HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 31, 2018

RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

TEXAS DRAFT STAR AND CHIP MANAGED CARE SERVICES RFP

This week, our *In Focus* reviews Texas' draft STAR and CHIP managed care services request for proposals (RFP) issued by the state's Health and Human Services Commission (HHSC) on January 29, 2018. The STAR program is Texas' Medicaid managed care program for pregnant women, newborns, children, and parents. The purpose of the draft RFP is to gather "suggestions and ideas to enhance, expand and support" the services offered through these programs. A formal RFP is anticipated to be released April 6, 2018.

As of January 2017, STAR enrollment was nearly 3 million and CHIP enrollment exceeded 390,000. Projected calendar year (CY) 2020 premiums for the STAR program are estimated to exceed $9.2 billion, and projected CY 2020 premiums for the CHIP program are estimated at approximately $790 million.

Services and Populations Covered

The STAR program provides preventive, primary, acute care, behavioral health, and pharmacy services to pregnant women, newborns, children, and parents who meet income requirements. Texas estimates the STAR population will grow approximately 3 percent to 3,163,084 between January 2018 and the anticipated operational start date of contracts.

Texas' CHIP program provides primary and preventative health care to low-income, uninsured pregnant women and children who are not eligible for Medicaid, including children with special health care needs. Texas estimates the CHIP population will grow approximately 11 percent to 465,531 between January 2018 and the anticipated operational start date of contracts.

Texas has three additional managed care programs that are not covered under this draft RFP: STAR+PLUS, which covers SSI-eligible individuals age 21 and older, dual eligibles, individuals eligible for the Medicaid for Breast and Cervical Cancer program, individuals enrolled in various HCBS waivers, and individuals with disabilities age 65 or older; STAR Health, which covers children who receive Medicaid through the Texas Department of Family and Protective services, including foster kids; and STAR Kids, which covers individuals with disabilities age 21 or younger.

New Administrative Payment Bid Requirement

The RFP includes a new requirement that managed care organizations (MCOs) must submit an administrative expense component that will be considered in development of the MCO's total capitation payment. Each MCO must submit a proposed administrative per member per month (PMPM) rate for both STAR and CHIP by service area and risk group, and that PMPM amount will constitute the MCO's sole compensation for the allowable administrative costs. HHSC reserves the right to adjust the MCO's proposed Administrative Bid and negotiate an alternative rate if the MCO's proposed rate is higher than rates developed by HHSC. PBM administrative payments must be included in the bid as well as the administrative components of any subcontracted services such as behavioral health and vision.

Service Areas and Number of Awards

The draft RFP covers all 13 STAR service areas that comprise the state. HHSC anticipates awarding contracts to at least two MCOs per service area. Respondents may select what service areas they will serve, but they must serve all counties in their proposed service areas.

Contract Term

HHSC anticipates the initial operational contract dates to run from January 1, 2020, through December 31, 2021. Contracts may be extended but will not exceed a total of eight operational years.

SCORING

Scoring criteria for the draft RFP is divided into four categories, with nearly half of the total score tied to the extent to which goods and services meet HHSC's needs and the needs of its members. Components of this criteria include respondents' expertise in providing services to similar populations, the administrative payment bid, and past medical cost performance. Other scoring criteria categories include indicators of vendor performance; the effect of contracting with a respondent on HHSC's productivity; and the ability of a respondent to implement and maintain services.

Texas STAR And CHIP RFP Scoring		
Scoring Criteria	**Examples of Scoring Criteria Compenents**	**% of Total Score**
Extent to which goods and services meet HHSC's needs and the needs of members	- Extent to which the proposal exhibits the respondent's expertise in providing services to populations comparable populations - Administrative payment bid and past medical cost performance - Quality and reliability of goods and services, including the ability to retain and recruit a provider network	48%
Indicators of vendor performance	- Past performance in the state including ability to integrate physical and behavioral health - Financial solvency - Capacity of organizational structure	24%
Effect of contracting with respondent on productivity of HHSC	- Level of effort of agency to monitor and maintain a good working relationship with respodent	14%
Delivery terms	Ability to: - Complete transition phase and implement services by operational start - Maintain services through contract - Comply with potential termination of contract	14%

RFP TIMELINE

Public comments on the draft RFP are due March 1, 2018, and the formal RFP will be released April 6, 2018. Implementation of the programs is scheduled for January 1, 2020.

Texas STAR And CHIP RFP Timeline	
RFP Activity	**Date**
Draft RFP Released	January 29, 2018
Public Comments Due	March 1, 2018
RFP Release Date	April 6, 2018
Vendor Conference (Anticipated)	April 12, 2018
Deadline for Submitting Questions	April 19, 2018
Responses to Vendor Questions Posted	May 15, 2018
Proposals Due	July 2, 2018
Anticipated Evaluation Period	July 3, 2018 - September 26, 2018
Anticipated Contract Start Date or Effective Date	January 24, 2019
Operational Start Date	January 1, 2020

Current Market

The most recent STAR and CHIP enrollment data by plan, which was released by the state in February 2017, shows STAR enrollment at 2.9 million and CHIP enrollment at 425,000. Of the 18 plans participating in the STAR program at that time, Superior Health Plan (Centene) and Amerigroup (Anthem) enrolled the most STAR members, with 24.0 percent and 19.3 percent market shares, respectively. Of the 17 plans participating in CHIP, Superior Health Plan (Centene) and Amerigroup (Anthem) again held the highest market shares, with 23.0 percent and 16.3 percent market shares, respectively. Texas Children's Health Plan held a 14.7 percent share.

Enrollment in Texas STAR and CHIP Managed Care Plans, February 2017						
Plan Name	STAR	% of STAR Total	CHIP	% of CHIP Total	Total	% of Total
Centene/Superior Health Plan	699,456	24.0%	97,867	23.0%	797,323	23.9%
Anthem/Amerigroup	562,190	19.3%	69,404	16.3%	631,594	18.9%
Texas Children's Health Plan	343,088	11.8%	62,603	14.7%	405,691	12.1%
Community Health Choice	240,451	8.2%	32,201	7.6%	272,652	8.2%
Parkland Community Health Plan	164,592	5.6%	27,963	6.6%	192,555	5.8%
Driscoll Children's Health Plan	147,448	5.1%	7,232	1.7%	154,680	4.6%
UnitedHealthcare	125,311	4.3%	10,910	2.6%	136,221	4.1%
Molina	96,685	3.3%	32,431	7.6%	129,116	3.9%
Cook Children's Health Plan	101,259	3.5%	22,309	5.2%	123,568	3.7%
Community First Health Plan	104,105	3.6%	19,073	4.5%	123,178	3.7%
FirstCare	90,579	3.1%	5,300	1.2%	95,879	2.9%
Aetna	70,725	2.4%	10,812	2.5%	81,537	2.4%
El Paso First	65,180	2.2%	10,770	2.5%	75,950	2.3%
RightCare from Scott and White Health Plan	44,301	1.5%	N/A	N/A	44,301	1.3%
Blue Cross Blue Shield of Texas	24,927	0.9%	6,435	1.5%	31,362	0.9%
Seton Health Plan	17,983	0.6%	7,556	1.8%	25,539	0.8%
Sendero Health Plans	13,403	0.5%	2,089	0.5%	15,492	0.5%
CHRISTUS Health Plan	5,411	0.2%	481	0.1%	5,892	0.2%
Total Texas	2,917,094		425,436		3,342,530	

Source: TX Health and Human Services Commission, HMA

Link to draft RFP: http://www.txsmartbuy.com/sp/HHS0000636%20DRAFT

HMA MEDICAID ROUNDUP

Alabama

Alabama to Release RFP for Medicaid LTSS Integrated Care Networks. The Alabama Medicaid Agency announced on January 11, 2018, that it will release a request for proposal (RFP) for its Medicaid long-term services and supports Integrated Care Network program (ICN) in March 2018. The state will select a single ICN entity that will work with individuals in nursing facilities and in home and community-based settings to improve education and outreach, promote home and community based services, and expand comprehensive and integrated case management. Alabama will announce the award winner in April or May 2018, and the program will go live in October 2018.

Arizona

Arizona Attracts 7 Bidders for Medicaid Managed Care RFP. On January 25, 2018, Arizona released a list of seven health plans that submitted bids for the state's Complete Care procurement, which will integrate physical and behavioral Medicaid managed care programs. The following companies submitted proposals:

1. Magellan Complete Care of Arizona, Inc.
2. UnitedHealthcare Community Plan
3. Mercy Care
4. Banner – University Family Care Plan
5. Health Net Access, Inc. (Centene)
6. Health Choice Arizona, Inc. (Steward Health Choice Arizona)
7. Care1st Health Plan Arizona, Inc. (WellCare) Read More

Arkansas

Arkansas Names Mark White DHS Deputy Director. The Arkansas Department of Human Services (DHS) announced on January 31, 2018, that Mark White will serve as deputy director of the Division for Aging, Adult, and Behavioral Health. White's appointment is effective February 19. He previously served a stint as deputy director from 2015 to 2016. Read More

Delaware

Delaware to Penalize Medicaid Plans for Poor Health Outcomes. *The News Journal* reported on January 30, 2018, that Delaware has changed its Medicaid managed care contracts, adding financial penalties to plans that don't meet certain outcomes-based performance measures. The new three-year contracts will address seven measures, including management of diabetes cases, asthma management, cervical cancer screenings, breast cancer screenings, obesity management, timeliness of prenatal care, and 30-day hospital readmission rates. Read More

Florida

Florida DOH, Office of Children's Medical Services (CMS), Releases Managed Care Program ITN. Florida's Department of Health (DOH) released an Invitation to Negotiate (ITN) for services for the Statewide Medicaid Managed Care Program and Children's Health Insurance Program (CHIP) on January 30, 2018. The Department intends to award one statewide contract to a respondent to assist with the administration of the Children's Medical Services plan. The Department will award additional contracts only if there is no acceptable statewide respondent for all areas of the state. Respondents may propose statewide or on a regional cluster with either a full-risk model or a phased-in risk model. Respondents may opt to be full risk in one or two regional clusters and partial risk in the others and may submit a statewide and regional cluster reply simultaneously. Respondents must provide services for both Title XIX and Title XXI enrollees in every regional cluster for which they submit a reply. Regional clusters are as follows: Northern Florida-AHCA Regions 1-4; Central/Southwestern Florida- AHCA Regions 5-8; and South/Southeastern Florida-AHCA Regions 9-11. The anticipated term of the resulting Contract will be from January 1, 2019, through September 30, 2023. The deadline for receipt of responses is April 27, 2018. The anticipated notice of intent to award is June 26, 2018. Read More

Budget Proposal Calls for Redistribution of Medicaid Rate Enhancements to Hospitals. *Health News Florida* reported on January 31, 2018, that a budget proposal from the Florida Senate would redistribute more than $300 million in Medicaid automatic rate enhancements to hospitals as well as add $50 million in new funding. The change would result in Medicaid payments falling drastically for some hospitals, while others would see increases. Automatic rate enhancements are currently provided to 28 hospitals in the state. Read More

Georgia

Republican Lawmakers Continue to Oppose Medicaid Expansion. The *Georgia Health News* reported on January 29, 2018, that Republican leaders in Georgia continue to oppose Medicaid expansion, and the initiative is unlikely to make it onto the state's legislative agenda this year. This is despite guidance from the Trump administration that it would permit Medicaid work requirements, a move that has Republicans in several states reconsidering expansion. Georgia House Speaker David Ralston (R-Blue Ridge) and the administration of Governor Nathan Deal continue to oppose expansion. Read More

Idaho

Idaho Reveals Plan to Allow Individual Health Coverage that Skirts ACA Requirements. *Modern Healthcare* reported on January 24, 2018, that Idaho has revealed a plan to allow health insurers to sell individual policies that do not comply with key provisions of the Affordable Care Act. Dean Cameron, director of the Idaho Department of Insurance, hopes these plans will attract healthy individuals and help shore up the individual health insurance risk pool given the demise of the individual mandate. Read More

Kansas

Kansas May Seek 3-Year Renewal of Existing Medicaid Managed Care Contracts After Governor Scraps KanCare 2.0. Kansas Governor Sam Brownback announced on January 24, 2018, that the state was halting plans to roll out the proposed KanCare 2.0 Medicaid managed care program amid cost concerns. Instead, the state will seek a three-year renewal of existing KanCare Medicaid managed care contracts with Anthem/Amerigroup, Centene/Sunflower State Health Plan, and UnitedHealthcare; or, it will evaluate the KanCare 2.0 bids it has already received "without the cost increase drivers" that had caused state lawmakers to raise concerns about the new program. The Brownback administration will still attempt to implement Medicaid work requirements, one of the features of the KanCare 2.0 proposal.

Minnesota

Task Force Calls for Reform of Senior Care Oversight to Prevent Abuse. *The Star Tribune* reported on January 29, 2018, that a Minnesota task force led by Elder Voice Family Advocates has released a report calling for immediate reform of state regulations concerning senior care facilities to prevent further abuse of the elderly. The task force, which was formed at the request of Governor Mark Dayton, recommends tougher penalties and criminal prosecution, increased oversight, and access for victims and families to reports of abuse. Dayton plans to work with lawmakers to implement the recommendations in the upcoming legislative session. Read More

Mississippi

Mississippi Removes Provider Cuts from Medicaid Reauthorization Bill. *The Jackson Free Press* reported on January 30, 2018, that the Mississippi Senate Medicaid Committee has removed a provision from a Medicaid reauthorization bill that would have cut provider reimbursements by 5 percent. The bill, which would reauthorize the Mississippi Division of Medicaid for three years, now moves to the Senate for debate. Read More

Missouri

Governor Blames Proposed Education Cuts on 'Massive' Medicaid Spending Hike. *The St. Louis Post-Dispatch* reported on January 28, 2018, that "massive" Medicaid costs are among the key drivers cited by Missouri Governor Eric Greitens for his proposal to cut the state's higher education budget. However, health policy experts dispute the claim, noting that Missouri Medicaid growth in recent years has been on par with national averages. Read More

Montana

Montana Proposed Medicaid Rule to Reduce Coverage for Dental Procedures. The *Billings Gazette* reported on January 28, 2018, that the Montana Department of Health and Human Services proposed a new rule that would reduce coverage for dental procedures for adults and some children on Medicaid. The rule would end coverage for dentures, crowns, and bridges for adults; limit comprehensive orthodontic treatment for children up to age 20 with specific conditions; and reduce reimbursement rates for dentists by nearly 3 percent. The proposal, which is open for public comment until February 9, would save the state approximately $2.4 million. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Murphy Releases Healthcare Transition Committee Recommendations. New Jersey Governor Phil Murphy released the New Jersey Healthcare Transition Committee Report that was submitted to his administration. The report includes the following recommendations:

- Office of Health Transformation. Establish an Office of Health Transformation to oversee the transformation of health goals and enhance agency coordination.

- Improve healthcare access, value. Improve the experience, value, and accessibility of healthcare by expanding access to health insurance while reducing premiums, stabilizing the insurance market, and maintaining gains made under the Affordable Care Act (ACA); reforming out-of-network billing; insuring all children; improving maternal health and birth outcomes; implementing Hospice and Palliative Care Best Practices and a Statewide Practitioner Orders for Life Sustaining Treatment (POLST) registry; and improving accessibility to telehealth.

• Family planning. Restore, expand, and defend state and federal family planning funding and direct a comprehensive, multi-agency strategy to maximize access to family planning.

• Opioid use solutions. Address the opioid crisis and other substance abuse problems through behavioral health integration and reform; education campaigns to target audiences; and changes to end the regulatory logjam in Mental Health/Substance Use Disorder services.

• Access to health care data. Establish a statewide database to aggregate and utilize claims information to increase health care data access and promote cost transparency.

• Medicaid program improvements. Improving patient experiences, quality, and cost effectiveness of care in the state's Medicaid program by increasing the use of evidence-based performance strategies in Medicaid regulations and contracts with Medicaid Managed Care Organizations (MCOs); integrating care for individuals dually eligible for Medicare and Medicaid; developing the next iteration of Medicaid Accountable Care Organizations (ACOs); and improving Medicaid program efficiencies.

Governor Murphy Commits to Sign Family Planning Legislation. *NJ.com* reported on January 23, 2018, that New Jersey Governor Phil Murphy has said he will sign legislation to restore funding to family planning clinics in New Jersey. Six family planning centers closed when they lost $7.5 million in state grants to support family planning and women's health when Governor Christie took office. Read More

New Jersey Assembly Bill Would Prohibit Exiting Commercial Carriers from Keeping Medicaid Contracts. New Jersey Assembly bill 352 was pre-filed for introduction in the 2018 session by Assemblywoman Carol Murphy. The bill would prohibit health insurance carriers from contracting as a Medicaid managed care organization with the New Jersey Department of Human Services if they withdraw from the state's individual or small-employer health insurance market. Read More

Governor Murphy Releases Health Initiatives Description. New Jersey Governor Phil Murphy has released a description of his key initiatives including his commitments to health care:

"Governor Murphy believes that health care is a right, not a privilege, and will work to ensure that all New Jerseyans have access to affordable health care. The Affordable Care Act was a huge step in the right direction and reduced the uninsured population in the state by hundreds of thousands, and Governor Murphy will defend it against all attacks in Washington. He will fight back against any attempts to slash Medicaid funding or end the Children's Health Insurance Program, which are crucial to many New Jerseyans. And Governor Murphy is committed to taking action at the state level to make health care more affordable and accessible."

In further support of Governor Murphy's health access agenda he signed Executive Order No. 4 on January 21, 2018, which would ensure that all New Jersey residents have access to health care by calling upon all State entities that interact with the public to provide information to the public about the Affordable Care Act marketplace and ways to enroll in it. Read More

New Jersey Health Care Quality Institute Host Webinars Highlighting Efforts to Improve Medicaid. The New Jersey Health Care Quality Institute (NJHCQI) hosted a webinar in partnership with The Nicholson Foundation on January 29, 2018, that highlighted the state's ongoing efforts to implement recommendations made in Medicaid 2.0: Blueprint for the Future. The release of the Blueprint in March 2017 has prompted the following:

- **Introduction of S3529.** A bill that would provide for an improved system for eligibility determination for Medicaid and NJ FamilyCare.
- **Introduction of S3528.** A bill that would establish a Medicaid Enrollee Encounter Database as part of Rutgers' Integrated Population Health Data (iPHD) project.
- **NJHCQI host stakeholder meetings to advance the Blueprint's key recommendations.** These stakeholder sessions convene to develop recommendations and strategic plans that NJHCQI will share with the state related to value-based purchasing around the maternity episode of care, data transparency, patient center medical homes (PCMH) for medically complex children, end of life care, long-acting reversible contraception, and the next iteration of the Medicaid accountable care organizations (ACOs).
- **Development of a value-based purchasing maternity episode of care initiative.** The proposed initiative is a three-year value-based demonstration that would reward participating providers contracting with managed care organizations (MCOs) that are able to reduce the total cost of care for a maternity episode of care by implementing the NJHCQI's model.

A recording of the webinar can be found here.

New Mexico

New Mexico Inadvertently Terminates Medicaid Coverage for Some Foster Kids. The *Albuquerque Journal* reported on January 24, 2018, that glitches in a new computer eligibility system resulted in New Mexico inadvertently terminating Medicaid coverage for some children in foster care or adopted out of foster care. The New Mexico Children, Youth and Families Department will issues letters to approximately 4,000 foster and adoptive families to alert them of the issue. Medicaid eligibility will be retroactively applied to affected children. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Governor Cuomo Announces $700 Million Award for One Brooklyn Health. New York Governor Andrew M. Cuomo announced on January 24, 2018, the award of $700 million in funding to One Brooklyn Health — a new partnership between Brookdale University Hospital Medical Center, Interfaith Medical Center, and Kingsbrook Jewish Medical Center. The award closely follows recommendations made by Northwell Health, which had been commissioned by the New York State Department of Health to conduct a feasibility study for providing comprehensive, sustainable health care in central and northeastern Brooklyn. Specifically under the award:

• $210 million will be used to develop a new 32-site ambulatory care network;
• $384 million will support infrastructure improvements at Brookdale, Interfaith, and Kingsbrook; and
• $70 million will support the creation of an enterprise-wide Health Information Technology platform.

The remaining funds of $36 million will be reserved for future awards. Read More

Catholic Health ACO Withdraws from Medicare Shared Savings Program. *Buffalo Business First* reported on January 24, 2018, that New York's Catholic Medical Partners has decided to withdraw from the Medicare Shared Savings Program (MSSP). The group, which partnered with Catholic Health five years ago to participate in the federal program, saw significant savings in year one but was unable to sustain those gains in subsequent years. CEO Dr. Michael Edbauer said "achieving those cost reduction mandates became even more difficult in 2016 when the program shifted to a shared risk model." Read More

New York PPS's Earn Over $3 Billion in DSRIP Funding. The New York Department of Health (DOH), announced that Performing Provider Systems (PPS's) have earned more than $3 billion or approximately 95% of possible DSRIP funds. DOH's report marks the halfway point of DSRIP Year 3, which ended September 30, 2017. PPS's have met all state and/or PPS requirements for 13 projects, bringing the total number of completed projects to 44. The next PPS payments will be determined March 31, 2018. This announcement follows the news that the Nassau-Queens PPS will award $1.8 million to 33 community-based organizations for health improvement activities. Read More

South Nassau Communities Hospital Joins Mount Sinai Health System Network. South Nassau Communities Hospital announced on January 24, 2018, that it will become the flagship hospital on Long Island for the Mount Sinai Health System. The two hospitals signed a letter of intent last May and have been exploring the details of a relationship since. The news follows a similar Long Island affiliation finalized in late 2016 between NYU Langone and Winthrop-University Hospital, resulting in the newly named NYU Winthrop Hospital in Mineola, New York. Read More

North Carolina

Community Care of North Carolina Names 3 Regional VPs. The *Triangle Business Journal* reported on January 26, 2018, that Community Care of North Carolina (CCNC) is expanding its executive team in preparation for the state's transition to Medicaid managed care. CCNC has promoted Tammie McLean to regional vice president, eastern region; Jennifer Wehe-Davis to regional vice president, western region; and Tara Kinard to regional vice president, central region. The three had previously served as directors in their respective regions. Read More

Oregon

Oregon CCO Model Reduces Cost, Shows Progress on Quality, Study Says. *OPB* reported on January 29, 2018, that Oregon has seen reductions in cost trend and improvement in certain quality measures after transitioning its Medicaid program to a model based on provider-led coordinated care organizations (CCOs), according to a study. Patient satisfaction also increased; however, access to care declined slightly. The study was conducted by the Oregon Health & Science University's Center for Health Systems Effectiveness. Read More

Pennsylvania

Attorney General Announces $8 Million Settlement for Consumers and State Agencies. Pennsylvania Attorney General Josh Shapiro announced on January 26, 2018, that nearly 2,000 Pennsylvania consumers will receive a share of a $3 million settlement the state negotiated with Chester County biopharmaceutical company Cephalon Inc. In addition, Cephalon is paying $3.93 million to a group of Pennsylvania agencies, including the Department of Human Services' Medicaid Program and the Department of Aging's PACE Program. The Cephalon settlement, entered into by a coalition of 47 attorneys general, resolves claims that the company violated antitrust and consumer protection laws by delaying the entry of lower-cost generic versions of Provigil into the marketplace, and that the company made misrepresentations to the U.S. Patent & Trademark Office. Read More

Pennsylvania Awarded $300,000 Grant for Early Childhood Programs. The Pennsylvania Department of Human Services (DHS) announced on January 29, 2018, that the receipt of a Heinz Endowments grant of $300,000 for early childhood programs to increase their financial sustainability and demonstrate strong child outcomes. DHS, in partnership with Tuscarora Intermediate Unit 11, will use the grant award to pilot regional shared-service alliances to support improving high-quality early child care programs. Three pilot sites will be selected. Read More

Texas

Infant Mortality Rates Vary Widely by Zip Code, Ethnicity, Study Says. *The Texas Tribune* reported on January 18, 2018, that Texas infant mortality rates vary widely by zip codes, according to a study by the University of Texas System and UT Health Northeast. While the statewide average is 5.7 deaths per 1,000 births, zip codes like 76164 (Fort Worth) averaged 12.3 per 1,000 and 78203 (San Antonio) averaged 16 per 1,000. Infant mortality also varied greatly by race and ethnicity, with the highest rates among blacks and the lowest among Hispanics. Read More

Utah

Utah Lawmaker Again Proposes Medicaid Expansion Aimed at 60,000 in Coverage Gap. *Deseret News* reported on January 28, 2018, that Utah State Senator Gene Davis (D-Salt Lake City) has again proposed Medicaid expansion for some 60,000 state residents in the coverage gap. Utah already offers a Targeted Adult Medicaid expansion for homeless individuals with drug addiction or mental health issues, but that program only covers 500 people. Read More

Utah Releases Medicaid Dental Managed Care RFP. The Utah Department of Health released a request for proposal on January 19, 2018, for two Medicaid dental managed care organizations to provide full-risk coverage through a Prepaid Ambulatory Health Plan. The contracts will be for five years.

Virginia

Republicans Open Door to Medicaid Expansion with Work Requirements. The *Richmond Times-Dispatch* reported on January 30, 2018, that Virginia Republicans are willing to discuss the possibility of Medicaid expansion with the caveat that the program includes work requirements, according to Virginia House Speaker Kirk Cox (R-Colonial Heights). Cox made the remarks in a letter to Virginia Governor Ralph Northam, who supports expansion, but opposes work requirements. Two bills before the Republican-controlled House Rules Committee would expand Medicaid but require that able-bodied recipients work at least 20 hours a week or demonstrate that they are actively seeking employment or participating in job training. Read More

House Committee Votes for Medicaid Work Requirements. *The Richmond Times-Dispatch* reported on January 30, 2018, that the Virginia House Rules Committee voted 14-3 to adopt legislation that would require the state to seek federal approval to implement Medicaid work requirements. In a recent shift, Republican lawmakers indicated they could support Medicaid expansion provided the state enacts work requirements. Under the bill, individuals on Medicaid for three months would have to work five hours a week, rising to 20 hours after a year in the program. The bill now moves to the House Appropriations Committee. Read More

National

New York, Minnesota File Lawsuit Over Basic Health Program Funding Cuts. *Fierce Healthcare* reported on January 29, 2018, that New York and Minnesota filed a lawsuit against the Trump administration for reducing federal Basic Health Program funding. The funding cuts impact New York's Essential Plan, which covers about 700,000 individuals, and MinnesotaCare, which covers about 87,000. New York and Minnesota are the only two states to implement the Basic Health Program, an option created by the Affordable Care Act to help states provide individuals just above the income cutoff for Medicaid with coverage even more affordable than Exchange plans. Read More

Young, Healthy Don't Stay on Medicaid, Study Says. *Modern Healthcare* reported on January 24, 2018, that young and healthy individuals tend not to stay on Medicaid and instead leave the program after getting a job or increased hours at work, according to Avalere Health. The findings come as state governments are instituting work requirements as a condition of Medicaid eligibility. The study was funded by Anthem. Read More

MACPAC Votes to Ask Congress to Allow States to Implement Medicaid Managed Care Without a Waiver. *Modern Healthcare* reported on January 26, 2018, that the Medicaid and CHIP Payment and Access Commission (MACPAC) voted 12-0 to ask Congress to allow states to implement Medicaid managed care programs without a waiver using the state plan amendment process instead. Currently, states need a 1915(b) or 1115 waiver. MACPAC hopes the change will reduce the administrative burden on states. Last month, MACPAC urged Congress to extend waiver renewal periods and streamline the application process. Read More

Republicans at State, Federal Level Seek Cuts to Non-Emergency Medical Transportation. *Kaiser Health News* reported on January 30, 2018, that Republicans at the federal and state level are looking to roll back benefits and cut funding for non-emergency medical transportation (NEMT). Iowa, Indiana, and Kentucky, for example, have received federal waivers allowing them to cut NEMT services, and Massachusetts has a waiver pending. Medicaid covers more than 100 million NEMT trips annually at a cost of nearly $3 billion, according to a 2013 estimate. Read More

Lawmakers Seek Rule Allowing Providers to Prescribe Opioid Addiction Treatments Via Telemedicine. *The Hill* reported on January 30, 2018, that Senators Claire McCaskill (D-MO), Lisa Murkowski (R-AK), and Dan Sullivan (R-AK) are asking the Drug Enforcement Administration (DEA) to issue new regulations that would allow providers to prescribe medication for opioid addiction via telemedicine in rural areas. Current law requires an in-person medical evaluation. Read More

Industry News

Partners HealthCare to Enter Definitive Agreement to Acquire Care New England Health System. *Modern Healthcare* reported on January 25, 2018, that Massachusetts-based Partners HealthCare announced its intent to enter into a definitive agreement to acquire Rhode Island-based Care New England Health System. The deal would include Kent Hospital, Women & Infants Hospital, Butler Hospital, and Providence Center. Memorial Hospital in Pawtucket, Rhode Island, is excluded from the transaction. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
February 27, 2018	Iowa	Contract Awards	600,000
March 2018	Alabama ICN (MLTSS)	RFP Release	25,000
March 1, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
April or May 2018	Alabama ICN (MLTSS)	Contract Award	25,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 6, 2018	Texas STAR and CHIP	RFP Release	3,342,530
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
July 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September 2018	North Carolina	Contract awards	1,500,000
September 26, 2018	Texas STAR and CHIP	Evaluation Period Ends	3,342,530
October 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

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ConcertoHealth® Moves Corporate Headquarters to Aliso Viejo, Launches Five-Year Growth Plan. Read More

ConcertoHealth® Expands Presence in Detroit with New Clinical Administration Office in Southfield. Read More

HMA News

Upcoming Webinar - New Life for 1332 Waivers: Next Steps in State Health Insurance Exchange Market Innovation (February 7, 1 – 2 EST). With the current administration aiming to provide increased state flexibility in the use of federal healthcare funds, ACA Section 1332 State Innovation Waivers may attract renewed interest. Section 1332 waivers allow states to modify certain aspects of their health insurance Exchange markets and operating rules, for example, easing regulations on benefit levels, allowing flexibility in how subsidies are spent, and developing reinsurance programs to promote the stability of individual markets. While only a handful of states have applied to date, Section 1332 waivers remain an important policy lever to watch. Read More

Upcoming Webinar - Innovations in Medicaid Managed Long-Term Services and Supports: How Health Plans are Providing Support to Family Caregivers (February 28, 1 – 2 EST). Join Health Management Associates and the AARP Public Policy Institute as we discuss the findings of the new report on Emerging Innovations in Managed Long-Term Services and Supports (LTSS) for Family Caregivers. The report shows that health plans are increasingly recognizing and supporting family caregivers for individuals with LTSS needs. The webinar will also feature the real-world experiences of Anthem Inc., a health plan that is helping family caregivers in LTSS settings. The emerging innovations report is part of the joint Long-Term Services and Supports State Scorecard series and supported by The Commonwealth Fund, The SCAN Foundation, and the AARP Foundation. Read More

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; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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