

HEALTH MANAGEMENT ASSOCIATES  
**HMA Weekly Roundup**

Trends in State Health Policy

..... April 18, 2018 .....



RFP CALENDAR

HMA News

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- LOUISIANA MEDICAID EXPANSION RESULTS IN JOBS, GENERATES TAX REVENUES, STUDY SAYS
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## IN FOCUS

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**THE POLICY, IMPLEMENTATION AND OPERATIONS OF MEDICAID PERSONAL RESPONSIBILITY INITIATIVES: AN INTRODUCTION**

This week, our *In Focus* section highlights HMA Medicaid Market Solutions (MMS) which is supporting state flexibility in designing and implementing initiatives, including Section 1115 Demonstration Waivers, promoting member engagement and personal responsibility. Over the coming weeks, HMA MMS will present a series of articles providing an in-depth look at the facets of these new Medicaid models.

Flexibility to offer benefit and coverage variations existed prior to implementation of the Affordable Care Act, notably in targeted demonstration programs such as Indiana's Healthy Indiana Plan or Rhode Island's RIte Share. However, state experimentation with new coverage options vastly increased with the start of the state option to expand Medicaid to all adults with income up to 133 percent of the federal poverty level. In most states this population had never previously been eligible for Medicaid coverage, and in general, states that elected to cover these individuals under Medicaid aligned the benefits, cost sharing, and eligibility requirements with the state's existing Medicaid program. A selection of states, however, including Iowa, Arkansas, Michigan and Indiana opted to request Section 1115 Demonstration Waivers<sup>1</sup> to gain more program flexibility and test new coverage models to address the unique needs of this new Medicaid population. As these waivers moved forward, states including Kentucky and New Hampshire requested authority to incorporate increased program flexibility around coverage for those covered by the Medicaid expansion. With additional flexibility promised by recent CMS guidance,<sup>2</sup> the number of states exploring these coverage flexibilities may continue to increase.

The core concept underpinning these demonstrations is that non-disabled adult Medicaid recipients, particularly the expansion group authorized by the Affordable Care Act, are fundamentally different than the aged and disabled, children, and pregnant women historically covered by Medicaid. For states exploring coverage models that vary for non-disabled adult Medicaid recipients, an underlying premise is that the non-disabled adult population has a greater ability to engage in and take responsibility for their health. It is this expectation that underpins state program designs that align coverage for the non-disabled adults with coverage available outside of Medicaid and hinge access to certain benefits on member payment of premiums or engagement in healthy activities, including work and education.

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<sup>1</sup> Under Section 1115 Demonstration Waivers, states receive authorization to implement programs that may have different cost-sharing, benefits, provider networks, or eligibility requirements than allowed under the federal Medicaid statute. States in receipt of these waivers must provide additional reporting to CMS on a quarterly and annual basis, and must engage an independent evaluator to conduct a rigorous program evaluation.

<sup>2</sup> Department of Health and Human Services, Secretary of Health and Human Services. Price, Verma Letter. March 14, 2017. [www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf](http://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf).

Centers for Medicare and Medicaid Services, Section 1115 Process Improvements. November 6, 2017. [www.medicare.gov/federal-policy-guidance/downloads/cib110617.pdf](http://www.medicare.gov/federal-policy-guidance/downloads/cib110617.pdf).

Centers for Medicare and Medicaid Services Opportunities to Promote Work and Community Engagement. January 11, 2018. [www.medicare.gov/federal-policy-guidance/downloads/smd18002.pdf](http://www.medicare.gov/federal-policy-guidance/downloads/smd18002.pdf).

The technical components that allow states to pursue these personal responsibility programs include modifications to the state's existing state plan and, in many cases, receipt of Section 1115 demonstration authority, as described below.

- Benefit Variation. To date CMS has not approved benefit variation for the non-disabled adult population without an aligned Alternative Benefit Plan. The option also exists for states to vary benefits for the expansion population via an Alternative Benefit Plan without an aligning waiver demonstration.
- Cost-Sharing Variation. Common cost-sharing variations include incorporating premiums or member contributions to health savings accounts as well as adding increased copayments for the non-disabled adult population. Cost-sharing flexibility and the ability to target copayments to certain populations, and add premiums for individuals with income under 150% of the poverty level requires a CMS-approved 1115 waiver.
- Member Incentive. Member incentive programs that incorporate member accounts, increase member benefits when members participate, or provide additional payments to Managed Care Plans for the provision of incentive programs require 1115 authority.
- Community Engagement Requirements. Community engagement initiatives which require certain members in the non-disabled population to complete work or work-equivalent activities as a condition of eligibility requires 1115 waiver authority. This is a new flexibility authorized under the current administration and currently approved by CMS for Arkansas, Indiana, and Kentucky.

Personal responsibility Medicaid programs may incorporate only one of these design options or may weave these components together in an effort to achieve the state's goals of more engaged and healthier Medicaid members.

As stand-alone components, each of these policies require distinct implementation, operational, and systems considerations for state Medicaid programs, managed care entities, system vendors, and other state stakeholders. When these components are implemented in concert, the complexity of these decisions increases exponentially. In addition, while states may have similar policy goals that they are seeking to achieve through one or more of these policies, the decisions regarding the implementation, systems and operational considerations vary greatly across states. This results from the unique resources and organizational structure of each state Medicaid program, and shows that there is not one approach for how to implement these initiatives. However, there are common sets of operational hurdles and decisions for each distinct implementation, as well as lessons learned that can be shared across states.

Due to this needed variability, states and state partners seeking to understand the path forward in personal responsibility implementations will benefit from mapping the policy options, operational considerations, and potential systems challenges that may arise when incorporating these changes into the existing Medicaid program. Further, states and state partners developing 1115 demonstrations will benefit from increased awareness of the enhanced reporting and evaluation requirements and consideration and planning for these requirements on the front end to ensure adequate data quality and availability.

In the coming series of articles and a supporting webinar, the HMA MMS team will leverage its expertise in supporting the design, implementation and ongoing operations of multiple personal responsibility demonstrations to provide unique insight into the various aspects of each distinct policy and program component making up the newest wave of Medicaid demonstration projects.



## HMA MEDICAID ROUNDUP

### *Alaska*

**Senate Proposes \$20 Million in Medicaid Cuts.** *Alaska Public Media* reported on April 16, 2018, that the Alaska Senate has proposed cutting \$20 million from the state Medicaid budget by shifting health care claims for eligible Alaska Natives and American Indians to the federal Indian Health Service. Meanwhile, the Alaska House approved \$70 million more in Medicaid spending than the Senate. [Read More](#)

### *Arizona*

**Arizona Proposes End to 90-Day Retroactive Medicaid Coverage.** *Modern Healthcare* reported on April 16, 2018, that Arizona has asked the Centers for Medicare & Medicaid Services (CMS) to approve a Medicaid waiver that would end 90-day retroactive Medicaid coverage. The proposal is projected to cut \$40 million in provider reimbursements, raising concerns over uncompensated care costs for hospitals and excessive medical bills for patients. Arizona had more than 1.6 million Medicaid and CHIP enrollees as of January 2018. [Read More](#)

### *Florida*

**Florida Delays SMMC Reprourement Award Announcement Until April 24.** The Florida Agency for Health Care Administration announced on April 16, 2018, that it would release its Notice of Intent to Award contracts for the Statewide Medicaid Managed Care program on April 24, 2018. The announcement was previously expected on April 16. A total of 21 insurers submitted bids for the procurement, including the 11 incumbent plans. [Read More](#)

**Florida AIDS Plan Protests State Medicaid Managed Care Contract Bid Decision.** *WLRN* reported on April 13, 2018, that the AIDS Healthcare Foundation/Positive Healthcare has filed a written protest against Florida, after learning that the plan wasn't among those selected to negotiate a Medicaid managed care contract with the state in the latest procurement. Positive Healthcare serves 2,000 individuals in Miami-Dade, Broward, and Monroe counties. The winning bids will be publicly announced later this month. Contracts will begin in January 2019. [Read More](#)

## Georgia

**Georgia Hit With Lawsuit for Allegedly Denying Payment to Providers Serving Individuals with Disabilities.** *The Atlanta Journal-Constitution* reported on April 12, 2018, that four not-for-profit provider groups, including United Cerebral Palsy of Georgia and Coastal Center for Developmental Services, have filed a state lawsuit against two Georgia health agencies for allegedly denying providers compensation for services provided to individuals with disabilities. Healthcare provider organizations say they were forced to subsidize caregivers as a result. The lawsuit says that the Georgia Department of Community Health and Georgia Department of Behavioral Health and Development Disabilities also failed to notify Medicaid patients that the funds to provider payments were not forthcoming. [Read More](#)

## Illinois

**Illinois Freezes Medicaid Enrollment at BCBS-IL, Cites Inadequate Provider Network.** *Chicago Tribune* reported on April 17, 2018, that Illinois has frozen Medicaid managed care enrollment at Blue Cross Blue Shield of Illinois in certain regions of the state, citing an inadequate Medicaid managed care provider network and failure to respond to grievances and appeals. BCBS-IL will not be available as a choice to new Medicaid members and will not receive auto-assignments until the insurer complies with state Medicaid requirements. The state has also fined the company \$150,000. The insurer has an estimated 470,000 Medicaid members in the state. [Read More](#)

## Iowa

**Iowa Medicaid Plan Again Begins Accepting New Members.** *Quad-City Times/The Gazette* reported on April 11, 2018, that Anthem/Amerigroup Iowa has once again begun actively accepting new Medicaid managed care members in the state. Following news that AmeriHealth Caritas was exiting the market, Anthem/Amerigroup announced that it lacked the capacity to take on additional members. That left United Healthcare of the River Valley as the only other option for members. Separately, the state is seeking a third plan to enter the market starting in 2019. [Read More](#)

## Louisiana

**Louisiana Medicaid Expansion Results in Jobs, Generates Tax Revenues, Study Says.** *Associated Press* reported on April 14, 2018, that Medicaid expansion had a net positive impact of \$3.5 billion on the Louisiana economy in fiscal 2017, according to a study commissioned by the state. In addition to providing Medicaid coverage to 470,000 adults, expansion in Louisiana also created or supported 19,200 jobs and added \$178 million in state and local taxes. [Read More](#)

## Minnesota

**Minnesota Medicaid Advocates Cite Food Stamp Program as Cautionary Tale in Work Requirements Debate.** *The Star Tribune* reported on April 11, 2018, that opponents of Medicaid work requirements in Minnesota are citing as a cautionary tale the state's decision to implement work requirements in the food stamp program in 2014. Since then, approximately 66,000 individuals have lost Supplemental Nutrition Assistance Program (SNAP) benefits. Supporters of work requirements, such as state Representative Matt Dean (R-Dellwood) and state Senator Michelle Benson (R-Ham Lake), say that lessons from the SNAP program should be studied and incorporated into any Medicaid work program. [Read More](#)

## Mississippi

**Mississippi Must Pay \$2 Million to Hospitals for Medicaid Reimbursements, Court Rules.** *The Hixsburg Post* reported on April 15, 2018, that the Mississippi Supreme Court has ordered the state Medicaid program to pay back \$2 million to 12 hospitals after changing its reimbursement payment formula for radiology and laboratory services. The court ruled that the state's recalculation caused hospital costs to be understated and the charges to be overstated. [Read More](#)

**Mississippi Medicaid Work Requirements Could Result in 5,000 Losing Coverage Annually.** *The Clarion Ledger* reported on April 12, 2018, that Mississippi applied for a federal Medicaid waiver in October 2017 to implement a work requirement for over 50,000 able-bodied adults and is still waiting for approval from the Centers for Medicare & Medicaid Services (CMS). Medicaid officials project that about 5,000 residents will become ineligible for coverage annually over the next five years. Work requirement waivers have been approved in Kentucky, Indiana and Arkansas. [Read More](#)

## New Hampshire

**New Hampshire Lawmaker Proposes Broadening Medicaid Enhancement Tax.** *The Concord Monitor* reported on April 18, 2018, that New Hampshire House Finance Chairman Neal Kurk (R-Weare) proposed broadening the state's Medicaid Enhancement Tax to fill a \$36 million budget hole. The tax, which is currently paid by hospitals, would be extended to include a broad range of providers according to the proposal. Kurk added the proposal as an amendment to a bill that funds mental health initiatives. [Read More](#)

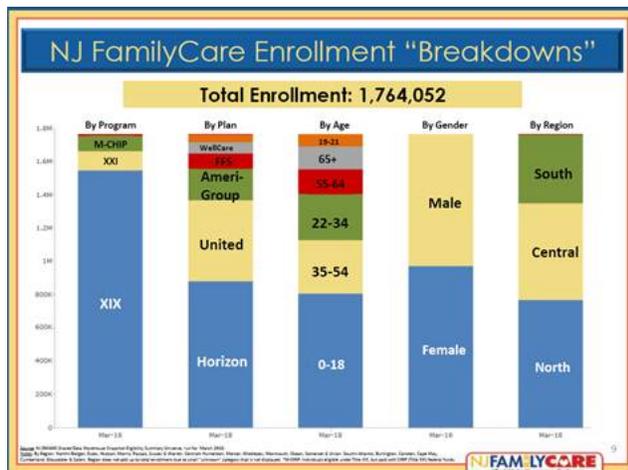
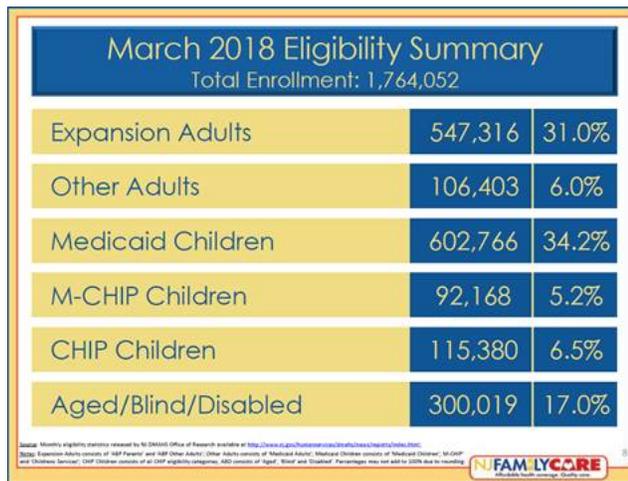
## New Jersey

### HMA Roundup – Karen Brodsky ([Email Karen](#))

**New Jersey Updates From the Medical Assistance Advisory Council Quarterly Meeting.** On April 11, 2018, the New Jersey Medical Assistance Advisory Council (MAAC) met to receive updates on the Medicaid program. Sarah Adelman was introduced as a newly appointed deputy commissioner to the Department of Human Services. Ms. Adelman will work with the Division of Medical Assistance and Health Services (DMAHS), Division of Developmental Disabilities, and the Division of Aging Services.

#### NJ FamilyCare Update

- March 2018 enrollment in NJ FamilyCare stands at 1,764,052 with a minor increase over the last month, and a net decrease in enrollment of 1.2 percent from a year ago. A full 94.7 percent of enrollees are in managed care.
- NJ FamilyCare enrollees represent 19.6 percent of the state’s population and one-third of all children (at 805,080).
- Enrollment is divided across eligibility categories, program, MCO, age, gender, and region (see data package below).



- All of the Medicaid MCOs now operate statewide with the expansion of WellCare into one more county.
- DMAHS is still planning to introduce a universal provider screening and enrollment process through the replacement MMIS. DMAHS is working with Molina, the MMIS contractor on policies and procedures and system amendments to implement this process.

#### *State Fiscal Year 2019 Initiatives*

DMAHS is working on four initiatives:

1. **Improving Access to Long-Acting Reversible Contraception (LARC).** Currently Medicaid covers LARC in all settings except in the immediate post-partum period in the delivery room. Governor Murphy recently signed legislation giving Medicaid authority to cover LARC in all settings, including the delivery room.
2. **Expanding Access to Family Planning Services (proposed).** A limited benefit package available through fee-for-service (FFS) is being developed and a State Plan Amendment will be submitted to CMS for approval to expand Medicaid coverage of family planning services for women and men who are state residents of child bearing age (19-55) and have incomes between 138% and 205% FPL.
3. **Improving Treatment for Hepatitis C.** Governor Murphy announced an expansion to its coverage protocol for Sovaldi from individuals with a Metavir score stage F2 through F4 to now include individuals with a Metavir score stage F0 through F4, effective July 2018.
4. **Improving Access to Autism Services.** An internal workgroup is developing an expanded comprehensive service package for the treatment of autism beyond the limited coverage provided through the Autism Spectrum Disorder (ASD) pilot. Governor Murphy included \$17 million in the proposed state budget to include ABA, PT, OT and ST, plus Naturalistic supports, Floortime and Social Emotional Learning. DMAHS will prepare a State Plan Amendment for CMS approval.

#### *MLTSS Update*

Elizabeth Brennan, Assistant Director of the Division of Aging Services gave an update on the MLTSS program.

- *Enrollment:* As of February 2018, long term care services were delivered through Medicaid FFS (11,744), under MLTSS (41,860) and in PACE programs (969), totaling 54,573.
- *Rebalancing:* The rebalancing trend from institutional to home and community based services (HCBS) is stable. New Jersey Medicaid serves 51.6% of the LTC population in a nursing facility and 46.7% under HCBS. The remaining LTC population receives services under the PACE program.
- *Service Costs:* Nursing facility costs topped the list of MLTSS expenditures at \$1.7 billion in State FY 2017 and PCA/Home-Based Support Care was the second costliest service at \$222.2 million. Expenditures for all MLTSS services are detailed in data package on next page.

**MLTSS Population's LTC Services Utilization, SFY17**

Long Term Care Service Type	Utilization Dollars
NF/SCNF Services	\$1,710,764,634
PCA/Home-Based Support Care	\$222,260,602
Assisted Living	\$63,650,092
Medical Day Services	\$53,696,264
Private Duty Nursing	\$32,490,894
Community Residential Services	\$13,228,420
TBI Habilitative Therapies	\$9,936,089
Home-Delivered Meals	\$8,285,563
Structured Day Program	\$3,895,072
PERS Set-up & Monitoring	\$2,586,195
Respite	\$2,089,713
Residential Modifications	\$1,108,144
Other	\$626,108
Social Adult Day Care	\$521,124
Supported Day Services	\$10,292
<b>Grand Total</b>	<b>\$2,125,149,206</b>

SOURCE: NJ DMHAS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/22/2018.  
 NOTES: Claims represent encounters paid through the date that the SDR was accessed. Substitutions are not included in this data. Data not shown for services whose claims represent 5% or less of total claims.  
 LTC Services not shown include: Adult Family Care, Assisted Living Program, Caregiver Training, Chore Services, Cognitive Therapy (Group/Indiv.), Community Transition Services, Home-Delivered Meals, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Occupational Therapy (Group/Indiv.), PERS Monitoring, PERS Setup, Physical Therapy (Group/Indiv.), Residential Modifications, Respite (Daily/Hourly), Social Adult Day Care, Speech/Language/Hearing Therapy (Group/Indiv.), Structured Day Program, Supported Day Services, TBI Behavioral Management, and Vehicle Modifications.



*Medicaid Substance Use Disorder (SUD) Waiver*

The SUD waiver deliverables are all currently pending CMS approval including: 1) the SUD Program Implementation Plan, 2) SUD Program Health IT Plan, 3) SUD Program Evaluation Design, and 4) SUD Program Monitoring Protocol. The components of six SUD milestones, an overview of the monitoring protocol, and a service implementation timeline were shared, and are available in the MAAC slide deck in the data package below.

**NJ Legislation Proposes Review of Medicaid Reimbursement to Nursing Facilities Under MLTSS.** On April 12, 2018, Assemblyman John Burzichelli introduced a bill (A3846/S2470) that would require the Department of Human Services (DHS) to conduct a study of nursing facility reimbursement as it pertains to the managed long term services and supports (MLTSS) program. The study would look at the current costs of nursing facility based long term care, analyze the adequacy of the rates to costs, and recommend alternative rate methodologies which are further defined in the bill. The bill has been referred to the Assembly Human Services Committee. A copy of the bill can be found [here](#).

**Horizon BCBS New Jersey to Appeal Ruling to Disclose Report Behind OMNIA Construction.** *NJ Spotlight* reported on April 12, 2018, that Horizon Blue Cross Blue Shield of New Jersey will appeal a court ruling that requires they disclose the McKinsey & Company report used to develop its controversial OMNIA tiered networks. The court cited the report as a “legitimate public interest” in a lawsuit filed by seven healthcare systems that were relegated to the less favorable Tier 2 network based on quality metrics and other metrics in the report. [Read More](#)

## *New York*

### HMA Roundup – Denise Soffel ([Email Denise](#))

**New York Reduces Facilities Eligible for Medicaid-Funded Breast Cancer Surgery.** New York Medicaid policy limits reimbursement for breast cancer surgery to those facilities providing a high volume of surgeries. This was done based on research showing survival rates increase for women who have their breast cancer surgery performed at high-volume facilities and by high-volume surgeons. Medicaid recipients can only receive mastectomy and lumpectomy procedures associated with a breast cancer diagnosis at high-volume facilities defined as averaging 30 or more all-payer surgeries annually over a three-year period. The policy does not restrict a facility's ability to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients. The Department of Health completed its tenth annual review of breast cancer surgical volumes for 2014 through 2016 and identified 76 low-volume hospitals and ambulatory surgery centers throughout New York State. These facilities have been notified of the restriction effective April 1, 2018. [Read more](#)

**New York Receives Approval for Care Coordination for Individuals with Intellectual/Developmental Disabilities.** New York received federal approval for a state plan amendment that authorizes Care Coordination Organizations (CCOs) to provide Health Home Care Management services to people with intellectual and/or developmental disabilities (I/DD) beginning July 1, 2018. The New York Department of Health (DOH), in collaboration with the NY Office for People with Developmental Disabilities (OPWDD), is working to expand the Health Home program to serve individuals with I/DD. The Health Home model will provide the strong and stable person-centered approach to holistic service planning and coordination required to ensure delivery of quality care. Health Home Care Management is an enhanced type of service coordination that is meant to better support people with complex needs. As part of the state's People First agenda, care management will address not only services provided through the OPWDD, but also physical, behavioral health, and other healthcare and wellness services. The delivery of specialized health home services for the I/DD population is seen as the first phase and foundation for the transition to managed care serving the I/DD population. It is anticipated that CCOs will expand and transition from the provision of Health Home Care Management to become specialized managed care organizations, or to enter agreements with existing plans to provide Health Home Care Management to the I/DD population. [Read More](#)

**New York Report Examines Disproportionate Share Hospital Payments.** The Citizens Budget Commission has released a report examining how Disproportionate Share Hospital (DSH) payments are allocated in New York and how cuts in federal payments will affect various types of hospitals. The report notes that New York distributes \$3.6 billion annually in DSH payments, but its distribution fails to target the hospitals with the greatest need. The report argues that the latest delay of federal DSH reductions should push the state to revise its allocation methodology to allow funding to be directed where it is needed most. New York's distribution methodology establishes a hierarchy for where funds are allocated. The hospitals affiliated with the State University of New York (SUNY) and the State's inpatient psychiatric hospitals have first priority and receive DSH payments up to their full uncompensated and undercompensated care losses. Voluntary hospitals (i.e., nonpublic) have second priority county hospitals have third priority, and hospitals of New York City Health + Hospitals (H+H) have lowest priority. H + H receives the remainder of funding available from the federal government, which typically is not enough to fully reimburse uncompensated and undercompensated care losses. The report notes that under the current policy the future \$1.4 billion in federal DSH cuts will be borne almost entirely by H + H. [Read More](#)

**New York Developing an Agenda for Long-Term Care.** As part of New York Governor Cuomo's State of the State address, Cuomo announced the formation of a Long Term Care Planning Council charged with addressing the needs of the growing aging population. To help shape that agenda, the Department of Health in conjunction with the Office for the Aging have released a [survey](#) on barriers and gaps for New York's long term care system. The Council will use the findings to identify priorities, determine the most cost-effective evidence-based interventions, and prepare a strategic plan to meet the emerging needs of New York's aging. The survey includes questions about barriers to providing appropriate care as well as gaps in services currently available to people with disabilities and aging populations. The state is encouraging widespread sharing of the survey which will be open until June 18.

**New York Assembly Plans Hearings on Medical Aid in Dying Legislation.** New York Assembly member Richard Gottfried will hold hearings on proposed legislation that would enable terminally ill individuals with decision-making capacity to voluntarily request and receive a prescription for medication to end their lives. The public hearings are meant to provide an important opportunity for supporting and opposing arguments to be heard, questioned, and put into perspective. According to the hearing notice, the growing interest in the concept of Aid in Dying (AID) and similar legislation that has been enacted in several states motivated the decision to hold hearings. Two hearings are planned, one in Albany on April 23rd and one in New York City on May 3rd. [Read More](#)

**Former Medicaid Director Plans to Enter Private Sector.** *Politico* reported on April 16, 2016, that former New York Medicaid Director Jason Helgeson "plans to advise private equity and venture capital firms, do some consulting for a large international firm, create his own consulting firm, work on policy and advocacy and, possibly, some academic work." [Read More](#)

## Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

**Pennsylvania Public Health Gateway Gains Traction with Providers.** *Healthcare Informatics* reported on April 11, 2018, that provider participation is beginning to ramp up in Pennsylvania’s Public Health Gateway (PHG). PHG is a single point of entry for healthcare information organizations (HIOs) submitting data for provider organizations to dozens of applications in the Department of Health and Department of Human Services. Provider participation was initially slow, partly due to trying to coordinate with two separate agencies. One of the promising uses of the PHG is for submitting electronic clinical quality measures for Medicaid managed care organizations. David Kelley, chief medical officer of the Pennsylvania Medicaid program, said his organization is moving away from manual chart reviews to more effectively gather eCQMs. [Read More](#)

*HMA is under contract with the Pennsylvania Department of Health to provide technical assistance for the development and use of the Public Health Gateway.*

## Rhode Island

**Rhode Island Receives Apology for Botched Medicaid Benefits System.** *Associated Press* reported on April 13, 2018, that Rhode Island lawmakers received an apology from Deloitte Consulting for the botched launch of a computer system designed to handle applications for Medicaid and food stamps. A Deloitte representative testifying before the Rhode Island House Oversight Committee said that problems related to the Unified Health Infrastructure Project or RI Bridges didn’t show up in initial testing. [Read More](#)

## Tennessee

**Tennessee House Rejects Medicaid Expansion Amendment.** *U.S. News & World Report/Associated Press* reported on April 16, 2018, that the Tennessee House rejected an amendment that would have allowed Republican Governor Bill Haslam to expand the Medicaid program. The amendment was proposed by House Minority Leader Craig Fitzhugh (D-Ripley) and attached to a bill that would require insurance to cover certain cancer treatments for state employees. Fitzhugh said he would be willing to include work requirements as part of the expansion. The state legislature has rejected several attempts to expand Medicaid. [Read More](#)

## Utah

**Utah to Decide on Medicaid Expansion through Ballot Initiative.** *The Hill* reported on April 16, 2018, that the Utah Decides Healthcare advocacy group has obtained 165,000 signatures from registered voters for a November ballot initiative on Medicaid expansion, more than the required 113,000 signatures needed to earn a ballot spot. The program would cover a projected 150,000 individuals up to 138 percent of the federal poverty level and prohibit enrollment caps. Separately, the state has its own proposal for a partial expansion covering 60,000 individuals up to 100 percent of the federal poverty level and including work requirements. [Read More](#)

## Virginia

**Virginia House Passes Medicaid Expansion Again.** *The Daily Press* reported on April 17, 2018, that the Virginia House of Delegates passed a budget that includes funding for Medicaid expansion, similar to one previously rejected by the state Senate. The budget includes changes such as stricter work requirements. It now moves to the state Senate. The deadline for a state budget is July 1. [Read More](#)

**Virginia Medicaid Expansion Impasse Persists in Special Session.** *WTOP* reported on April 11, 2018, that an impasse over Medicaid expansion continued to prevent Virginia lawmakers from agreeing on a two-year state budget during a special session this week. The deadline for a state budget is July 1. Medicaid expansion in Virginia would impact about 400,000 residents. [Read More](#)

## National

**More Governors Propose Medicaid Enhancements Than Cuts, Says Kaiser Study.** The Kaiser Family Foundation reported on April 11, 2018, that more state governors are proposing Medicaid enhancements in the fiscal 2019 budget year than those proposing cutbacks. Among the state budgets studied, Kaiser found that 23 proposed Medicaid enhancements, while 11 proposed spending cuts. Separately, 15 states are either considering or have already submitted waivers for Medicaid work requirements. Governors were also focused on the opioid epidemic and behavioral health. HMA Principal Kathy Gifford co-authored the report. [Read More](#)

**Lawmakers Urge CMS to Collect \$1 Billion in Improper Medicaid Payments.** *CQ Health* reported on April 12, 2018, that members of the House Oversight and Government Reform subcommittee urged federal regulators to begin collecting an estimated \$1.2 billion in inaccurate payments made to California, Kentucky and New York. Medicaid and Children's Health Insurance Program deputy director Tim Hill faced tough questioning during a subcommittee hearing over CMS' failure to collect the funds. U.S. Rep. Mark Meadows (R-NC) gave Hill 30 days to explain the CMS decision. He also told Carolyn Yocom, director of health care for the Government Accountability Office, to present within 60 days for identifying improper payments. [Read More](#)



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## INDUSTRY NEWS

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**Blackstone to Acquire Center for Autism and Related Disorders.** New York-based investment firm Blackstone announced on April 13, 2018, that its private equity arm has agreed to acquire the Center for Autism and Related Disorders, a California-based provider of center, school, and home-based behavioral therapy. [Read More](#)

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## COMPANY ANNOUNCEMENTS

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**MeridianHealth Joins Community Care Physician Network of North Carolina to Create Greater Value for Patients through Advanced Medical Homes.** [Read more](#)

**MCG Health's Dr. Monique Yohanan to Speak at 2018 ACMA National Conference on Solutions to Address the Opioid Epidemic.** [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
Spring 2018	North Carolina	RFP Release	1,500,000
Spring 2018	New Hampshire	RFP Release	160,000
April 2018	Alabama ICN (MLTSS)	RFP Release	25,000
April 11, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Proposals Due	~1,600
April 24, 2018	Iowa	Contract Awards	600,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
April 12, 2018	Washington FIMC (Remaining Counties)	Proposals Due	~1,600,000
April 24, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
May 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
June 2018	Alabama ICN (MLTSS)	Contract Award	25,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 2018	North Carolina	Contract awards	1,500,000
October 2018	Puerto Rico	Implementation	~1,300,000
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	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
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 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
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	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

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## HMA NEWS

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### New This Week on HMA Information Services (HMAIS):

**Public Documents:*****Medicaid Program Reports and Updates***

Texas Presentation to the House Appropriations Committee on CHIP RSA RFP, Apr-18

New Jersey DMAHS Transportation Broker Services Contract Audit Report, Mar-18

District of Columbia DHCF Proposed Budget and Financial Plan Presentation, FY 2019

New York Enacted Budget, FY 2019

New Jersey FamilyCare Section 1115 Demonstration Renewal Application, Mar-18

Kentucky MCO Annual EQRO Compliance Reviews, 2017

Colorado Medicaid MCO Program Integrity Review Report, Oct-17

Kentucky EPSDT Encounter Data Validation Report: Dental Services, Sep-16

***Medicaid RFPs, RFIs, and Contracts***

Alabama Medicaid Agency Pharmacy Administrative Services RFP, Apr-18

Kentucky Medicaid Managed Care Contracts, SFY 2018

**Medicaid Data and Updates**

Mississippi Medicaid Managed Care Enrollment is Down 1.2%, Jan-18 Data

Mississippi Medicaid Managed Care Enrollment Share by Plan, Jan-18 Data

Pennsylvania Medicaid Managed Care Enrollment is Up 0.7%, Feb-18 Data

Pennsylvania Medicaid Managed Care Enrollment Share by Plan, Feb-18 Data

West Virginia Medicaid Managed Care Enrollment is Down 1.6%, Mar-18 Data

West Virginia Medicaid Managed Care Enrollment Share by Plan, Mar-18 Data

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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**HMA Receives Five Stars in Forbes' 2018 ranking of "America's Best Management Consulting Firms."** In partnership with Statista Inc., Forbes has developed a list of "America's Best Management Consulting Firms." HMA is proud to be ranked one of only 6 consulting firms to achieve a 5-star ranking in healthcare and life sciences. According to Forbes, "Statista surveyed 7,500 partners and executives of management consultancies, as well as 1,000 senior executives who had worked with such firms over the last four years. Respondents were asked to recommend consultancies across the predetermined sectors and functional areas; self-nominations were not considered. Statista then identified the firms with the highest number of recommendations and organized them into star ratings: five stars for "very frequently recommended," four stars for "frequently recommended" and three stars for "recommended."

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<http://healthmanagement.com/about-us/>

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