Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

April 3, 2019

RFP Calendar

HMA News

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In Focus

HMA Analysis of 2020 Medicare Advantage Rate Notice and Final Call Letter

This week, our *In Focus* reviews the Announcement of Calendar Year (CY) 2020 Medicare Advantage (MA) Capitation Rates and Medicare Advantage and Part D Payment Policies (Rate Announcement) and Final Call Letter, issued by the Centers for Medicare & Medicaid Services (CMS) on April 1, 2019. The Rate Announcement and Call Letter includes final updates to MA payment rates and guidance to plan sponsors as they prepare their bids for CY 2020. Bids for CY 2020 are due to CMS on or before Monday June 3, 2019. It is important to

note that the Announcement and final Call Letter does not take into consideration the Health and Human Services (HHS) Office of Inspector General (OIG) proposed rule which seeks to remove anti-kickback protection for prescription drug rebates, which, if finalized as proposed, could have significant impacts on Part D plans' bids. While the administration has not provided any guidance on how plans should construct their 2020 bids in response to the rebate changes, HHS could decide to delay the rule's effective date to 2021 or CMS may allow plans to update their 2020 bids later this year.

Overall, the Rate Announcement and Final Call Letter signals the Trump Administration's continued support to expand enrollment in MA. While CMS adopted many of its original proposals, the agency demonstrated receptiveness to feedback from the plan community in its final policies. Further, the net payment update is nearly 1.0 percentage point greater than its proposals, which should enable most plans to offer attractive benefit packages and premium stability for 2020. Key polices, including changes between the Advance Notice and Draft Call Letter (ANCL) and Rate Announcement and Final Call Letter, are highlighted below. HMA's analysis of the ANCL for CY 2020, as well as well as other proposed regulations impacting Part C and Part D policies can be found here.

Rate Announcement and Final Call Letter Highlights

- ***Increase in MA Payment Rates***: 2020 MA plan revenues, on average, are expected to increase by 2.53 percent in 2020, up from the 1.59 percent estimated as a part of the ANCL, in large part resulting from an increase in the effective growth rate. Consistent with prior years, the CY 2020 expected change in plan revenues does not incorporate CMS' estimate of underlying coding change, which is expected to increase average plan risk scores by 3.3 percent on average. Although the 2020 payment increase is smaller than the 3.4 percent net increase in 2019, it is a large increase relative to historical trends. HMA continues to expect this payment update will produce a favorable payment environment for MA plans and will lead to increased enrollment growth in the program.
- ***Enhancement of the Risk Adjustment Model***: In accordance with the 21st Century Cures Act, which requires that CMS update the 2020 risk adjustment model to take into account the number of beneficiary conditions, CMS adopted its "alternative payment condition count model" (APCC) which incorporates additional diagnoses into the model, including dementia and ulcers. As proposed in the ANCL, CMS will calculate risk scores by blending data equally (50/50) from the existing 2017 CMS Hierarchical Condition Categories (CMS-HCC) model and the new APCC. In addition, CMS made final its proposal to increase the weight of encounter data in calculating the risk score. Consistent with its proposal, CMS will use 50 percent encounter data and fee-for-service (FFS) diagnoses (with inpatient Risk Adjustment Processing System (RAPS) data to supplement encounter data) and 50 percent RAPS and FFS diagnoses.

- ***Refinements to Special Supplemental Benefits for the Chronically Ill (SSBCI)***: CMS made final its proposal to implement provisions of the Bipartisan Budget Act of 2018 (BBA) that permit MA plans to vary supplemental benefit offerings based on the medical conditions and needs of chronically ill enrollees. However, in a reversal from its initial proposal, and in response to stakeholder feedback, CMS will permit plans for 2020 to offer items and services that include capital or structural home improvements (e.g., permanent ramps) so long as those items and services have a "reasonable expectation" of improving or maintaining overall function. CMS also solicited comments regarding whether or not the agency should permit consideration of social risk factors to determine permissible supplemental benefits for future policy making. While CMS received comments in support of using social determinants, the agency clarifies that statute limits SSBCI to only those that are chronically ill. The extent to which plans will offer these supplemental benefits in 2020 is unclear, but these additional flexibilities and benefits may present opportunities for plans and non-traditional service providers to pursue partnerships to offer innovative benefit design.
- ***Emphasis on Opioid Utilization***: CMS made final a number of its provisions focused on reducing opioid abuse and provided additional guidance to plans. First, CMS reiterated that, beginning January 1, 2020, MA plans must cover opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a Medicare Part B benefit. With regard to OTPs, commenters requested additional clarity with respect to bid preparations, eligible providers, drug policy, and compliance. In response, CMS indicated that additional guidance, including how to arrange for services, is forthcoming. Second, CMS emphasized that, in addition to the new OTP benefit, plans should offer supplemental benefits that provide coverage of non-opioid pain management treatments. Third, CMS restated that Part D plans should offer opioid-reversal agents (i.e., naloxone) on generic tiers. Some stakeholders expressed concerns that the inclusion of all forms of naloxone on generic tiers would limit plans' ability to negotiate with manufacturers, potentially leading to an increase in naloxone list prices and, in turn, higher premiums. In response, CMS will encourage sponsors to include "at least one" naloxone product on a generic tier.
- ***Investigation of Dual-eligible Special Needs Plan (D-SNP) Lookalikes:*** In the ANCL, CMS indicated that it will increase its scrutiny and oversight of conventional MA plans that offer benefit designs that mirror those of a D-SNP, but do not otherwise meet D-SNP statutory requirements. CMS also requested comments on the extent to which these plans impact informed enrollee choice, competition, meaningful care coordination, and provider burden. Based on stakeholder feedback, CMS identified three areas for further investigation and potential future regulatory changes related to D-SNP lookalikes: 1) benefit design and nondiscrimination, 2) beneficiary education, marketing, and broker compensation, and 3) enhanced requirements for MA plans with high proportions of dual-eligible beneficiaries.

- ***Maintaining Existing Part D Tier Composition Requirements:*** In response to "overwhelming opposition" from plan sponsors, CMS has elected to maintain the existing Part D plan tier composition policy and will not prohibit placement of generics on brand tiers (and vice versa) or eliminate the non-preferred tier. Plans will continue to have the ability to maintain a maximum threshold of 25 percent generic composition for the non-preferred drug tier. However, CMS will continue to monitor the extent to which current tier composition policies have an adverse impact on beneficiary access to generic alternatives.

- ***Modifications to Part D Auto-ship Policy:*** As proposed in the ANCL, CMS will replace its current policy requiring plans receive affirmative consent prior to shipping or delivering a new or refill prescription and will permit Part D sponsors to permit their network pharmacies to offer a voluntary auto-ship program. In response to stakeholder feedback, CMS will: remove the requirement that a beneficiary use a drug for four continuous months in order to qualify, eliminate the requirement for obtaining consent on an annual basis, permit plans to provide an approximate shipping date range rather than an exact date for reminders, and permit plans to provide beneficiaries with information on how to determine cost-sharing of an upcoming shipment rather than requiring the exact amount. CMS also clarified that pharmacies may request the enrollee return unwanted medications, but they cannot require return as a condition of a refund.

- ***Future Direction of Provider Directories:*** While CMS did not include any specific proposals regarding MA plan provider directories in the ANCL, the agency acknowledged a lack of improvement in accuracy as well as the challenges in collecting and maintaining accurate and timely information. In the final Call Letter, CMS stated that the agency received several comments from plan stakeholders expressing support for an industry-wide solution for improving provider directories. CMS indicated that the agency agrees with these comments and is researching options for assisting plans and providers in identifying a single source for demographic provider directory data.

- ***Changes to Star Ratings***: CMS made final several proposed changes to the Star Ratings program including a policy to adjust 2020 Star Ratings for plans experiencing "extreme and uncontrollable circumstances," such as major weather events or natural disasters, using a policy similar to the one adopted for the 2019 Star Ratings. CMS also made final its proposal to remove measures with low statistical reliability, including two Part D appeals measures, starting in 2022. In addition, CMS made final a measure set used for the 2020 Categorical Adjustment Index and it made final the inclusion of measures including a Transitions of Care Measure (Part C) and a measure of Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C). Consistent with its policy for adopting new measures, CMS will first add these measures to the display page in CY 2020. In addition, in response to industry concerns, CMS will maintain the measure of Statin Use in Persons with Diabetes (SUPD) (Part D) with a weight of 1.

HMA continues to analyze these provisions and others included in the CY 2020 Announcement and Call Letter. For more information or questions about HMA's Medicare Practice or the MA Announcement and Call Letter, please contact Mary Hsieh or Jon Blum.

Link to 2020 Medicare Advantage and Part D Rate Announcement and Final Call Letter Fact Sheet

HMA Medicaid Roundup

Arkansas

Lawmakers Vote to Keep Medicaid Expansion for Another Year. *The New York Times/Associated Press* reported on April 2, 2019, that the Arkansas legislature voted to keep the state's Medicaid expansion program for another year, despite a federal judge's ruling striking down the program's work requirements. The legislation now heads to the governor's desk. Read More

Governor Reaffirms Commitment to Medicaid Expansion Despite Adverse Ruling on Work Requirements. *The Arkansas Nonprofit News Network* reported on March 28, 2019, that Arkansas Governor Hutchinson is urging the Trump administration to appeal a federal judge's order blocking the state from continuing to enforce Medicaid work requirements. Despite the adverse ruling, Hutchinson reaffirmed his commitment to Medicaid expansion. Read More

Florida

Florida Receives CMS Approval for Behavioral Health Housing Pilot. *HealthLeaders* reported on March 28, 2019, that the Centers for Medicare & Medicaid Services (CMS) has approved a Florida section 1115 pilot program that provides behavioral health services and temporary housing to Medicaid beneficiaries with severe mental illness and/or substance use disorders. The state must follow certain home and community-based services and conflict of interest requirements. Florida will also be required to develop performance measures to address tenancy services requirements, mobile crisis management, and self-help/peer support. Florida submitted the waiver request to CMS in 2016. Read More

Georgia

House Rejects Hospital Provider Fee Bill Over Concerns About Financial Transparency. *Georgia Health News* reported on March 28, 2019, that the Georgia House rejected hospital provider fee legislation, after hospitals raised concerns over financial transparency requirements connected to an overall effort to reform state certificate of need rules. The bill, which was already approved by the state Senate, is primarily aimed at raising reimbursement rates for hospitals that see a lot of Medicaid patients. Read More

Illinois

Illinois Files Order to Liquidate Medicare Plan Community Care Alliance. *Modern Healthcare* reported on April 1, 2019, that Illinois filed an order in state court to liquidate Medicare plan Community Care Alliance of Illinois (CCAI). CCAI, with fewer than 10,000 Medicare, prescription drug, and dual members, didn't appeal. Insurance contracts will remain in force until the Illinois Department of Insurance decides on the terms of cancellation or renewal. CCAI is a subsidiary of Family Health Network (FHN). Read More

Illinois Hospitals Staff Up to Chase Down Medicaid Managed Care Payments. *Modern Healthcare* reported on April 1, 2019, that Illinois hospitals have increased administrative staff to address payments for denied or delayed Medicaid managed care claims. An analysis by the state Department of Healthcare & Family Services found that 11 percent of the 825,000 Medicaid managed care claims submitted in the first quarter of 2018 were denied, largely because of missing information or prior authorization requirements. Read more

Iowa

Iowa to Lose Another Medicaid Plan as UnitedHealthcare of the River Valley Announces Exit. *The Gazette* reported on March 29, 2019, that UnitedHealthcare of the River Valley is exiting Iowa's Medicaid managed care program, according to the Iowa Department of Human Services. Contract negotiations between UnitedHealthcare and the state were stalled after plan officials pushed back on performance measures with financial penalties. UnitedHealthcare will continue providing coverage to the nearly 427,000 Medicaid beneficiaries in the state until July 1, 2019, when Iowa Total Care (Centene) is scheduled to join the program. Read More

Kansas

Senate Republican Leaders Seek to Stall Vote on Medicaid Expansion. *The New York Times/Associated Press* reported on April 2, 2019, that Kansas Republican leaders want their moderate GOP colleagues to stop pushing for Medicaid expansion this year. A GOP appointed legislative committee plans to study proposals that could garner broader support from Republicans such as implementing work requirements or requiring drug testing for people receiving the expanded coverage. In the meantime, supporters of Medicaid expansion want the Senate to allow a vote. More than 150,000 additional people would qualify for Medicaid with the expansion. Read More

Louisiana

Governor Is No Longer Pursuing Medicaid Work Requirement. *The Associated Press* reported on April 1, 2019, that Louisiana Governor John Bel Edwards is no longer pursuing Medicaid work requirements, which had already stalled in the state legislature a year ago. Instead, Edwards is now pushing a workforce skills training pilot for about 50 Medicaid expansion recipients. Read More

Louisiana to Disenroll 37,000 Medicaid Beneficiaries for Not Meeting Income Requirements. *KPLC* reported on March 27, 2019, that 37,000 Louisianans will lose Medicaid coverage on April 1 because they no longer meet the state's income requirements. The state has tightened its monitoring of income eligibility by instituting a new Medicaid verification system that checks beneficiary income every three months with the Louisiana Workforce Commission. Louisianans losing coverage will have about 60 days to apply for health insurance on the federal exchange, HealthCare.gov. Read More

Minnesota

Minnesota Individual Plans Post Strong 2018 Financial Performance. *The St. Paul Business Journal* reported on April 2, 2019, that not-for-profit health plans in Minnesota saw profits rise in 2018, in part from a state reinsurance program that helped buoy financial performance in the individual market, according to results released by the Minnesota Council of Health Plans. Two plans – Blue Cross Blue Shield of Minnesota and UCare – could be issuing millions in Affordable Care Act rebates to consumers. Read More

Missouri

Missouri Saw Rise in Risk of Suicide Among Children With Mental Illness After To Transition Medicaid Managed Care, Study Finds. *Kaiser Health News* reported on April 1, 2019, that Missouri experienced an increase in the risk of suicide after the state transitioned 2,000 children diagnosed with mental health illness to Medicaid managed care, according to a study from the Missouri Hospital Association. The study acknowledged that factors other than the shift to managed care may have played a role, including social media, cyberbullying, and lack of access to specialized mental health care. The study found that the percentage of these children experiencing thoughts of suicide doubled after the transition to managed care. Overall, the suicide rate among children in Missouri has doubled from 2.8 per 100,000 in 2003 to 6.4 per 100,000 in 2017. Read More

Montana

House Committee Passes Bill to Continue Medicaid Expansion, Add Work Requirements. *ABC Fox Montana/Associated Press* reported on March 29, 2019, that the Montana House approved a bill to continue the state's Medicaid expansion and add work requirements. The measure, sponsored by Representative Ed Buttrey (R-Great Falls), would also increase premiums on individuals who remain on Medicaid expansion for more than two years and calls for taxes on hospital revenues for outpatient services. The state estimates the amended bill would cost the state an additional $15 million to $20 million per year over the next four fiscal years and result in about 4,000 individuals losing coverage. The bill now heads to the Senate for final vote. Read More

Nebraska

Nebraska Announces Plan to Expand Medicaid by 2020. On April 1, 2019, the Nebraska Department of Health and Human Services announced its intention to go forward with a voter-approved Medicaid expansion initiative by October 1, 2020, having submitted a plan to federal regulators for approval. An estimated 90,000 adults would be eligible for expansion, with coverage offered through the state's existing three Medicaid managed care plans: Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, and WellCare of Nebraska. Members will receive basic coverage to start; however, they can earn enhanced coverage including vision and dental by participating in care and case management, selecting a primary care provider, and receiving an annual checkup. Read More

New Hampshire

Senate Passes Medicaid Telehealth Bill. *mHealthIntelligence.com* reported on March 29, 2019, that the New Hampshire Senate recently passed a bill expanding Medicaid coverage for telehealth services. The bill, which heads to the House for a final vote, would allow a patient to receive primary care in addition to specialty care via telehealth and enables Medicaid to cover far more connected care services than previously. For primary care, remote patient monitoring, and substance abuse disorder services, the bill requires that the patient has established prior face-to-face in-person care. Read More

New Hampshire Approves Medicaid Managed Care Contracts. *The News & Observer* reported on March 27, 2019, that the New Hampshire Executive Council approved Medicaid managed care contracts awarded earlier this year to Well Sense (owned by BMC Health Plan), New Hampshire Healthy Families (owned by Centene), and AmeriHealth Caritas. The contracts cover 180,000 Medicaid beneficiaries and total $1 billion. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Proposes Medicaid Managed Care Rules Readoption with Amendments. *The New Jersey Register* reported on April 1, 2019, that the New Jersey Department of Human Services, Division of Medical Assistance and Health Services released the proposed readoption of the rule for Managed Health Care Services for Medicaid/New Jersey FamilyCare Beneficiaries with amendments. This release opens the rule to a 60-day public comment period ending on May 31, 2019. The rule which was scheduled to expire on January 24, 2019, was extended to July 23, 2019. Many of the provisions were amended to reflect updates to the program since the rule has not been revised since 2006.

New York

HMA Roundup – Denise Soffel (Email Denise)

Legislature Approves State Budget. On March 31, 2019, the New York legislature approved the state budget for the current fiscal year which began April 1, 2019. The approved budget totals $175.5 billion, of which $73.9 billion, or 42.1 percent, is spending on Medicaid. For the first time since the Medicaid Redesign Team introduced a Global Spending Cap for New York's Medicaid program, the governor has proposed increasing Medicaid spending by 3.6 percent, above the 3.1 percent allowed under the global cap. The Governor rescinded that increase during the 30-day budget amendment period but both houses of the legislature rejected the cut, and it was not included in the final budget. Read More

New York Crystal Run Health Plan Seeks to Exit Managed Care Market. *The Times Herald-Record* reported on March 29, 2019, that New York's Crystal Run Healthcare will seek state approval to eliminate its health plans. Company leaders said they are exiting the insurance market due to the ACA's faulty risk-adjustment methodology. Crystal Run serves serving 6,401 members, including 1,660 in Medicaid managed care. Enrollment is limited to individuals who reside in Sullivan and Orange counties. Crystal Run Healthcare is a large multispecialty group practice in Sullivan and Orange Counties. Crystal Run began operating a Medicaid managed care plan in 2016 and also operates an ACO and participates in the Medicare Shared Savings Program. Read More

New York Drug Utilization Review Board Seeks New Members. The New York State Department of Health is seeking new members for the Medicaid Drug Utilization Review Board (DURB). The DURB establishes medical standards and criteria for Drug Utilization Review programs, develops educational interventions for physicians and pharmacists, reviews therapeutic classes in the Medicaid Fee-for-Service Preferred Drug Program (PDP), and makes recommendations for supplemental rebates. The DURB currently has one open physician seat, one open pharmacist seat, and two open consumer-advocate seats. Questions regarding membership and candidacy should be submitted to dur@health.ny.gov.

New York Home Care Workers Lose Wage Dispute. On March 26, 2019, the New York Court of Appeals upheld a Department of Labor interpretation of how home health care aides must be paid. Under the Department of Labor rules, a home health attendant working a 24-hour shift can be paid for only 13 hours of work per day, assuming that they are allowed eight hours of sleep and three hours for meals. The Court reversed the decisions of two intermediate appellate courts, both of which had rejected the Department of Labor interpretation, holding that such home attendants must be paid for the entire 24-hour on-premises shift, regardless of what the attendants are doing (or not doing) during that time. The case was brought by two home care workers who argued that New York's minimum wage law requires that workers be paid for the time an employee is required to be available for work. Had the decision been allowed to stand, it would have meant that home care agencies pay for an additional 11 hours of care per day, almost doubling the cost of care, estimated to increase costs for home care in New York's Medicaid program by tens of millions of dollars. Read More

New York Approves WellCare Medicaid Managed Care Expansion To Three More Counties. WellCare Health Plans announced on April 2, 2019, that it will offer Medicaid managed care, Child Health Plus, and Essential Plan coverage in three more New York counties – Broome, Richmond, and Suffolk – after receiving approval from state regulators. WellCare of New York has approximately 155,000 Medicaid, 89,000 Medicare Advantage, and 52,000 Medicare Prescription Drug Plan members in the state. WellCare currently serves Nassau, Kings, Queens, Manhattan, Bronx, Erie, Niagara, Steuben, Schuyler, Albany, Schenectady, Rensselaer, Duchess, Orange, Ulster, and Rockland counties in New York. Read More

North Carolina

North Carolina Audit Finds Behavioral Health LME/MCOs Had $440 Million in Excess Savings. *The News & Observer* reported on March 27, 2019, that North Carolina Local Management Entities/Managed Care Organizations (LME/MCOs) covering behavioral health care had nearly $440 million in excess savings in fiscal years 2015 through 2017 combined, according to a report from the Office of the State Auditor. Excess savings refer to unspent funds remaining from capitated payments received by LME/MCOs, which averaged $2.6 billion from state and federal sources annually over the three-year period. LME/MCOs cover Medicaid mental health, developmental disability, and substance abuse services. Read More

North Dakota

North Dakota Expands Telemedicine Services to Combat Psychiatrist Shortage. *Stat News* reported on March 28, 2019, that North Dakota is increasing the use of telemedicine as an option for mental health care, allowing providers in cities and out-of-state to deliver services in rural areas. There are 25 psychiatrists (including three out-of-state) who use telemedicine to provide services through the state human services department clinics. These psychiatrists conducted nearly 500 telemedicine appointments in December 2018. Read More

Ohio

Ohio to Review Work Requirement Plans. *The Statehouse News Bureau* reported on March 29, 2019, that in response to the work requirements for Arkansas and Kentucky being thrown out by a U.S. District Court judge who deemed them to be "arbitrary and capricious," Ohio will be reviewing its plan for work requirements. Ohio Medicaid says that its work requirements are different from those in Arkansas and Kentucky, but that they will still review their plan. Read More

Ohio Hospital Pharmacy Problems Addressed, But Other Issues Identified. *The Columbus Dispatch* reported on March 27, 2019, that a federal inspection at an Ohio hospital still found significant issues that could threaten the hospital's compliance. Mount Carmel West Hospital, which has been under review since December because one of its doctors allegedly ordered excessive doses of opioids for patients, has remedied the deficiencies in its pharmacy department, but now has other issues to address. Mount Carmel's other hospital, St. Ann's, had a full inspection on March 15, for which the results are forthcoming. Read More

Pennsylvania

PA Department of Human Services Budget Updates Presented at Public Meeting. Representatives from the Pennsylvania Department of Human Services (DHS) presented their budget requests for Fiscal Year (FY) 2019-2020 at the March 28, 2019, Medical Assistance Advisory Committee (MAAC).

Office of Medical Assistance Programs (OMAP) Budget Presentation
Appropriations for $18.2 billion in total funds for Medical Assistance are:

- $14.4 billion for capitation
- $2.3 billion for Fee-for-Service programs
- $0.8 billion for Medicare Part D
- $0.2 billion for Medical Assistance Transportation Program (MATP)
- $0.5 billion for other expenses

The Medical Assistance Transportation appropriation maintains the same county-based program for FY 2019-20. The department will implement a regional broker model to administer the transportation program in FY 2020-21. No timeline for the HealthChoices RFP was provided.

Office of Long-Term Living (OLTL) Budget Presentation
The OLTL budget request expands the total number of individuals covered in the OLTL waivers and includes funds to establish a single responsibility for financial eligibility determinations. Total federal, state, and other funding for OLTL was about $9.59 billion, an increase of $755,260,000 in available funding:

- Community HealthChoices: approximately $7.223 billion
- Long-term Care: $1.297 billion
- Home and Community-Based Services: $371,318,000
- Managed Long-Term Care: $328,655,000
- Services to Persons with Disabilities: $245,997,000
- Attendant Care: $124,094,000

Office of Mental Health and Substance Abuse Services (OMHSAS) Budget Presentation
Total funding for OMHSAS is $4,766,000,000, with HealthChoices Behavioral Health Managed Care taking up 74 percent of that budget. As of December 2018, 2,618,000 people were enrolled in HealthChoices Behavioral Health. OMHSAS also requested the following for FY 2019-2020:

- Community Health Services: $670,453,000
- State-operated facilities: $461,177,000
- DHS Administered BHSI/drug and Alcohol and Act 152: $53,156,000
- Medicaid: $3,581,000,000
- Special Pharmaceutical Benefits Program (SPBP): $852,000

Office of Developmental Programs (ODP) Budget Presentation
The 2019-2020 budget provides $2,117,000,000 in state funds for ODP, including:

- Community Services Waiver Program: $1,672,826
- Autism Intervention and Services: $29,683,000
- Community ID Services: $148,725,000
- Private Intermediate Care Facilities for the Intellectually Disabled: $148,148,000
- State Intellectual Disabilities Center: $117,136,000

Tennessee

Medicaid Program Cuts 128,000 Kids over the Past Two Years. *The Tennessean* reported on April 2, 2019, that Tennessee has cut at least 128,000 children from the state's TennCare and CoverKids programs over the last two years because they are no longer qualified or their families failed to submit renewal forms. Families have complained they were unaware their children had lost coverage. Read More

Utah

Utah Receives CMS Approval for Partial Medicaid Expansion Waiver. *Politico* reported on March 29, 2019, that the Centers for Medicare & Medicaid Services (CMS) has approved Utah's proposal for a partial Medicaid expansion waiver for adults up to 100 percent of poverty. The plan, which replaces a voter-approved Medicaid expansion initiative, would reduce projected expansion enrollment by 60,000 as well as institute Medicaid work requirements. The state still awaits approval for enhanced federal funding and per-person limits on the amount of federal funding received. Coverage under the waiver is expected to start April 1, 2019. Read More

West Virginia

West Virginia Medicaid Expansion Improves Access to Opioid Treatment, Study Finds. *U.S. News & World Report* reported on April 1, 2019, that Medicaid expansion in West Virginia resulted in an increase in the number of individuals accessing treatment for opioid use disorder between January 2014 and December 2016, according to a study by researchers at Johns Hopkins University, George Washington University, and the Rand Corporation. West Virginia continues to have highest rate of drug overdose deaths in the country. Read More

Wisconsin

Wisconsin to Implement Medicaid Work Requirements Despite Federal Judge's Ruling. *The Wisconsin State Journal* reported on March 30, 2019, that Wisconsin will proceed with the implementation of Medicaid work requirements this fall unless federal regulators say otherwise. Last week, a federal judge blocked work requirements in Arkansas and Kentucky after finding that the requirements fail to promote the objectives of Medicaid. Wisconsin Medicaid beneficiaries would lose coverage for failing to meet monthly work requirements; however, after six months they can reapply. The state can also charge monthly premiums and co-payments of up to $8 for non-emergency ER visits. Read More

National

Senate Majority Leader McConnell Nixes Idea to Repeal, Replace ACA Before 2020 Election. *The Hill* reported on April 2, 2019, that Senate Majority Leader Mitch McConnell (R-KY) indicated to President Trump that the Senate will not work on a comprehensive health care package to replace the Affordable Care Act before the 2020 election. The comment was in response to Trump's request for Republican senators to create legislation to replace the ACA. Read More

Senate Passes Bill to Fund for Medicaid Health Homes for Chronically Ill Children. *Modern Healthcare* reported on April 2, 2019, that the U.S. Senate passed the Advancing Care for Exceptional Kids Act, which would help states establish a hospital-coordinated health home program for chronically ill children through increased federal Medicaid funds. The bill, sponsored by Senators Chuck Grassley (R-IA) and Michael Bennet (D-CO), increases the federal Medicaid match by 15 percent for two fiscal quarters. Read More

Federal Judge Blocks Rule Aimed at Expanding Association Health Plans. *Modern Healthcare* reported on March 28, 2019, that U.S. District Judge John Bates blocked a rule from the U.S. Department of Labor aimed at expanding access to association health plans. Under the rule, employers could form associations solely for the purpose of creating association health plans that skirt Affordable Care Act market requirements. The Trump administration is expected to appeal the judge's ruling. Read More

GAO Recommends Reassessment of Medicare, Medicaid Medical Record Documentation Requirements. The Government Accountability Office (GAO) urged federal regulators to reassess Medicare and Medicaid medical records documentation requirements and specifically ensure that Medicaid medical reviews effectively address the causes of improper claims payments. In a March 2019 report titled, "CMS Should Assess Documentation Necessary to Identify Improper Payments," GAO noted that most of the improper payments made in 2017 were related to insufficient documentation. It added that Medicaid medical reviews by the Centers for Medicare & Medicaid Services (CMS) "may not provide the robust state-specific information needed to identify causes of improper payments."

New York, Minnesota Could See $300 Million in Federal Funding Cuts for Basic Health Program. *Modern Healthcare* reported on March 29, 2019, that New York and Minnesota would see federal funding for the Basic Health Program (BHP) cut by $300 million over two years from a change in payment methodology proposed by the Centers for Medicare & Medicaid Services (CMS). The new payment methodology incorporates enrollee age, geographic area, household income, and plan type instead of calculating payments based on premium tax credits and cost-sharing. CMS said that states would have to make up for the shortfall themselves. The Affordable Care Act's BHP, which is offered solely in New York and Minnesota, covers individuals at 133 percent to 200 percent of poverty. Read More

Arkansas, Kentucky Medicaid Work Requirements Struck Down By Federal Judge. *Kaiser Health News* reported on March 27, 2019, that U.S. District Judge James Boasberg struck down Medicaid work requirements in Kentucky and Arkansas, finding that the requirements fail to promote the objectives of Medicaid. It is the second time Boasberg has blocked Kentucky from implementing work requirements. The ruling also blocks Arkansas from continuing the policy, which has already resulted in more than 18,000 failing to meet work requirements in the state. Read More

Industry News

Encompass Health to Acquire Alacare Home Health & Hospice. Encompass Health announced on April 1, 2019, that it has entered into a definitive agreement to acquire the assets of privately owned Alacare Home Health & Hospice. Alacare, based in Birmingham, AL, operates 23 home health and 23 hospice locations in Alabama. The transaction is expected to close in the second quarter of 2019. Read More

Fairness Project Plays Role in Successful Medicaid Expansion Ballot Initiatives. *Health Affairs* reported on March 29, 2019, that The Fairness Project, a not-for-profit organization launched in 2015 with support from the Service Employees International Union-United Healthcare Workers West (SEIU-UHW), played a key role in all four successful Medicaid expansion ballot measures in November 2018. A total of 405,000 uninsured low-income individuals would be impacted by full expansion in these four states: Idaho (90,000); Maine (70,000); Nebraska (90,000); and Utah (155,000). Read More

Community Health Systems To Sell Tennova Healthcare-Lebanon. Community Health Systems announced on March 29, 2019, a definitive agreement to sell its Lebanon, Tennessee, 245-bed hospital, Tennova Healthcare, and its assets to subsidiaries of Vanderbilt University Medical Center. The transaction is expected to close in the third quarter of 2019. Read More

Blue Sprig Pediatrics Announces Acquisition of Tangible Difference Learning Center. Blue Sprig Pediatrics announced on March 29, 2019, that it has acquired the assets of clinic-based autism applied behavior analysis provider Tangible Difference Learning Center (TDLC), which has three Houston locations. Terms of the transactions were not disclosed. Read More

Western MD Health System, UPMC Announce Affiliation. *Modern Healthcare* reported on April 1, 2019, that Cumberland, MD-based Western Maryland Health System (WMHS) has signed a non-binding letter of intent to enter into an affiliation agreement with University of Pittsburgh Medical Center (UPMC). Details of the affiliation have not been announced. However, the two organizations already have a clinical affiliation in which UPMC behavioral health, oncology, and cardiovascular and neurological surgery specialists practice in WMHS' acute-care hospital. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
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 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
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

Janet L Meyer – Principal

A leader in not-for-profit healthcare, Janet L. Meyer is a seasoned and results-oriented professional experienced in integrated delivery systems, community-driven transformation and publicly funded healthcare.

During her career, she has served Medicaid enrollees at the highest level as a health plan chief executive (CEO) and chief operating officer (COO).

Before joining HMA, Janet was CEO of Health Share of Oregon where she led certification, development and implementation of the state's largest coordinated care organization (CCO) serving Medicaid enrollees. She successfully developed and implemented strategic plans and tactical initiatives to address health disparities, upstream prevention initiatives, and targeted programs for vulnerable and high-risk populations.

With a focus on data and analytics, she worked to elevate equity and the elimination of disparities in the CCO by prioritizing staff education and development programs, appointment of a chief engagement and equity officer, funding a fully staffed equity team, and prioritizing disparities and equity metrics.

A leader in developing community based, cross-sector collaboratives, Janet also worked to develop and implement strategies to build and maintain strong, cross-functional teams, mutually-beneficial partnerships, and products and services to reach a diverse audience. She has significant experience with alternate payment methodologies and Medicaid rate setting. Her previous work also included clinic management, leading product diversification initiatives and assisting with Medicare Advantage rollout.

Janet earned a Master of Health Administration from the University of Michigan and a bachelor's degree from the University of Oregon.

HMA NEWS

Upcoming Webinars:

April 16, 2019 - Rethinking Behavioral Health Crisis Systems: Saving Lives, Saving Resources. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Arizona Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Florida Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Iowa Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Indiana Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Louisiana Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Michigan Medicaid Managed Care Rates by Eligibility Category, 2017-18
- Alabama Medicaid Enrollment is Down 2.1%, 2017 Data
- Colorado RCCO Payments Top $150 Million, FY 2018 Data
- Illinois Dual Demo Enrollment is Down 1.7%, Feb-19 Data
- Indiana Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Kansas Medicaid Managed Care Enrollment is Down 1.1%, Mar-19 Data
- Missouri Medicaid Managed Care Enrollment is Down 1.4%, Feb-19 Data
- New Mexico Medicaid Managed Care Enrollment is Flat, Mar-19 Data
- New York CHIP Managed Care Enrollment is Up 2.5%, Mar-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Connecticut Dental Administrative Services Organization RFP, Mar-19
- Florida Statewide Medicaid Managed Care Model Contract, Feb-19
- Hawaii Kōkua Services for the Med-QUEST Program RFP, Mar-19
- Louisiana Independent Verification & Validation Services RFP, Mar-19
- Minnesota Families and Children MA and MinnesotaCare RFP and Related Documents, Apr-19
- Minnesota Senior Health Options and Minnesota Senior Care Plus RFP and Related Documents, Apr-19
- New York Integrated Care for Kids (InCK) Model RFP, Apr-19
- Virginia DMAS Organizational Transformation RFP and Award, Mar-19
- Vermont OneCare ACO Model Contract, 2019

Medicaid Program Reports, Data and Updates:

- CMS Home and Community-Based Settings Final Rule Guidance Responses to FAQs, Mar-19
- Exchange Open Enrollment Period Final Reports, 2015-19
- GAO – CMS Should Assess Documentation Necessary to Identify Improper Payments Report, Mar-19
- Medicaid Managed Care Enrollment for 300 Plans in 38 States, Plus Ownership and For-Profit vs. Not-for-Profit Status, Updated Apr-19
- U.S. Medicaid, CHIP Enrollment at 72.6 Million, Dec-18 Data
- Connecticut Department of Social Services: People Served by Gender, Age-groups, Race, Ethnicity, Program, Assistance Type, and Medical Benefit Plan, 2012-18

- Florida Managed Medical Assistance (MMA) 1115 Demonstration Waiver Approval and Amendments, 2019
- Maine 1115 MaineCare Medicaid Waiver Application, Approval, and Withdrawal, 2017-19
- Maine 1915(c) Home and Community-Based Services Waiver – Intellectual Disabilities and Autism Spectrum Disorder, Renewal and Amendment, 2016-19
- Maine Demonstration for Individuals with HIV/AIDS 1115 Waiver Documents, 2014-18
- Medicaid Managed Care Rates by Eligibility Category, 2018
- North Carolina Support of Advanced Medical Homes Care Management Data Needs Policy Paper, Feb-19
- New Hampshire Building Capacity for Transformation 1115 Waiver Documents, 2014-19
- New Jersey 2018 CAHPS Results for Medicaid Managed Care Plans
- New York DOH Medicaid Updates, Mar-19
- Ohio Medicaid Enrollment by Eligibility Category, Feb-19
- Oklahoma SoonerCare 1115 Waiver Documents, 2015-19
- Pennsylvania Governor's Proposed Executive Budget, 2019-20
- Pennsylvania Implementation of the Functional Eligibility Determination (FED) Process for Medical Assistance (MA) Long-Term Services and Supports (LTSS) Bulletin, Apr-19
- Pennsylvania Medical Assistance Advisory Committee Meeting Materials, Mar-19
- South Dakota Governor's Proposed Budget, FY 2020
- South Dakota Individuals Eligible for Medicaid by Age and County, Feb-19
- Texas HHSC Targeted Opioid Response Report, Mar-19
- Utah 1115 Primary Care Network Demonstration Waiver Documents, 2016-19
- Vermont Accountable Care Organizations and the VT All-Payer ACO Model Agreement Presentation, Feb-18
- Vermont OneCare ACO Budget Submission, FY 2019
- Wisconsin Senior Care 1115 Waiver Documents, 2013-19

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:

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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.
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