Addiction Services (MHAS) to design an 1115 waiver application for SUD residential treatment services. ODM anticipates the implementation of the SUD waiver will require a $7.5 million investment and enhancements to Medicaid's care coordination services. ODM and MHAS are designing a robust Behavioral Health Care Coordination (BHCC) model targeted at individuals with the most complex and urgent substance use disorder and mental health needs, including pregnant women with opioid use disorder and their infants. Read More

Ohio to Step Up Oversight of Medicaid Managed Care. *The Columbus Dispatch* reported on March 20, 2019, that Ohio is improving oversight of Medicaid managed care plans, according to Medicaid director Maureen Corcoran. The increased scrutiny follows concerns over pharmacy benefit management spread pricing. Read More

Oklahoma

OxyContin Maker to Pay $270 Million to Settle Opioid Crisis Case. *The Wall Street Journal* reported on March 26, 2019, that Purdue Pharma LP and its owners, the makers of OxyContin, have agreed to pay $270 million dollars to resolve claims by the Oklahoma attorney general that the company helped fuel the opioid crisis. Oklahoma is one of 37 states to sue Purdue Pharma over opioids, and the Oklahoma settlement is the first to emerge from more than 1,600 opioid lawsuits Purdue faces from states, cities, and counties. The $270 million settlement will go to an addiction and treatment center, medicines for the center, local cities and counties, and litigation costs. The settlement could influence pending lawsuits and settlement talks. Read More

Pennsylvania

Pennsylvania Releases Report on Residential Services for Residents with Intellectuals Disabilities and Autism. Pennsylvania Department of Human Services (DHS) Secretary, Teresa Miller, released the *Improving the Quality of Residential Services* report highlighting the improvements in residential services for Pennsylvanians with intellectual disabilities and autism. Pennsylvania has expanded services to 7,500 individuals since 2015, investing more than $381 million. An additional $15 million proposed in 2019-20 budget the department could serve 765 individuals on the Office of Developmental Programs (ODP) emergency wait list through the community living waiver, and 100 people who experience unanticipated emergencies through the consolidated waiver. Governor Wolf's 2019-20 budget proposal invests $1.8 million to increase the frequency of licensing inspections and enables DHS to hire 30 additional licensing staff focusing on residential and day programs. Read More

Tennessee

House Subcommittee Advances Medicaid Block Grant Proposal. *The Tennessean* reported on March 20, 2019, that the Tennessee House Finance, Ways and Means Subcommittee cleared a Medicaid block grant proposal, despite more than 30 organizations expressing opposition of the measure. The House bill now heads to the full finance committee for review. Read More

National

DOJ Changes Position, Seeks Invalidation of the ACA. *Politico* reported on March 25, 2019, that the U.S. Justice Department has changed its position and is supporting a federal judge's ruling that the Affordable Care Act (ACA) is unconstitutional without an individual mandate penalty and should be struck down. The DOJ had previously sought to invalidate certain elements of the ACA, such as insurance protections for pre-existing conditions, while seeking to reverse the district judge's ruling on other elements of the law. Democratic attorneys general are appealing the district court's ruling, and the U.S. Court of Appeals is considering the case. Read More

Exchange Enrollment Falls 2.6 Percent in Open Enrollment Period for 2019 Coverage. *Modern Healthcare* reported on March 25, 2019, that health plan enrollment through Affordable Care Act Exchanges slid by about 300,000, or 2.6 percent, in the open enrollment period for 2019 coverage, according to Centers for Medicare & Medicaid Services (CMS). Enrollment in state-based Exchanges actually increased nearly 1 percent; however, enrollment in the federal Exchange declined. Read More

House Democrats Seek to Build on Affordable Care Act. *The New York Times* reported on March 25, 2019, that House Democrats will unveil a more incremental legislative health package that builds on the Affordable Care Act (ACA) in lieu of a Medicare-for-all type of proposal. The legislative package aims to protect people with pre-existing conditions, lower health care costs, provide more subsidies for families, and reverse actions by the Trump administration against the ACA. House Speaker Nancy Pelosi (D-CA) along with other Democrats see this new bill as a more efficient way of achieving universal health care. The legislative package will also include a bipartisan bill that would provide federal money to states that want to expand Medicaid but haven't yet. Read More

CMS Clarifies HCBS Rule on Isolation of Residents in Group Homes, Assisted Living. *Modern Healthcare* reported on March 22, 2019, that the Centers for Medicare & Medicaid Services (CMS) released new guidance on the 2014 home and community-based services (HCBS) final rule, clarifying whether assisted living facilities and group homes are complying with rules against isolating residents from participating the larger community. Facilities that isolate residents could lose Medicaid funding. States have until 2022 to implement the HCBS rule. Read More

CMS Takes Aim at Potentially Inappropriate Medicare Lab Test Billing. *Modern Healthcare* reported on March 26, 2019, that the Centers for Medicare & Medicaid Services (CMS) is analyzing whether clinical labs improperly unbundled Medicare billing codes for panel diagnostic tests in order to receive higher payments, according to CMS administrator Seema Verma. The effort is in response to a request for increased oversight from Senate Finance Chair Chuck Grassley (R-IA). 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 EDT 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

Centene to Acquire WellCare in $17.3 Billion Deal; Burdick to Join Centene Management Team. Centene announced on March 27, 2019, an agreement to acquire WellCare Health Plans for $17.3 billion in cash and stock. The combined company will have 22 million members across 50 states, including 12 million in Medicaid and 5 million in Medicare. WellCare shareholders will receive approximately $305 per share, comprised of 3.38 shares of Centene common stock and $120 in cash. Michael Neidorff will remain Centene chairman and chief executive. WellCare chief executive Ken Burdick and chief financial officer Drew Asher are expected to join the Centene senior management team. Read More

Health Partners Plans Names Denise Croce as New CEO. The Board of Directors of Health Partners Plans (HPP) announced on March 21, 2019, that Executive Vice President, Clinical and Provider Management Denise Croce will be named president and CEO of HPP. William George, the current President and Chief Executive Officer, will retire June 1. Croce first worked at HPP from 2004 through 2006 as Senior Vice President of Health Care Management Operations before returning to Health Partners Plans in 2016 as Executive Vice President of Clinical and Provider Management. HPP, a not-for-profit managed care organization, serves more than 262,000 members in Southeastern Pennsylvania. Read More

Anthem Blue Cross-CA, Sutter Health Reach Medi-Cal Network Agreement. *The Sacramento Bee* reported on March 20, 2019, that Anthem Blue Cross of California Medi-Cal members will continue to have access to care from Sutter Health facilities through December 31, 2022, under a new agreement. The long-running contract dispute had already impacted thousands of Anthem Medi-Cal members in northern California. 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

HMA Welcomes

Zach Gaumer – Senior Consultant

Zach Gaumer is an accomplished policy analyst and project manager with nearly 20 years of health policy experience. He possesses a deep understanding of Medicare, healthcare payment systems, federal and state policymaking, healthcare datasets, research methods and policy reform efforts. Zach is a skilled researcher with a passion for answering complicated payment policy questions.

Prior to joining HMA, Zach was a principal policy analyst at the Medicare payment Advisory Commission (MedPAC). During his tenure at MedPAC, Zach was an expert advisor to U.S. Congressional committee staff on Medicare payment systems. Specifically, Zach is an expert on hospital payment policy and many other hospital and health system support services.

He has expertise with payment systems related to ambulatory surgical centers, emergency departments, telehealth services, observation care, ambulances, new technologies, electronic health records systems, and value-based payment models. Zach's research and technical skills include policy impact estimation, payment policy modeling and forecasting, Medicare claims and cost report data analysis, private payer data analysis, regulatory and legislative analysis, and qualitative data gathering methods such as structured interviews and surveys. While at MedPAC, Zach also managed junior staff, published two articles in Health Affairs and presented at conferences on behalf of the organization.

Earlier in his career, Zach had positions at other entities analyzing federal and state health policy and health and pension benefits systems including the U.S. Government Accountability Office, where he conducted health policy research and produced reports related to the Medicare Advantage program, Accountable Care Organizations, Medicare's end-stage renal disease program and specialty hospitals.

He also worked for the Massachusetts Health Management Organization Association, researching state legislative and regulatory insurance policy changes and Hewitt Associates (now AON Hewitt) consulting with Fortune 500 companies about their health and pension benefits programs.

Zach has a bachelor's degree from Kenyon College and a Master of Political Studies from Johns Hopkins University with concentrations in health policy and international affairs.

HMA News

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

April 3, 2019 - The Importance of Race and Ethnicity in Accounting for Social Risks in Medicare Value-Based Payments. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:
- District of Columbia Medicaid Managed Care Enrollment is Down 2.7%, Nov-18 Data
- Maryland Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Mississippi Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- New Hampshire Medicaid Managed Care Enrollment is Down 0.9%, 2018 Data
- Ohio Dual Demo Enrollment is Up 3.7%, Mar-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Rhode Island Medicaid Managed Care Enrollment is Down 3.9%, 2018 Data
- Rhode Island Dual Demo Enrollment is 15,250, Mar-19 Data
- South Carolina Dual Demo Enrollment is Up 23.2%, Feb-19 Data
- Texas Dual Demo Enrollment is 40,537, Mar-19 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.0%, Feb-19 Data

Public Documents:
Medicaid RFPs, RFIs, and Contracts:
- Alabama Independent Disproportionate Share Hospital (DSH) Audit RFP, Mar-19
- Alaska Medicaid, CHIP, and TANF Program Eligibility Determinations and Best Practices RFP, Mar-19
- Arizona DDD Health Plan RFP, Proposals, Awards, Contracts and Related Documents, Mar-19
- Hawaii Alternative Payment Structures for Substance Abuse Prevention Services RFI, Mar-19
- Iowa Takeover of Core Medicaid Management Information System Services RFP and Award, Jan-19
- Indiana Asset Verification System RFI, Mar-19
- Iowa MMIS Modernization RFI, Mar-19
- KanCare 2.0 Medicaid & CHIP Capitated Managed Care RFP Protests, 2018
- Pennsylvania Medical Assistance Transportation Program (NEMT) RFA, Q&A, Databook, and Other Related Documents, 2018-19
- Vermont Statewide Women's Substance Use Disorder Services Technical Assistance RFP, Mar-19

Medicaid Program Reports, Data and Updates:
- Arizona AHCCCS Population Demographics, Mar-19
- California Managed Care Advisory Group Meeting Materials, Mar-19

- Connecticut Medical Assistance Program Oversight Council Meeting Materials, Feb-19
- Kentucky Medicaid Fee and Rate Schedules, 2019
- Louisiana Health Information Technology Roadmap, 2018-21
- Michigan Medical Care Advisory Council Meeting Materials, Dec-18
- Michigan DHHS Trend Report of Key Program Statistics, 2017-19
- New Hampshire Special Meeting Related to Managed Care Contracts – Medicaid Care Management, MCO Presentations to Governor, Executive Council, Mar-19
- New Hampshire Medicaid Enrollment by Eligibility Group and County, Feb-19
- New Jersey Family Care Enrollment by Age, Eligibility Group, and County, 2016-18, Feb-19
- New York Managed Care Statewide Executive Summary Reports, 2017-18
- North Carolina Final Guidance on BH, IDD Tailored Plan Eligibility and Enrollment, Mar-19
- Oklahoma Health Care Authority Annual Reports, 2014-18
- Oklahoma Medicaid Emergency Department Utilization by Race, Age, Eligibility Group, 2015-18
- Oklahoma Medicaid Emergency Department Utilization by Race, Age, Eligibility Group, 2015-18
- Oregon Medicaid Advisory Committee Meeting Materials, Mar-19
- Pennsylvania Medicaid Nursing Facility Services Availability and Costs, 2017-18
- South Carolina Medicaid Enrollment by County and Plan, Feb-19
- Vermont Green Mountain Care Board Advisory Committee Meeting Materials, Feb-19
- Vermont Blueprint for Health Annual Reports, 2015-18
- Vermont Medicaid Program Enrollment and Expenditures Reports, SFY 2019
- Vermont Review of OneCare ACO All-Inclusive Population-Based Rates, Dec-18
- Vermont OneCare ACO Certification, 2019
- Vermont Enrollment Trend Report, 2014-17
- Washington Medicaid Managed Care External Quality Review Reports, 2012-18
- Washington Medicaid Dental Cost, Utilization, and Provider Caseload, FY 2007-18
- Washington Medicaid Dental Enrollment, Payments by Age Group and County, 2014-18

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; Los Angeles, California; New York, New York; Philadelphia, Pennsylvania; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
http://healthmanagement.com/about-us/

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