

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... May 10, 2017



In Focus



HMA Roundup



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THIS WEEK

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IN FOCUS

STATES RECEIVE MORE TIME TO BRING HCBS SETTINGS INTO COMPLIANCE

This week, our *In Focus* section comes to us from HMA Senior Consultant Rachel Patterson, MPA, of our Washington, D.C., office. Rachel provides an update on this week's news that The Centers for Medicare & Medicaid Services (CMS) has extended the timeline for states to comply with a 2014 rule defining the settings for Medicaid home and community-based services (HCBS). On May 9, 2017, the CMS Center for Medicaid and CHIP Services issued an [Informational Bulletin](#) extending the deadline for states to demonstrate compliance with the settings criteria by three years, to March 17, 2022. It does

not extend the deadline for final CMS approval of Statewide Transition Plans, which must still be approved by March 17, 2019. The bulletin makes no changes to the underlying rule, nor indicates plans to do so.

The rule, released on January 16, 2014, sets a national minimum standard for community integration and experience of services in Medicaid-funded HCBS and represents the most significant change in the program since it was created in the 1980s. The rule requires that settings be integrated in and support full access to the community, including opportunities to seek employment and work in competitive, integrated settings. The rule focuses on the experience of individuals receiving services in home and community-based settings, and is intended to ensure that services funded as HCBS are not institutional in nature. It sets special protections for residents of provider-owned and -controlled settings, such as the ability to control one's own schedule, receive visitors, and have access to food. Settings that are not found to be in compliance, but which the states wish to continue to fund through HCBS, will go through a process of "heightened scrutiny" from CMS. The rule will have the biggest impact on services for people with intellectual/developmental disabilities and older adults who receive services in settings like group homes and assisted living.

States were initially given a five year implementation period – until March of 2019 – to write a Statewide Transition Plan describing their plans to come into compliance with the rule, seek public input on the plan, have the plan approved by CMS, and bring all settings into compliance. To date, only one state – Tennessee – has received final approval of their plan. Twenty states have received initial approval from CMS with specific feedback on steps necessary to receive final approval:

Alabama	Indiana	Montana	Rhode Island
Alaska	Iowa	Nebraska	South Carolina
Arkansas	Kentucky	New Mexico	Utah
Delaware	Louisiana	Ohio	Virginia
Hawaii	Missouri	Oregon	Washington

The new deadline gives states additional time to bring settings into compliance, but maintains the March 2019 deadline on approval for Statewide Transition Plans. The timeline increase is consistent with state and provider feedback on the complexity of transitioning the HCBS system. Some states had been asking for more time, including Ohio, which proposed a compliance date of 2024 in their transition plan.

Earlier this year, Health and Human Services (HHS) Secretary Tom Price and CMS Administrator Seema Verma sent a letter to the nation's governors regarding the new administration's approach to working with states. The letter indicated that HHS would provide additional time and increase state involvement in assessing compliance with the HCBS settings rule. The informational bulletin published this week addresses the timeline; states and providers should look out for more releases regarding the role of states in assessing compliance, particularly in the heightened scrutiny process.

For more information on the HCBS settings rule or the implications of the extension, contact Rachel Patterson at rpatterson@healthmanagement.com.



HMA MEDICAID ROUNDUP

Alabama

Medicaid Application Process Can Limit Access to Care for Pregnant Women. *AL.com* reported on May 8, 2017, that low-income pregnant women in Alabama are experiencing long waits to see an obstetrician because the state is allowed up to 45 days to approve or deny applications for Medicaid eligibility. According to the Alabama Department of Public Health, the percentage of women in the state receiving sufficient prenatal care dropped from 79 percent in 2003 to 75 percent in 2015. While physicians typically like to see pregnant women in their eighth week, the Medicaid approval process could mean women don't see a doctor until they are 13 weeks pregnant or later. [Read More](#)

Arkansas

Lawmakers Tighten Eligibility Requirements for Medicaid Expansion. *Arkansas Business Online* reported on May 2, 2017, that Arkansas lawmakers have voted to tighten eligibility requirements for the state's hybrid Medicaid expansion, Arkansas Works, which provides federal funds to purchase private insurance. The legislation will decrease the income eligibility cap for Arkansas Works from 138 percent of the federal poverty level to 100 percent, potentially resulting in 60,000 individuals moving off the program. Additionally, the remaining recipients would be subject to work requirements as a condition of eligibility. Over 300,000 individuals are currently enrolled in the program, which was established four years ago as an alternative to expanding Medicaid under the Affordable Care Act (ACA). The new restrictions must be approved by the Centers for Medicare & Medicaid Service prior to taking effect. [Read More](#)

Colorado

Providers Report Payment Delays. *The Denver Post* reported on May 7, 2017, that Medicaid providers in Colorado are experiencing payment delays following the state's implementation of a new payment system on March 1. Clinics, therapists, and mental health centers fear that payment delays could force them to postpone services, forgo payroll, or eventually cease operations. The state Department of Health Care Policy and Financing says that it expects the percentage of paid claims to improve as providers become more familiar with using the system. [Read More](#)

Lawmakers Propose Reversing \$528 Million Cut to Hospitals, Increasing Medicaid Copays. *The Denver Post* reported on May 4, 2017, that Colorado lawmakers have proposed the reversal of a planned \$528 million cut to

hospitals while increasing Medicaid copays. The bill reclassifies the hospital provider fee program that helps reimburse hospitals for uncompensated care. Under current law, the fee counts towards the state's constitutional spending limits, potentially reducing funding in other government areas. Meanwhile, Medicaid copays would double on prescription drugs from \$1.25 to \$2.50, while co-pays for urgent care and outpatient services would also increase. Lawmakers are optimistic they have the votes to pass both chambers. The measure would also increase funding for roads and schools, provide a tax break to small businesses, hike recreational marijuana taxes, and lower the state's spending cap by \$200 million. [Read More](#)

Florida

HMA Roundup – Elaine Peters ([Email Elaine](#))

Florida 2017 Legislative Session Concludes. The Florida Legislature concluded the 63-day 2017 Legislative Session on May 8, 2017. The Legislature had to extend their session by three days to pass the budget. Lawmakers passed an \$82.4 billion budget (\$30.9 billion general revenue) for FY 2017-18, while setting aside \$3.2 billion in reserves. The budget is basically flat (less than a 1 percent increase over the current year budget) making significant cuts to hospitals and colleges. Major budget priorities include an across-the-board pay raise for state employees, as well as investments in Florida's education system and environment, while providing broad-based tax relief and property tax relief for Florida's families and businesses. Lawmakers passed around 250 bills during the 2017 Legislative Session, but the majority of bills relating to health care died. Below is a summary of the major Medicaid issues funded in the budget as well as the results of some of the health care legislation.

FY 2017-18 Legislative Budget Highlights

- **Medicaid Price Level and Workload Adjustment (\$568.1 million total, \$181.9 million General Revenue (GR)).** Funding for an estimated 4.2 million Medicaid beneficiaries and price level adjustments. This includes an average managed care rate increase for Managed Medical Assistance (MMA) of 4.5 percent and Long Term Care (LTC) of 1.0 percent.
- **Florida KidCare Enrollment (\$62.7 million total, \$712,286 GR).** Funding for the KidCare program estimated at 224,431 children.
- **Managed Care Underpayments – (\$185.4 million total, \$75.2 million state).** Funding to compensate MCOs for the underpayments due to incorrect capitation rates between the SSI and TANF eligibility groups from prior years.
- **Hospital Reductions (\$521.1 million total, \$200 million GR).** Reduces hospital inpatient DRG Base rate by 5% and hospital inpatient and outpatient exemptions (add-ons) through a tiered payment methodology.
- **Low Income Pool (\$1.5 billion total, \$578.9 million IGTs).** Funding is held in reserve pending a budget amendment by the Agency to release funds, subject to federal approval of the final special terms and conditions (STCs) of the LIP.

- **Physician Supplemental Payments (\$246 million total, \$94.4 million IGTs).** Funding is held in reserve pending a budget amendment by the Agency to release funds, subject to federal approval of a payment methodology for medical school faculty physician supplemental payments.
- **Rate Adjustors for Diagnosis Related Groups (DRG) for Stand Alone Children's Hospitals (\$24.5 million total, \$9.4 million GR).** Funding to increase the High Medicaid and High Outlier Provider Adjustor for the DRG reimbursement methodology for hospital inpatient services (from 2.128 to 2.548).
- **Rural Inpatient Hospital Reimbursement Adjustment (\$6.5 million total, \$2.5 million GR).** Funding for sole community hospitals that meet the definition of rural hospitals in the DRG reimbursement methodology services for hospital inpatient.
- **Enhanced Ambulatory Patient Grouping (EAPG) Hospital Outpatient.** An EAPG reimbursement methodology for hospital outpatient services is implemented July 1, 2017 that will cap provider gains and losses to ensure budget neutrality.
- **Nursing Home Prospective Payment System (PPS).** The Agency is directed to convene a working group to review relevant issues and make recommendations specific to the transition to a prospective payment system for nursing home reimbursement with a report due by December 1, 2017, prior to the October 1, 2018 implementation date for a PPS for nursing home providers.
- **SAMH Safety Net System.** The Agency, in consultation with the Department of Children and Families, is directed to seek federal approval for a designated state health program (DSHP) to improve the quality of and access to behavioral health services for Medicaid and non-Medicaid eligible individuals that allows the state to use general revenue funds expended on behavioral health services in the substance abuse and mental health safety net system as state match for federal funds.
- **Florida Medicaid Management Information System (FMMIS) (\$7.5 million total).** Funding for the Medicaid FMMIS/DSS/Fiscal Agent procurement project.
- **Medicaid Fee Increase for Pediatric Cardiology Services (\$1.9 million total, \$750,000 GR).** Funding for a rate increase for pediatric cardiology services.
- **Private ICF/DD Rate Increase (\$2.6 million total, \$1.0 million GR -** Funding to increase private Intermediate Care Facility/Developmentally Disabled rates.
- **Actuarial Services - (\$850,000 total).** Funding for the Agency to competitively contract with an independent consultant for actuarial services.
- **Medicaid APD iBudget Waiver (\$3.7 million total, \$1.4 million GR).** Funding to serve an additional 341 individuals on the waitlist for home and community-based services.

- **Medicaid APD Provider LPN Rate Increase (\$3.4 million total, \$1.3 million GR).** Funding for a rate increase for nursing services provided by Licensed Practical Nurses (LPNs).

2017 Healthcare Legislation Highlights

Florida's legislative session ended without a major overhaul of the state's health care system and most major health care legislation died. This includes a proposal that would have provided more flexibility in health care known as "direct primary care" agreements as well as other House health care policies that centered on the deregulation of hospitals, hospices, nursing homes, trauma centers, and ambulatory surgical centers. Additionally, a bill to restructure the state's Medicaid program died that would have consolidated the program from 11 regions throughout the state into 8 larger regions and would have directed state health officials to contract with additional health plans for each region later this year. One health care bill (SB 2514) that did pass reflects policy decisions lawmakers agreed to in the 2017-18 budget. Medicaid highlights include:

- Authorizing optional eligibility for persons diagnosed with AIDS who have an AIDS related infection and are at risk of hospitalization with incomes at or below 300 percent of the federal poverty level.
- Requires the transition from a cost-based to a prospective payment reimbursement methodology for nursing home providers, effective October 1, 2018.
- Authorizes, rather than requires, a Medicaid managed care plan to offer a network contract to certain medical equipment and supplies providers in the region, provided the vendor meets established standards.
- Specifies individuals with cystic fibrosis who qualify for hospital care to be enrolled in Medicaid LTC managed care, and requires individuals currently enrolled in the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver to transition into LTC managed care by January 1, 2018, subject to federal approval.
- Appropriates \$1.5 billion for the Low Income Pool program and \$246 million for medical school faculty physician supplemental payments. The Agency is required to submit budget amendments requesting release of funds held in reserve, subject to federal approval of payment methodologies and identification of intergovernmental transfers (IGTs) to support the required state match.

Georgia

Piedmont Healthcare to Acquire Columbus Regional Health. *Modern Healthcare* reported on May 9, 2017, that Georgia-based Piedmont Healthcare announced its intent to acquire Columbus Regional Health. The move would expand Piedmont's presence into Southwest Georgia. Columbus Regional chief executive said that the system has been looking for a partnership or affiliation for the past year. Prior talks between Piedmont and Columbus Regional's St. Francis Hospital broke off two years ago. [Read More](#)

Illinois

Advocate Health Care to Reduce Spending by \$200 Million. *Chicago Sun Times* reported on May 4, 2017, Advocate Health Care will cut spending by \$200 million, in part because of delays in payments from the state of Illinois. Advocate operates 12 hospitals in the state. Jim Skogsbergh, chief executive, stated that spending reductions are a response to rising medical costs and lower Medicaid and Medicare rates, rather than the failed bid to merge with NorthShore University HealthSystem. [Read More](#)

Indiana

Half of HIP 2.0 Expansion Members Failed to Make Monthly Payments, Evaluation Finds. *USA Today* reported on May 8, 2017, that more than half of the beneficiaries in Indiana's HIP 2.0 Medicaid expansion program have failed to make monthly payments required to receive the top tier of benefits, according to a new evaluation. Of the 590,315 individuals who were eligible during the 22 months after Indiana expanded Medicaid, 55 percent either never made the first payment or missed one while on the program. Critics of HIP 2.0 say the program poses a barrier to care and should not be used as a model in other states. The state has countered that few members were locked out of coverage; instead, most who missed payments were transferred to a lower benefit tier. [Read More](#)

Iowa

Medica May Pull Out of Exchange Market, Leaving No Insurers for 2018. *The Washington Post* reported on May 3, 2017, that Medica has stated it may exit the Iowa Exchange market in 2018, which could leave Iowa as the first state with no insurers on the Affordable Care Act Exchange. The state's two other Exchange insurers, Aetna and Wellmark, have already stated they will not be participating going forward. Insurers have two months to decide if they will participate next year. [Read More](#)

Medicaid Managed Care Complaints Continue. *The Des Moines Register* reported on May 9, 2017, that according to state quarterly reports, complaints of terminated or reduced health services in Iowa's year-old statewide Medicaid managed care program rose 270 percent through March 2017. A total of 1,268 grievances were filed during the first quarter of 2017. Meanwhile, the three MCOs that manage the program, AmeriHealth Caritas, UnitedHealthcare, and Anthem's Amerigroup, reported transportation, provider, and disenrollment issues. [Read More](#)

Louisiana

Lawmakers to Explore Medicaid Work Requirements. *The Advocate* reported on May 6, 2017, that Louisiana is considering Medicaid work requirements, with the state legislature expected to request a study of the concept later this year. The idea was proposed by state Senator Sharon Hewitt (R-Slidell), who argued that Medicaid growth is unsustainable. Since Governor John Bel

Edwards expanded Medicaid in July 2016, more than 423,000 net new enrollees have been added. [Read More](#)

Louisiana Proposes Tapping Old Patent Law to Create Generic Hepatitis C Drugs. *Kaiser Health News* reported on May 4, 2017, that Louisiana is proposing to tap into a 1910 patent law that would allow the Trump administration to sidestep patents and contract with a generic supplier to provide lower-priced Hepatitis C drugs. The law gives power to the federal government to develop products in the interest of the public good and provide pharmaceutical manufacturers reasonable compensation. If successful, other states would reap the benefits of the move. The proposal would need to be approved by U.S. Health & Human Services Secretary Tom Price. Currently, Louisiana is spending \$764 million annually to provide Hepatitis C medication to Medicaid beneficiaries and individuals who are uninsured. [Read More](#)

Maryland

Exchange Plans Seek 38.5 Percent Premium Hike for 2018. *Baltimore Business Journal* reported on May 5, 2017, that Maryland insurers are seeking an average 38.5 percent premium increase for individual Exchange plans in 2018. CareFirst BlueCross BlueShield, Cigna, Evergreen Health, and Kaiser Permanente submitted rate requests, with proposed increases ranging from 9 percent to 150 percent. Evergreen will be back in the Exchange market as a for-profit plan in 2018, after dropping out in 2017. [Read More](#)

Maryland Health Care Commission to Be Led by Heritage Foundation Fellow Robert Emmet Moffit. *The Baltimore Sun* reported on May 10, 2017, that Robert Emmet Moffit has been appointed chairman of the Maryland Health Care Commission. Moffit, who has served as a member of the commission since 2015, is currently a senior fellow at the Heritage Foundation. He has been a strong opponent of the Affordable Care Act. Maryland Governor Larry Hogan announced the appointment. Moffit succeeds Craig Tanio, M.D. [Read More](#)

New York

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

American Health Care Act Includes Provision to End County Responsibility for Medicaid. The American Health Care Act (AHCA) passed by the U.S. House of Representatives includes an amendment that affects only New York State. The Collins-Faso amendment would end county contributions to Medicaid for all New York State counties outside of New York City. The amendment was designed to encourage New York's nine Republican members of Congress to support the bill. New York is unusual in the role counties play in financing the state's Medicaid program, which historically had counties providing 25 percent of the cost (along with the state's 25 percent share and the federal 50 percent match). The amendment requires New York to take over the Medicaid costs currently covered by counties by 2020, shifting \$2.3 billion a year from counties to the state. [Read More](#)

Health Systems Continue Expansions. Two hospital systems in New York have announced plans to expand their footprint. Northwell Health announced a clinical-affiliation agreement with Crouse Health in central New York.

Crouse includes the 506-bed Crouse Hospital in Syracuse and 25-bed Community Memorial Hospital in Hamilton. Crain's HealthPulse reports that through the clinical partnership, Northwell will help Crouse expand its primary care network and develop population health and quality-improvement initiatives. Northwell currently has a presence in New York City, Long Island and Westchester; this affiliation positions Northwell to build a presence upstate. [Read More](#);

Mount Sinai Health System is negotiating an affiliation agreement with South Nassau Communities Hospital. Mt. Sinai is largely located in New York City, although it has hospital affiliations in NJ and FL, and physician practice affiliations across Long Island and the Hudson Valley. South Nassau is a 455-bed hospital in Oceanside, with nine satellite facilities in the region. Politico notes that the affiliation would provide Mt. Sinai with an institutional presence that would allow Mount Sinai a chance to grow its patient base so that it can better engage in risk-based contracting. [Read More \(2\)](#)

Division of Long Term Care Hosts Webinar on Fully Integrated Duals Advantage. The Division of Long Term Care hosted a stakeholder webinar/Fully Integrated Duals Advantage (FIDA) status update on Friday, April 28, 2017. FIDA enrollment was 4,599 as of April 1. Fourteen FIDA plans are operating in Region 1, which includes NYC and Nassau Counties. Region 2, made up of Suffolk and Westchester, began enrollment in March, and currently has one plan operating (AgeWell); more plans will be added as they complete readiness review. The Department of Health (DoH) ran a \$2M advertising campaign for the FIDA program from August 2016 - February 2017 targeted primarily at providers, in an effort to increase interest in the program. DoH sent letters and a FIDA FAQ to 6,800 providers in October 2016, and informational letters went out to 85,000 dually eligible beneficiaries who had previously opted- out of FIDA. The FIDA savings target has been reduced from 3 percent to 2.5 percent for the remaining years of the demonstration (through December 2019). DoH remains committed to integrated care for duals in New York State post-FIDA, and is planning a two-phase stakeholder process to inform its planning. The first phase will include FIDA plans and limited stakeholders, consisting of feedback sessions to recommend policy changes to the current program. The second phase will include planning for integrated care post-2019, and will be open to all stakeholders. Slides from the webinar will be posted on the Medicaid Redesign website. [Read More](#)

"Health Across All Policies" Initiative Update. As part of its Prevention Agenda, New York is pursuing a "Health Across All Policies" approach that addresses broad social determinants of health. The first cross-agency meeting was held in March, and included State agencies such as Energy, Transportation, Parks and Trails and Agriculture and Markets. Agencies have been asked to identify current and planned initiatives, regulatory proposals and capital investments and work with the New York Department of Health staff to identify how they might be modified to increase their positive impact on health. Participating agencies are also expected to collaborate with the New York State Office for the Aging (NYSOFA) to ensure that initiatives consider the needs of aging populations.

State to Require Quality Management Programs for Health Homes. New York is requiring that Health Homes implement a Quality Management Program to monitor and objectively evaluate quality, efficiency, and effectiveness, beginning June 1, 2017. The intent of the program is to promote a

culture of learning and continuous quality improvement, monitoring, and oversight within the Health Home network. Health Homes are meant to assure that members receive appropriate and effective care management services to prevent avoidable inpatient stays and emergency room visits; improve disease-related care and outcomes for individuals with Serious Mental Illness (SMI), HIV/AIDS, or chronic conditions including Substance Use Disorders (SUD); improve preventive care; and, lower Medicaid costs. [Read More](#)

Behavioral Health Value Based Payment Readiness Program. The New York State Office of Mental Health (OMH) and Office for Alcoholism and Substance Abuse Services (OASAS) have announced the launch of the New York State Behavioral Health (BH) Value Based Payment (VBP) Readiness Program. The New York State BH VBP Readiness Program is designed to strengthen community-based behavioral health providers throughout New York State, and prepare them to successfully participate in the transformation of the health care delivery system. The program will fund the formation of Behavioral Health Care Collaboratives (BHCC) in an effort to position BH Providers to succeed in the VBP environment. Funding will be available to support the development of shared infrastructure for the BHCC, such as clinical quality standards, data collection, analytics, and reporting. Applications for funding must include, at a minimum, agencies delivering all available Medicaid OMH and OASAS services, including Home and Community Based Services (HCBS), either as a lead agency, or as network providers. Applications will be evaluated based on the number of Medicaid managed care enrollees served by the proposed BHCC. Proposed BHCCs must submit a non-binding Notification of Interest no later than June 5, 2017 in order for their application to be considered. [Read More](#)

New Jersey

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

Department of Human Services gives budget testimony for FY 2018. On May 1, 2017, Acting Commissioner Elizabeth Connolly testified before the Assembly Budget Committee on the proposed Fiscal Year '18 budget. She began by summarizing accomplishments by the Department in FY17:

1. Transitioned from a system of cost-reimbursement contracts to a fee-for-service billing model for mental health and addiction providers
2. Made progress on many of the Medicaid 2.0 report recommendations released by the New Jersey Health Care Quality Institute
3. Satisfied and exceeded the target for the Mental Health Olmstead Settlement Agreement with the development of 1,065 new supportive housing units
4. Received CMS approval of the Community Care Waiver (CCW) to equalize benefits for individuals with intellectual and developmental disabilities who participate in the Supports Program and CCW, and to add more services
5. Continued progress with initiatives under the Comprehensive Medicaid Waiver including MLTSS
6. Entered into an agreement with the Department of Community Affairs to provide permanent housing vouchers with DHS function to individuals who receive Supplemental Security Income (SSI)

In FY18 DHS will be working on these budget initiatives:

1. Upon approval from CMS under the Comprehensive Medicaid Waiver renewal, DHS will explore the use of the High-Fidelity Housing First (HFHF) model for Medicaid enrollees at risk for homelessness or who are homeless
2. Collaborating with the Department of Labor to examine the provision of employment services to people who receive TANF, General Assistance (GA) and SNAP
3. Partnering with the Department of Health and Seton Hall Law School to streamline licensing and services for behavioral health providers and consumers to advance integrated care
4. Working with the Departments of Children and Families, Education, Health and Labor on a technical assistance grant from the National Governor's Association and CLASP to advance Two-Gen strategies that address challenges facing both parents and children.

A copy of the budget testimony can be found [here](#).

New Jersey Medicaid posts January 2017 MCO contract to website. The Medicaid managed care organization (MCO) contract between the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and its five contracted Medicaid MCOs was amended in January 2017 and released this month on the DMAHS website. Material contract changes are highlighted:

1. Definitions and provisions were added to describe **In Lieu of Services** and **Institution for Mental Diseases**.
 - a. **In Lieu of Services.** Contractors may provide In Lieu of Services when determined by the State to be medically appropriate and a cost-effective substitute for Medicaid State Plan or MLTSS covered services, the cost of which will not be included in determining rates.
 - b. **Institution for Mental Diseases.** The Contractor may offer an inpatient stay in an IMD for psychiatric or substance use disorder care as an in lieu of service to enrollees between 21-64 years of age for up to 15 days, after which the terms of MCO enrollment and federal match change depending on whether care was in a private or public IMD.
2. **Revisions to provide parity in covered mental health and substance use disorder benefits** for Medicaid, CHIP and Alternative Benefit Plan (Medicaid expansion) members
3. **Lead screening.** New requirement that MCOs must submit a report of all lead-burdened children twice a year.
4. **Medical homes.** The medical home provision has been updated to eliminate reference to the three-year demonstration and to establish a permanent requirement that MCOs identify PCPs who will provide care to enrollees with chronic health conditions and/or behavioral health conditions using a medical home model. It adds further detail on the model.
5. **Relationships with debarred or suspended persons prohibited.** Revisions were made to clarify and update the federal requirements that prohibit individuals or entities, including providers from having a relationship with the Contractor.

6. **Non-discrimination requirements.** The categories of enrollees whose assignment providers and subcontractors must accept was updated to include gender identity. Non-discrimination language was also updated to include gender identity.
7. **Special Investigations Unit (SIU) revisions.** Provisions concerning SIU compliance and sanctions were expanded upon.
8. **NJ MAPS.** A new provision that describes the New Jersey Medicaid Access to Physician Services Program (NJ MAPS Program) was added to preserve and promote access to medical services for Medicaid clients and underserved populations by setting minimum rates for professional services provided by qualified physicians and non-physician professionals affiliated with New Jersey schools of medicine and dentistry. This provision does not apply to services provided to individuals dually eligible for Medicaid and Medicare.

A complete copy of the January 2017 New Jersey Medicaid MCO contract can be found [here](#).

New Jersey Expands Safe Care Cam Program. On May 9, 2017, *NJ.com* reported that the growing number of misconduct complaints filed against home health care workers has led to the expansion of the state-run program, Safe Care Cam. As the number of home health care workers doubled in the last decade to nearly 59,000, the state has also been seeing an uptick of misconduct complaints. In response, the Director of Consumer Affairs, Steve Lee, initiated in December of last year Safe Care Cam, a program that loans out hidden cameras to family members of older adults and individuals with disabilities who suspect that their loved ones are at risk of caregiver abuse. These cameras can be installed in nursing homes, assisted living facilities, and other institutions. Additionally, the Division of Consumer Affairs is considering the elimination of conditional certificates, which allows new health care workers to start working inside patients' homes while a criminal background check is pending. [Read more](#)

North Carolina

DHHS Secretary Seeks Public Feedback on Proposed Medicaid Waiver. *North Carolina Health News* reported on May 9, 2017, that North Carolina Department of Health and Human Services (DHHS) Secretary Mandy Cohen is seeking public feedback on Medicaid changes proposed in June 2016 under former Secretary Rick Brajer, which include a statewide Medicaid managed care program. Secretary Cohen's office will hold public meetings around the state to discuss the planned overhaul. Moreover, Cohen announced she is interested in feedback on physical and behavioral health integration, provider transition to managed care, care management, social determinants of health, quality of care, payment, and access to care. [Read More](#)

CCNC Works to Improve Mental Health Care Access for Children in Foster Care. *Triangle Business Journal* reported on May 5, 2017, that Community Care of North Carolina (CCNC) is working to increase access to mental health services, checkups, screenings, immunizations, and dental care for children in foster care. The efforts are part of CCNC's pediatrics program, Foster Health NC. There are about 10,000 children in foster care in North Carolina. In the last three years, the percentage of foster children served by CCNC increased from 30 to 88 percent. [Read More](#)

Pennsylvania

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

University of Pennsylvania Announces \$1.5 Billion Hospital Pavilion. *Healthcare Design* reported on May 3, 2017, that the University of Pennsylvania will build a new, \$1.5 billion hospital on Penn Medicine’s West Philadelphia campus. The project is the largest capital project in Penn’s history. The Pavilion, which will house inpatient care for the Abramson Cancer Center, heart and vascular medicine and surgery, neurology and neurosurgery, and a new emergency department, is expected to be completed in 2021. The Pavilion will house 500 private patient rooms and 47 operating rooms in a 1.5-million-square-foot, 17-story facility. The Pavilion will include an adaptable room concept through which patient rooms are equipped to flex between an intensive care unit set-up, if needed, and a standard room as patients recover, or as the patient population and caregiving needs change. The hospital also will feature hybrid operating rooms and telemedicine functionality. In a sign of the health system’s financial strength, it plans to use profits from current operations to pay for most of the \$1.5 billion cost, borrowing just \$450 million, Muller said. The system is counting on some philanthropy to support the project as well. [Read More](#)

Tennessee

Hospitals Report Struggles Amid Rising Costs, Shrinking Payments. *The Tennessean* reported on May 7, 2017, that hospitals in Tennessee are struggling with rising costs and lower payments, according to a *USA Today* analysis of [Joint Annual Reports](#) filed with the state. After adjusting for discounts to health plans and Medicare, hospital revenues are falling short of costs. Many hospitals are now relying on other revenue sources, including grants and contributions, to stabilize finances. [Read More](#)

BCBS-TN to Participate in Knoxville Region Exchange Market in 2018. *Nashville Public Radio* reported on May 9, 2017, that BlueCross BlueShield of Tennessee (BCBS-TN) has agreed to offer Exchange coverage in the Knoxville, Tennessee region in 2018. The current insurer in the region’s marketplace, Humana, announced it would exit the market at the end of the year, leaving no plan choices for the 40,000 individuals it covers. In a letter sent to Tennessee insurance commissioner Julie McPeak, BCBS-TN stated that they may be forced to consider backing out of the region if market stability is an issue. [Read More](#)

National

House Narrowly Passes AHCA Bill to Repeal and Replace the ACA. *CNN* reported on May 4, 2017, that the House voted 217 to 213 to pass the American Health Care Act (AHCA) to repeal and replace the Affordable Care Act (ACA). The bill allows states to waive protections for individuals with preexisting conditions and requirements for federal essential health benefits, eliminates the individual mandate, and eliminates enhanced federal Medicaid expansion dollars in 2020, among other provisions. The bill now moves to the Senate, where it is expected to face greater opposition. [Read More](#) Separately, *Reuters* reported that the Senate will wait for a Congressional

Budget Office scoring of the AHCA bill before voting, according to Senate Majority Leader Mitch McConnell. [Read More](#)

CHIP Future Uncertain Following AHCA Passage. *Modern Healthcare* reported on May 7, 2017, that the Senate Finance Committee has postponed a planned hearing on reauthorization of the Children's Health Insurance Program (CHIP). Senate Democrats reportedly requested the delay so that CHIP would not be overshadowed by the broader debate over the American Health Care Act (AHCA). Advocates fear that CHIP reauthorization could be used as leverage by Senate Republicans to win support for AHCA. Funding for CHIP is scheduled to end in September of this year. [Read More](#)

Trump Administration May Seek Steep Cuts to Agency Charged With Fighting Opioid Epidemic. *ABC News* reported on May 5, 2017, that the Trump administration is considering \$364 million in budget cuts to the Office of National Drug Control Policy (ONDCP), which shapes policy aimed at battling the nation's opioid epidemic. The cuts, outlined in a preliminary budget document, would represent more than 90 percent of ONDCP's budget. Specifically, the cuts would eliminate funding for two large grant programs, one aimed at fighting drug-trafficking and another aimed at supporting drug-free communities. A White House spokesperson said that the administration has not made a final decision about ONDCP's budget. [Read More](#)

CMS Hints at Repealing Ban on Nursing Home Arbitration Agreements. *Modern Healthcare* reported on May 9, 2017, that The Centers for Medicare & Medicaid Services (CMS) has hinted at repealing a ban on nursing home arbitration agreements during a meeting with consumer organizations hosted by the White House Office of Management and Budget. The regulation prohibits nursing homes from requiring patients to enter binding arbitration agreements, which prevent patient disputes from being heard in court. Recently, CMS submitted a proposed rule to revise requirements imposed on long-term care facility arbitration agreements, but did not comment on the intent of the rule. During the meeting, CMS would not officially state what the pending rule would change, but hinted that they were in favor of arbitration over litigation. [Read More](#)

State Medicaid-Housing Agency Partnerships Technical Support Opportunity for States Informational Webinar. The Centers for Medicare & Medicaid Services' (CMS) Medicaid Innovation Accelerator Program (IAP) is launching a new technical support opportunity for state Medicaid agencies to develop partnerships between state Medicaid agencies and their local housing systems to foster additional community living opportunities for Medicaid beneficiaries. IAP will select up to eight states to participate in this nine-month opportunity. The State Medicaid-Housing Agency Partnerships Track is designed to offer intensive and hands-on technical support to move selected states towards building sustained collaborations with housing partners and with partners from other service agencies. Consistent with statute, CMS does not provide Federal Financial Participation for room and board in home and community-based services. This opportunity is available to all states except the eight that participated in this track in 2016: California, Connecticut, Hawaii, Illinois, Kentucky, Nevada, New Jersey, and Oregon. IAP is working closely with its federal partners, the US Department of Housing and Urban Development, the Substance Abuse and Mental Health Services Administration, the Office of the Assistant Secretary for Planning and Evaluation and the US Interagency Council on Homelessness on planning and

coordination of the program support. IAP will leverage its collaboration with federal agencies to promote partnerships between state Medicaid agencies, state housing finance agencies, public housing agencies, and other state and local housing and service agencies and providers. There will be an informational webinar Thursday, May 18, 2017, 3:00 pm - 4:00 pm ET. During this webinar, participants will learn about the technical support opportunity, ask questions, and hear about the state selection process. The deadline for Expression of Interest forms will be midnight (ET) on June 8, 2017. *HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Beneficiaries with Complex Needs and High Costs (BCN) tracks through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates.* [Webinar Registration Link](#)

Industry Research

Clubhouse Model Shows Promise in Supporting Individuals with Mental Illness. *Crain's* reported on May 9, 2017, that the "clubhouse model" for providing care management and support to individuals with mental illness has shown some success at not-for-profit organizations like Fountain House in New York. A study released by the NYU Health Evaluation and Analytics Lab this week, for example, showed that the clubhouse model helped reduce hospitalizations for high-need patients. Fountain House, which has helped to spread the clubhouse concept, acts as a social center and resource hub for individuals with mental illness, most of whom are on Medicaid, providing wellness, education, care management, and employment opportunities. [Read More](#)



INDUSTRY NEWS

Aetna to Exit All Exchange Markets in 2018. *Bloomberg* reported on May 10, 2017, that Aetna will exit the Delaware and Nebraska Exchanges in 2018, the last two states the company would have participated in. The announcement comes a week after Aetna announced it would not participate in Virginia. [Read More](#)

Addus HomeCare to Acquire Options Home Care. Addus HomeCare announced on May 4, 2017, that it has signed a definitive agreement to acquire Options Home Care, a subsidiary of HB Management Group and one of the largest home-based personal care providers in New Mexico. Addus says the acquisition will expand its current presence in the state. The transaction is expected to close in the third quarter of 2017. [Read More](#)

Sabra Health Care, Care Capital Properties Merge to Form \$7.4 Billion REIT. Sabra Health Care REIT, Inc. and Care Capital Properties, Inc. jointly announced on May 7, 2017, a definitive agreement to merge into a healthcare real estate investment trust (REIT) with an expected total market capitalization of \$7.4 billion. The deal is expected to close in the third quarter of 2017. The combined company will retain the Sabra name. [Read More](#)

Anthem Petitions U.S. Supreme Court to Review Cigna Merger. *Modern Healthcare* reported on May 5, 2017, that Anthem is filing a petition with the U.S. Supreme Court to review its proposed merger with Cigna Corp. The U.S. Court of Appeals recently upheld a lower court ruling issued in February that had blocked the merger over concerns it would harm competition. Anthem is arguing that the combined companies would result in cost savings for large employers. In February, Cigna sued Anthem for \$15 billion and for the right to exit the agreement. [Read More](#)

University of Kansas Health System, Ardent Health Services to Acquire St. Francis Health in Joint Venture. *KCUR.org* reported on May 4, 2017, that the University of Kansas Health System and Ardent Health Services announced plans to form a joint venture and acquire struggling St. Francis Health. Governor Sam Brownback is said to have helped facilitate the agreement. The two entities will provide \$50 million in operating capital in the first year and share equal governance on the joint board of directors. The agreement is expected to be finalized over the next 60 days. [Read More](#)

CareFirst Expects Exchange Losses to Hit \$600 Million. *Washington Business Journal* reported on May 5, 2017, that CareFirst BlueCross BlueShield has suffered \$500 million in losses from the Affordable Care Act Exchanges, and expects that number to increase to \$600 million in 2017, according to Chet Burrell, chief executive. Burrell attributes the losses to sicker-than-expected members, lack of adequate rate increases, and poor enforcement of the individual mandate. The news comes after the insurer announced last week that it is seeking rate increases of up to 58 percent for individuals on the

Exchanges in Maryland, the District of Columbia, and Virginia, where CareFirst covers over 200,000 individuals. [Read More](#)

Care Advantage to Acquire Stay at Home Personal Care. *PE Hub* reported on May 9, 2017, that Care Advantage, a Virginia-based home health care services provider owned by BelHealth Investment Partners, has agreed to acquire Stay at Home Personal Care from Commonwealth Senior Living. Stay at Home is a provider of in-home personal care services in Norfolk, Hampton, and Christiansburg, Virginia. [Read More](#)

Cimarron Healthcare Capital Finalizes Recapitalization of AMPS, Inc. *PR Newswire* reported on May 10, 2017, that Cimarron Healthcare Capital announced that it had finalized a recapitalization of Advanced Medical Pricing Solutions Inc. (AMPS). AMPS provides health care cost containment services to employers, health plans, and municipalities. Cimarron led an investor group including RAF Industries and Leavitt Equity Partners. Financial terms of the transaction were not disclosed. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 15, 2017	Delaware	Proposals Due	200,000
June 30, 2017	Illinois	Contract Awards	2,700,000
June, 2017	Oklahoma ABD	Contract Awards	155,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 10, 2017	Delaware	Contract Awards (Optional)	200,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
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
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of state dual eligible financial alignment demonstration status.

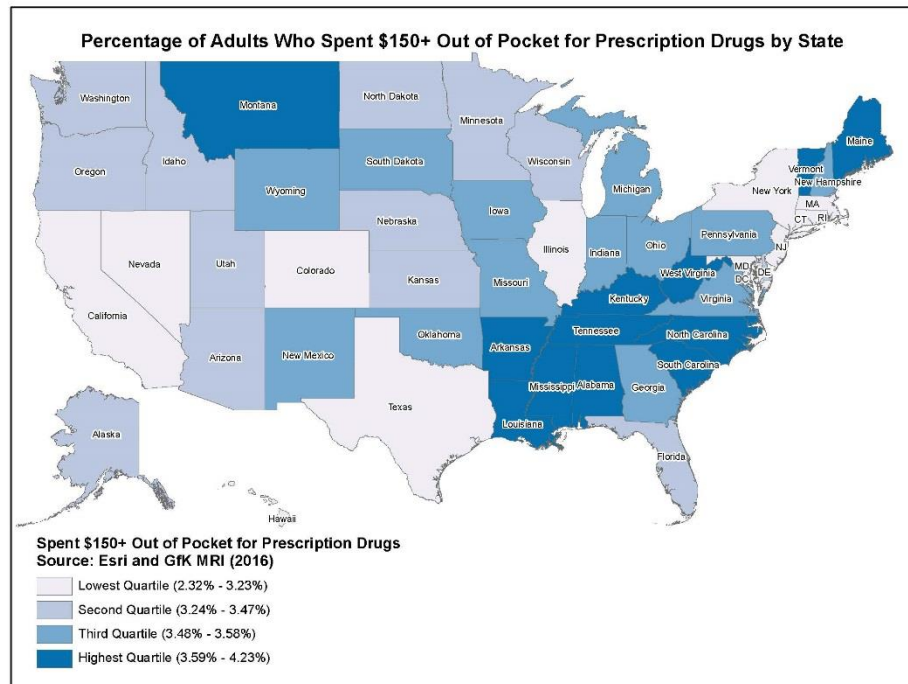
State	Model	Opt-in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	45,469	33.4%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York*	Capitated	1/1/2015 (Phase 2 Delayed)	4/1/2015 (Phase 2 Delayed)	124,000	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	10 States			1,254,200	386,647	30.8%	

* New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA NEWS

Over the next few weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) will continue to showcase a series of maps and other key informatics. Our fifth map in the series highlights data on **the percentage of adults who spent over \$150 out of pocket for prescription drugs by state**. Prescription drug spending increased sharply in 2014 – driven by growth in expenditures on specialty drugs. Approximately 1 in 4 people in the US who take prescription drugs report difficulty affording them.



What does your service area look like? HMA can drill down to county, zip code, or census tract - adding to the depth and breadth of knowledge around the health indicators affecting your community. For more information, contact **Anissa Lambertino** at alambertino@healthmanagement.com or (312)641-5007.

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; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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

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