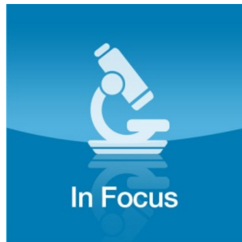
HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 6, 2018



RFP CALENDAR

HMA News

Edited by:
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THIS WEEK

- IN FOCUS: REGISTRATION OPEN FOR HMA CONFERENCE ON THE RAPIDLY CHANGING WORLD OF MEDICAID
- JUDGE ORDERS MAINE GOVERNOR TO IMPLEMENT MEDICAID EXPANSION
- ARKANSAS LAUNCHES MEDICAID WORK REQUIREMENTS
- FLORIDA ANNOUNCES ADDITIONAL AWARDS FOR STATEWIDE MEDICAID MANAGED CARE PROCUREMENT
- NEW JERSEY PASSES INDIVIDUAL HEALTH INSURANCE MANDATE
- ALASKA ANNOUNCES COORDINATE CARE DEMO AWARDS
- CMS RELEASES MEDICAID, CHIP QUALITY SCORECARD
- COMMUNITY HEALTH SYSTEMS COMPLETES PLANNED DIVESTITURES OF TWO HOSPITALS
- ANTHEM NAMES NORWOOD PRESIDENT OF GOVERNMENT BUSINESSES
- UPCOMING WEBINAR: PARTNERSHIP OPPORTUNITIES FOR PAYERS, PROVIDERS AND STATES: SUPPORTIVE HOUSING FOR HIGH UTILIZERS, JUNE 7, 1-2 EDT
- NEW THIS WEEK ON HEALTH MANAGEMENT INFORMATION SERVICES (HMAIS)

IN FOCUS

HMA CONFERENCE ON THE RAPIDLY CHANGING WORLD OF MEDICAID TO FEATURE INSIGHTS FROM 30-PLUS SPEAKERS, INCLUDING HEALTH PLAN CEOS, STATE MEDICAID DIRECTORS, PROVIDERS

Pre-Conference Workshop: Sept. 30
Conference: Oct. 1-2
Location: The Palmer House, Chicago

Health Management Associates is proud to announce its third annual conference on trends in publicly sponsored health care: *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers and States*.

The annual HMA conference has rapidly emerged as a premier health care event, attracting more than 400 Medicaid business executives and policy experts. More than 30 industry-leading speakers are already confirmed for this year's conference, including seven state Medicaid directors, a dozen top Medicaid managed care executives, and leaders from hospitals, clinics, community-based organizations, and other providers. This year's conference will cover a broad array of vital topics:

- Medicaid managed care
- Work requirements
- Waivers
- State innovations in Medicaid funding
- Value-based contracting
- Behavioral health
- Medicare-Medicaid integration
- Provider-led managed care
- Social determinants of health
- Delivery system reform
- Managing chronically ill patients
- Integrated care
- Pharmacy cost management
- Business process transformation
- Payer-provider convergence.

Early Bird registration is now open. Visit the conference website to register and for additional details. Group rates and sponsorships are available. If you have questions, contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. The complete conference agenda appears on the next page.

<table>
<tr><th colspan="2">The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers, and States</th></tr>
<tr><td colspan="2">Pre-Conference Workshop: Sunday, Sept. 30, 2018</td></tr>
<tr><td>1:00 - 5:00 pm</td><td>Medicaid 101: A Primer on the Medicaid Landscape
Medicaid is an incredibly complex program, with wide state variation in structure, benefits, payments, and policies. Even experts lack a complete understanding of how the program works in each of the 50 states and Washington, DC. That's why HMA is happy to offer a special Pre-Conference Workshop called Medicaid 101: A Primer on the Medicaid Landscape. During this interactive workshop, HMA consultants will provide attendees with an understanding of the basic building blocks of Medicaid and an update on the changing landscape for Medicaid programs and policies. Topics of discussion will include Medicaid waivers and State Plan Amendments, Medicaid managed care, delivery system reform and practice transformation initiatives, payment and funding models, and more.</td></tr>
<tr><td colspan="2">Conference Day One: Monday, October 1, 2018</td></tr>
<tr><td>7:00 - 8:00 am</td><td>Registration</td></tr>
<tr><td>8:00 - 9:00 am</td><td><u>Keynote Address</u>
Medicaid in an Era of Community Engagement and Shared Responsibility
The Trump administration's decision to support work requirements and other eligibility restrictions marks a dramatic turning point in the nation's 50-year-old Medicaid program. It's also the first salvo in the administration's stated goal of increasing community engagement and shared responsibility in Medicaid, including an emphasis on employment, healthy behaviors, premiums, drug screening, health savings accounts, and innovative approaches designed to drive accountability down to the member. The potential implications are far-reaching and raise important questions about the future of Medicaid financing, membership growth, payment models, and the design and structure of the program. During this keynote address, a leading health care expert will assess how the emerging community engagement movement will impact the future of Medicaid, with a special emphasis on the opportunities and pitfalls facing Medicaid managed care plans, providers and states.

Speaker to be announced.

<u>Moderator</u>
Gaylee Morgan, Vice President, HMA (Chicago, IL)</td></tr>
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<tr><td>9:00 - 10:30 am</td><td><u>State Medicaid Director Q&A Keynote Session</u>
How States Are Fostering Community Engagement and Innovation in Medicaid
States have increased flexibility under the Trump administration to experiment with a wide variety of new approaches to Medicaid, including work requirements, member premiums, and other forms of community engagement as well as new funding mechanisms like value-based care delivery. During this Q&A keynote session, state Medicaid directors will discuss how they are using waivers to restructure Medicaid programs to meet the unique needs and priorities of their states, with an emphasis on member engagement, payer and provider accountability, and innovation. Medicaid directors will also discuss the growing role of Medicaid managed care plans and assess the future of provider-led Medicaid managed care initiatives.

<u>Speakers</u>
Mari Cantwell, Chief Deputy Director, Health Care Programs, California Department of Health Care Services
Stephanie Muth, Associate Commissioner, Medicaid/CHIP Medical and Social Services Division, Texas Health and Human Services Commission
Justin Senior, Secretary, Florida Agency for Health Care Administration
Allison Taylor, Director of Medicaid, Indiana Family and Social Services Administration
Matt Wimmer, Administrator, Division of Medicaid, Idaho Department of Health and Welfare

<u>Moderator</u>
David Rogers, Managing Principal, HMA Medicaid Market Solutions (Tallahassee, FL)</td></tr>
<tr><td>10:30 - 11:00 am</td><td>Break</td></tr>
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11:00 - 12:30 am	**<u>Medicaid Managed Care Keynote Q&A Session</u>** **The Next Wave: How Medicaid Plans are Positioning Themselves for Success** Medicaid managed care plans have enjoyed unprecedented success, but they also face growing challenges. Along with a push by the Trump administration to implement community engagement, work requirements and other restrictions on eligibility, Medicaid plans are struggling with slowing membership growth, concerns over the actuarial soundness of capitated payments, and the threat of a fundamental restructuring of Medicaid financing at the federal level. Medicaid plans are also being pressed to rethink care delivery by addressing social determinants of health, partnering with providers in value-based payment arrangements, and supporting behavioral health and other integrated care initiatives. During this keynote Q&A session, executives from leading health plans will discuss what's next for Medicaid managed care, including a look at the types of investments, partnerships, and initiatives that will best position the industry for success. *<u>Speakers</u>* ***Catherine Anderson****, SVP, Policy & Strategy, UnitedHealth Community & State* ***John Baackes****, CEO, L.A. Care Health Plan* ***Patricia Darnley****, President, CEO, Gateway Health Plan* ***Scott Markovich****, VP, Medicaid Growth and Provider Development, Aetna Inc.* ***Patrick Sturdivant****, President, Virginia Medicaid Health Plan, Anthem Inc.* *<u>Moderator</u>* *Donna Checkett, Vice President, HMA (Chicago, IL)*
12:30 - 2:00 pm	**<u>Luncheon Keynote</u>** *Speaker to be announced.*

<table>
<tr><td rowspan="2">2:00 - 3:30 pm</td><td>Concurrent Breakout Session
Medicare-Medicaid Integration: Emerging Models and Opportunities
One of the biggest opportunities for state Medicaid agencies and health plans is better integration of services for individuals who are dually eligible for Medicare and Medicaid. This high-cost population consumes an outsized share of Medicaid and Medicare dollars and comes with a specific set of demanding needs and challenges. States and the federal government are increasingly turning to managed care to integrate and improve the quality of care and outcomes, as well as realize cost-efficiencies. During this session, regulators and health plan executives will outline emerging models and opportunities for Medicare-Medicaid integration. The discussion will look at the recent trend among states to require managed care organizations to operate both a Medicaid plan and a Medicare Advantage Dual Eligible Special Needs Plan. The session will also provide an update on the future of the CMS Dual Eligible Financial Alignment Demonstration, among other topics.

Speakers
Michael Monson, SVP, Long-Term Services & Supports, and Dual Eligibles, Centene Corp.
Cheryl Phillips, M.D., President, CEO, SNP Alliance, Inc.

Additional speakers to be announced.

Moderator
Sarah Barth, Principal, HMA (New York, NY)</td></tr>
<tr><td>Concurrent Breakout Session
Addressing Social Determinants of Health: Emerging Payer-Provider Partnerships
No one doubts the important role social factors play in the health of a population of people. The question is how can health care organizations best address social determinants of health such as unemployment, poverty, housing shortages, substandard education, and inadequate access to care? During this breakout session, health plans, providers and community-based organizations will discuss growing efforts to address social determinants of health in Medicaid populations, including a look at the types of services and partnerships health plans and other payers are most likely to support.

Speakers
Kathye Gorosh, SVP, Strategy & Business Development, AIDS Foundation Chicago
Karin Van Zant, VP, Executive Director, Life Services, CareSource
James Kiamos, CEO, CountyCare Health Plan
Cheryl Lulias, President, Executive Director, Medical Home Network; CEO, MHC ACO

Moderator
John O'Connor, Acting Managing Director, HMA Community Strategies (Los Angeles, CA)</td></tr>
</table>

	Concurrent Breakout Session **Behavioral Health: How Value-Based Contracting Is Driving Payer-Provider Partnerships** The nationwide rollout of value-based payments could benefit traditional providers of behavioral health care because behavioral health is in many ways is the ultimate valued-based service, with low costs and significant impacts on health outcomes. The challenge is making sure that behavioral health providers can fully participate in value-based opportunities, which require deep capital pools, and access to robust information technology infrastructures capable of capturing, analyzing and sharing data across the continuum of care. During this panel, health care executives from leading payers and providers will outline strategies for ensuring that behavioral health providers have the tools and resources they need to successfully make the transition to emerging value-based payment methodologies, and that the people they serve are able to reap the benefits of accountable care. *Speakers* ***Lou Dierking****, SVP, Behavioral Health Payer Channel Lead, Optum* ***David Guth****, CEO, Centerstone America* ***Jim Spink****, EVP and Tri-State/Mid-Atlantic Region Market President, Beacon Health Options* ***Ann Sullivan****, Commissioner, NYS Office of Mental Health* *Moderator* *Josh Rubin, Principal, HMA (New York, NY)*
3:30 - 4:00 pm	Break

	Concurrent Breakout Session **How Health Plans and Providers Are Joining Forces to Improve Patient Care** Convergence in health care is real, blurring the lines between payers and providers, and recasting how health care services are financed and delivered. That's true of health care in general and for Medicaid specifically. During this session, leading health care executives and regulators will address how convergence is changing the way care is paid for and delivered, with an emphasis on the implications for Medicaid populations. Speakers will also discuss how health plans and providers can best position themselves for success in this evolving market. *Speakers* ***Brent Layton**, EVP, Chief Business Development Officer, Centene Corp.* ***Ed Stellon**, Executive Director, Heartland Alliance Health* *Additional speakers to be announced.* *Moderators* *Karen Batia, Principal, HMA (Chicago, IL)* *Roxane Townsend, M.D., Managing Principal, HMA (Raleigh, NC)*
4:00 - 5:30 pm	Concurrent Breakout Session **Beyond the Basics: The Future in Medicaid Pharmacy Management and Pharmaceutical Care** Pharmacy benefits are moving beyond being just a commodity to becoming part of an integrated care model for Medicaid members and other vulnerable populations. The change is driven by state demands for improved outcomes as well as pressure to control costs given the explosion of biotech drugs and an evolving generic market. During this session, Medicaid managed care plans, pharmacy benefit managers, and providers will discuss a wide variety of emerging partnerships, innovations, and initiatives designed to better manage pharmacy benefits and engage members, driving improvement in medication adherence, fostering appropriate utilization, and addressing gaps in care. *Speakers* ***Andrew Fox**, Director, Healthcare Segment Development, Walgreens* ***James Gartner**, VP Pharmacy and Retail Strategy, CareSource* ***Scott Streator**, Managing Principal, Government Program Services, MedImpact Healthcare Systems, Inc.* ***Krista Ward, Senior Director, Medicaid, Express Scripts*** *Moderator* *Anne Winter, Principal, HMA (Phoenix, AZ)*

	Concurrent Breakout Session **Best Practices in Medicaid IT and Business Process Transformation** Most Medicaid programs have undertaken major information technology and business process transformation projects in recent years, most notably impacting functions traditionally managed with eligibility systems and Medicaid Management Information Systems (MMIS). Several states have noted that these projects are major priorities over the next three to five years, figuring prominently in efforts to implement delivery system and payment reforms, quality improvement initiatives, improved provider and managed care plan monitoring, population health management, and cost containment. During this session, a panel of Medicaid program leaders will share their approaches to IT and business process transformation projects, followed by an interactive discussion focused on best practices to implement and pitfalls to avoid. *Speakers to be announced.* *Moderators* *Wade Miller, Principal (Atlanta, GA)* *Juan Montanez, Principal (Washington, DC)*
5:30 - 7:00 pm	Cocktail Party
Conference Day Two: Tuesday, October 2, 2018	
7:00 - 8:00 am	Breakfast
8:00 - 9:00 am	**Keynote Address** **What's Next for Integrated Care: A Status Report and Forecast** One of the most important – and often elusive – goals in health care is delivery system reform designed to fundamentally change the way care is delivered to patients. Whether driven by new funding mechanisms, incorporating new provider-led care management entities, or relying on partnerships between health plans and providers, the goal is the same: Integrating, coordinating, and managing the physical, behavioral and social factors that impact an individual's health and wellness. During this keynote address, a leading health care executive will provide an update on the state of integrated care for Medicaid populations, assess which models are most likely to succeed, and discuss how health plans and providers can work together to take integrated care delivery to the next level. *Speakers* ***John Jay Shannon**, MD, CEO, Cook County Health & Hospitals System* *Moderator* *Pat Terrell, Vice President, HMA (Chicago, IL)*

9:00 - 10:30 am	<u>**Integrated Care for High-Cost Populations**</u> **Managing Chronically Ill Medicaid Patients – Emerging Payer-Provider Models** Successfully managing high-cost, chronically ill members is an important focus for Medicaid managed care plans. Initiatives have included a variety of disease management efforts, partnerships with patient-centered medical homes, and even the acquisition of primary care centers and clinics focused on high-risk patients. During this session, Medicaid plans, providers and states will address emerging models for serving chronically ill Medicaid populations, ensuring the most cost-effective care, and pointing the way to fundamental changes in the way care is delivered and financed. *<u>Speakers</u>* ***Leanne Berge***, *CEO, Community Health Plan of Washington* ***MaryAnne Lindeblad,*** *State Medicaid Director, Washington Health Care Authority* ***Rebecca Kavoussi***, *President - West, Landmark Health* *<u>Moderator</u>* *Betsy Jones, Managing Principal, HMA (Seattle, WA)*
10:30 - 11:00 am	Break
11:00 am - 12:30 pm	**The Role of Value-Based Payments in Fostering Delivery System Reform** Medicaid programs across the nation continue to experiment with a wide variety of value-based payment models designed to incentivize providers to change the way care is delivered. Whether it's through Coordinated Care Organizations in Oregon, Delivery System Reform Incentive Payment initiatives in New York and California, or accountable care efforts in Alabama, Colorado, and North Carolina, the emphasis is on fostering care coordination, behavioral health integration, and access to community-based services. During this session, leading providers, payers and states will provide an update on the successes and setbacks of their value-based payment initiatives, including insights into how health plans and providers can work together to help drive policies that promote more efficient use of Medicaid funding and services. *<u>Speakers</u>* ***Mandy Cohen, MD***, *Secretary, NC Department of Health and Human Services* ***Carlos Olivares***, *CEO, Yakima Valley Farm Workers Clinic* ***Lisa Trumble***, *SVP of Accountable Care Performance, Cambridge Health Alliance* *<u>Moderator</u>* *Dorothy Teeter, Principal, (Seattle, WA)*
12:30 pm	Adjourn

HMA Medicaid Roundup

Alaska

Alaska to Award Medicaid Coordination Care Contracts to UnitedHealth, Providence Family Medical Center. *State of Reform* reported on June 1, 2018, that Alaska has announced its intent to award Medicaid Coordinated Care Demonstration Project contracts to UnitedHealthcare and Providence Family Medical Center. United was selected for the Managed Care Organization model and Providence was selected for the Provider-Based Reform model. PeaceHealth Ketchikan Medical Center and Pinnacle Integrated Medicine were not selected for the provider model and have 10 days to file protests. Read More

Arkansas

Arkansas Launches Medicaid Work Requirements. *Modern Healthcare* reported that effective June 1, 2018, Arkansas became the first state to launch Medicaid work requirements. Non-disabled adult expansion beneficiaries will lose coverage if they don't have a job or participate in certain community activities. Hospitals and health plans expressed concerns about the difficulty of notifying beneficiaries of the new requirements. Arkansas has about 280,000 expansion members. Read More

California

General Assembly Passes Bill to Cover Immigrants Under Medicaid, Regardless of Status. *Modern Healthcare* reported on May 30, 2018, that the California General Assembly passed a bill extending Medicaid coverage to all immigrants, eliminating legal residency requirements in the state's Medicaid program. The legislation now moves to the state Senate for review. The coverage would cost California $3 billion for the 2018-19 fiscal year. Read More

Florida

Nursing Homes, Assisted Living Facilities Could Face Fines Over Lack of Backup Power Systems. *The Daytona Beach News-Journal/News Service of Florida* reported on June 3, 2018, that nearly 66 percent of Florida nursing homes and 18 percent of assisted living facilities have complied with state rules requiring emergency power sources to run air conditioning for up to 96 hours during electricity outages, according to data from Florida Agency for Health Care Administration. The rules took effect on June 1, 2018, in the aftermath of Hurricane Irma. Facilities not in compliance could face fines. Florida nursing homes will receive some Medicaid funding for equipment; however, no assistance is provided to assisted living facilities. Read More

Florida to Launch Website on Cost of Medical Procedures Without Florida Blue Data. *Naples Daily News* reported on May 31, 2018, that Florida is preparing to launch a $4 million website designed to provide consumers with information on the cost of medical procedures. However, the website, Florida Health Finder, will not include data from the state's largest commercial insurer. Florida Blue, which has about 5 million members, has until September to submit its claims data to the state Agency for Health Care Administration. The website currently includes data from Aetna, Humana and United. Read More

Florida Announces Additional Awards for Statewide Medicaid Managed Care Procurement. The Florida Agency for Health Care Administration announced on May 31, 2018, additional awards for its Statewide Medicaid Managed Care Program. The awards were made to Managed Medical Assistance Provider Service Networks and included Lighthouse Health Plan, LLC, for Region 1, and Miami Children's Health Plan, LLC. for Regions 9 and 11. To view the Notices of Intent to Award, click here.

CMS May Extend Public Comment Period for Florida Waiver on Retroactive Medicaid Eligibility. *Health News Florida* reported on May 30, 2018, that the Centers for Medicare & Medicaid Services (CMS) is considering extending the deadline for public comment on a Florida waiver proposal that would cut retroactive Medicaid eligibility from 90 to 30 days. The National Health Law Program asked for a one-week extension after learning that CMS' Medicaid.gov website was temporarily not allowing public comment submissions. The 30-day public comment period ends on June 5. Read More

Maine

Judge Orders Governor LePage to Begin Implementing Medicaid Expansion. *Bangor Daily News* reported on June 4, 2018, that Maine Superior Court Justice Michaela Murphy ordered Governor Paul LePage to begin implementing a voter-approved Medicaid expansion. Murphy ordered LePage to submit a plan for implementation within a week. The LePage administration previously missed an April deadline to submit a plan and was sued by advocates. LePage stated that he would not implement expansion without a funding plan from the state legislature. Read More

Michigan

Michigan Health Insurance Claims Assessment Tax Speeds Through Legislature. *Crain's Detroit Business* reported on May 30, 2018, that a revamped Michigan Health Insurance Claims Assessment tax sped through the state legislature and is now headed to Governor Rick Snyder's desk for signature. The legislation, which calls for a health insurance tax on both non-Medicaid insurance and Medicaid health maintenance organizations, is expected to generate about $600 million in the 2018-19 fiscal year that begins on October 1. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Murphy Signs Bill to Require Health Coverage or Pay a Penalty. *The New Jersey Business & Industry Association* reported on May 31, 2018, that New Jersey Governor Phil Murphy signed into law S-1877 known as the "New Jersey Health Insurance Market Preservation Act" which captures the requirements for an individual mandate set forth under the federal Affordable Care Act (ACA). The New Jersey Business & Industry Association reported on the passage of the bill and quoted Senator Joe Vitale (D-Middlesex), chair of the Senate Health, Human Services and Senior Citizens Committee saying, "Protecting the viability of the individual mandate is needed to maintain a foundation for the insurance market and to allow the success of the ACA to continue." A companion law was also signed (S-1878) to establish a reinsurance program that would reimburse carriers for health claims payments that exceed a threshold set by the state's Department of Banking and Insurance. Read More

Governor Murphy Signs Out-of-Network Bill to Protect Consumers from Unexpected Medical Charges. *New Jersey Spotlight* reported on June 3, 2018, that New Jersey Governor Phil Murphy signed into law the *Out of Network Consumer Protection, Transparency, Cost Containment and Accountability Act*, a controversial bill (A-2039/S-485) that ensures patients have clarity on a provider's network status before they receive services. Physicians have concerns about the new law, which they believe will compromise their negotiations with health plans and reduce revenue they count on to offset services for the uninsured. Read More

New Jersey Enacts Individual Health Insurance Mandate. *Politico* reported on May 30, 2018, that New Jersey Governor Phil Murphy signed legislation that will require all state residents to have health insurance effective January 1, 2019. Residents without health insurance will be required to pay an annual penalty of 2.5 percent of household income up to the average yearly premium of a bronze Exchange plan or a per-person charge of up to $2,085, whichever is higher. The state is expected to collect between $90 million and $100 million in penalties, which will go toward funding a reinsurance program. New Jersey and Massachusetts are the only states to enact an individual health insurance mandate. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

DHS to Host Public Comment Day on 1115 Waiver. The New York Department of Health will be hosting the first of two public comment days for its 1115 waiver program on June 19, 2018, at the Empire State Plaza in Albany. The day will begin with a public working session of the Project Approval and Oversight Panel (PAOP). PAOP is a stakeholder panel established to serve as advisors and reviewers of Performing Provider Systems status and project performance during the state's 5-year DSRIP program. Written public comments will be accepted through June 29th at 1115waivers@health.ny.gov. The meeting will be webcast here. The PAOP working session begins at 10:30 am; the public comment session will begin at 1 pm.

Health Home Quality and Utilization Data Now Available. The New York Department of Health has posted health home data for quality and utilization metrics on its Health Data NY website. Although the program measures/metrics have already been disseminated to health homes this is the first open source data for the Health Home program. Documents explaining the datasets can be found by clicking on the 'about' tab on the top right and scrolling down to attachments. The datasets include health home-specific performance on 46 quality measures based on the Centers for Medicare and Medicaid Services core set of health care quality measures, and four different measures of utilization: mental health utilization, nursing facility short stay, emergency department visits, and inpatient discharges. Data are available for 2013 – 2015. Click here for quality measures. Click here for utilization measures.

United Hospital Funds Releases Report on New York Primary Care and Behavioral Health. The United Hospital Fund has released a report on May 30, 2018, describing the experience of a pilot program aimed at integrating behavioral health and physical health. The report tracks the experience of 11 practices that adopted a framework to integrate behavioral health care into their practices. They find that small primary care practices participating in the project are successfully identifying people at risk for depression, and that those practices now also view routine screening for depression as equal to checking patients' vital signs and blood pressure. The practices participating in the project reported that their integration efforts resulted in improved quality of care. They were able to better identify and treat patients with depression using evidence-based approaches and help them self-manage and coordinate their health and behavioral care. Revenues began to increase as well, as practices started to bill for mental health screening. However, both primary care and behavioral health providers said the inability to get reimbursed properly still hinders their efforts. Read More

New York Launches Age-Friendly Health System Initiative. As part of this year's budget, New York Governor Andrew Cuomo announced a commitment to develop an age-friendly health system intended to provide better health outcomes for older adults, reduce waste associated with low-quality services, increase utilization of cost-effective services for older adults, and improve reputation and market share. The Department of Health is launching this initiative with a webinar on June 20th, from 3:30 – 4:30 that will describe what an age-friendly health system is, and how organizations can become age-friendly. Read More

NYC Health + Hospitals Names CFO. New York City's public hospital system, NYC Health + Hospitals announced that John Ulberg will take over as CFO. Ulberg is currently the state Medicaid program's chief financial officer, a position he has held for the last 10 years. He was a principal negotiator and designer for the state's Medicaid Redesign Team Waiver. Ulberg's responsibilities for the state's Medicaid program include Medicaid rate-setting, managing Medicaid spending under the global spending cap, and working to implement value-based payment. Read More

New York Attorney General Reports on Mental Health Parity Enforcement. The New York Attorney General's office released a report in May 2018, on the office's progress in enforcing federal and state mental health parity requirements, ensuring all New Yorkers can access behavioral health services, including substance abuse treatment. In response to numerous consumer complaints, the office launched an industrywide investigation in 2013 of how health plans were complying with state and federal mandates to cover mental health services. Since then, the state has won more than $2 million in restitution for consumers who were denied mental health claims and enforced eight national settlement agreements with seven health plans. Altogether, health plans have paid out $3 million in penalties. Read More

New York Delivery System Reform Incentive Payment Program Achieves Goals. New York's Delivery System Reform Incentive Payment (DSRIP) Program has achieved its third-year goals. The recently released quarterly report for the fourth quarter of DSRIP year 3, which ended on March 31, 2018, indicates that the state has met four statewide performance measures: statewide metrics performance, success of statewide projects, total Medicaid spending, and Managed Care plan expenditures. New York's DSRIP program has 25 Performing Provider Systems (PPS) made up of hospitals, providers and community-based organizations, which collaborate to provide Medicaid members and the uninsured with higher quality, more coordinated care. Through community-level collaborations and a focus on system reform, the ultimate goal of these projects is to improve quality of care and achieve a 25 percent reduction in avoidable hospital use over the five years of the program. The report indicates that New York exceeded performance goals on the majority of measures in place, including:

- Preventable hospital readmissions
- Preventable emergency room visits
- Patient connection to consistent source of primary care
- Access to timely appointments Read More

Ohio

Ohio Decides Not to Delay Medicaid Payments, Will Soften Hospital Payment Cuts. *Dayton Daily News* reported on June 4, 2018, that Ohio will not delay Medicaid payments to providers in June and will soften proposed cuts to hospitals reimbursement. The state initially planned the delays and cuts to offset a projected funding shortfall. However, a decline in Ohio's poverty rate has eased budgetary pressures. The cuts would have also impacted addiction and mental health services, which are also expected to transition from fee-for-service to managed care in July. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Holds May MAAC Meeting. At the May 24, 2018, meeting of the Pennsylvania Medical Assistance Advisory Committee, Acting Deputy Secretary of the Office of Medical Assistance Programs, Sally Kozak, announced that the Department of Human Services reads two April Commonwealth Court opinions regarding the HealthChoices award protests as cancelling the request for proposals. The department will be considering next steps over the next few months.

Department of Human Services Special Advisor Heather Hallman provided an update on the development of the state's Electronic Visit Verification (EVV) plan for compliance with the federal 21st Century Cures Act (the Act). The Act requires individuals providing personal care services and home health care services to complete electronic check-in and check-out with a description of services and location provided and who provided and received services.PA will ensure compliance with the Act's specified deadlines through its contract with the Commonwealth's EVV vendor DXC. Pennsylvania is still in the early stages of planning for compliance and welcomes feedback from stakeholders.

South Dakota

South Dakota Expands Substance Abuse Services to All Medicaid Eligibles. *The Rapid City Journal* reported on June 4, 2018, that South Dakota will expand substance abuse services to all individuals eligible for Medicaid in the state, effective later this month. Previously, the service was available only to pregnant women and adolescents. The change was cleared in a close vote of the state legislature's Rules Review Committee. Read More

Texas

Medicaid Plan Networks Fall Short, Report Suggests. The *Dallas Morning News* reported on June 4, 2018, that Texas Medicaid managed care organizations are overstating the number of physicians available to treat members and that the state isn't adequately monitoring health plan networks. The *Dallas Morning News* investigation found that Medicaid plans included physicians in their network directories who were not taking new patients, did not accept government-funded health plans, or did not serve Texas individuals any longer. Read More

Texas Sick, Disabled Struggle to Receive Necessary Care. *Dallas News* reported on June 3, 2018, that hundreds of sick children and disabled adults in Texas aren't receiving necessary medical care, largely because of a lack of adequate state oversight of Medicaid managed care plans, according to a *Dallas Morning News* investigative report. Since 2014, the number of appeals of care denials has risen 26 percent in programs for the elderly and disabled and 31 percent in programs for foster children, the report says. Read More

National

CMS to Offer States Technical Assistance for HCBS Rate Development, EVV Systems. The Centers for Medicare & Medicaid Services announced on June 6, 2018, that it has contracted with Lewis and Ellis and Korn Ferry to offer free technical assistance to state Medicaid agencies to assist with program and regulatory compliance for electronic visit verification and for home and community-based services rate setting. Read More

HHS to Focus on Prospective Payment Model to Drive Nursing Home Sustainability. *Modern Healthcare* reported on June 5, 2018, that the U.S. Department of Health & Human Services will focus on a proposed prospective payment model to improve quality and efficiency in nursing homes, according to Secretary Alex Azar. The model, which Azar touted in remarks to the American Health Care Association and National Center for Assisted Living, ties nursing home payments to patient health status rather than the volume of services provided. The model also rolls back regulations and reporting requirements and increases overall Medicare payments to nursing homes. Read More

CMS Releases Medicaid, CHIP Quality Scorecard. The Centers for Medicare & Medicaid Services released on June 4, 2018, a quality scorecard designed to provide state-by-state information on clinical outcomes and administrative efficiency for the Medicaid and Children's Health Insurance Program. Clinical performance measures will include postpartum care, well-child visits, immunizations, substance abuse treatment, and follow-up after hospitalization for mental illness. The scorecard will include information voluntarily reported by states as well as federally reported measures. Read More

Republicans Ask Supreme Court to Decide Whether Medicaid Beneficiaries Can Challenge Provider Disqualifications. *CQ News* reported on May 31, 2018, that 90 Republican lawmakers asked the Supreme Court to decide whether Medicaid beneficiaries can challenge a state's decision to disqualify a preferred Medicaid provider. In an amicus brief, lawmakers urged the Supreme Court to overturn a lower court ruling that approved of these challenges.Read More

Some States Consider Medicaid Buy-In Programs. *Governing* reported on June 4, 2018, that several states are considering legislation to allow individuals who don't qualify for Medicaid to buy into the program through the insurance Exchanges regardless of their income level. Currently Iowa, Massachusetts, Minnesota, Missouri, New Jersey and Washington have pending legislation to establish a Medicaid buy-in program. Read More

CMS to Revive Home Health Claims Review Demonstration. *Modern Healthcare* reported on May 30, 2018, that the Centers for Medicare & Medicaid Services will renew a home health claims review demonstration project initially launched in 2016. Providers who opt out will receive an automatic 25 percent reduction in claims payments. The original demonstration was aimed at preventing home health agencies from receiving improper payments; however, the program was suspended last year amid complaints of reduced access to care. The relaunch is slated for Illinois, Ohio, North Carolina, Florida, and Texas. Read More

Industry News

CVS Health Says Soistman to Remain Head of Aetna Medicaid. CVS Health announced on June 6, 2018, that Fran Soistman will remain head of government services for Aetna Medicare, Medicaid and Federal Plans businesses, following the merger of the two organizations. Soistman will report to Karen Lynch, currently president of Aetna, who will become an executive vice president of CVS Health and remain president of the Aetna business unit. Read More

Anthem Names Felicia Norwood President, Government Business. Anthem, Inc. announced on June 4, 2018, that Felicia Norwood has been named president of the company's government business division, effective June 18, 2018, responsible for Medicaid, Medicare and Federal Government Solutions lines. Norwood was most recently director of the Illinois Department of Healthcare and Family Services. She also served a stint as head of Aetna's Active Health Management subsidiary. Read More

Community Health Systems Completes Planned Divestitures of Two Hospitals. Community Health Systems, Inc. announced on June 1, 2018, that it had completed divestitures of 60-bed Byrd Regional Hospital in Leesville, LA, to Allegiance Health Management, and 85-bed Tennova Healthcare in Jamestown, TN, to Rennova Health. The effective date of both transactions is June 1, 2018. To view CYH Press Release (Byrd) click here. To view CYH Press Release (Jamestown) click here.

RFP Calendar

Date	State/Program	Event	Beneficiaries
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Spring/Summer 2018	North Carolina	RFP Release	1,500,000
June 2018	New Hampshire	RFP Release	160,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 7, 2018	Alabama ICN (MLTSS)	Proposals Due	25,000
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 or Rebid 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
July 11, 2018	Alabama ICN (MLTSS)	Contract Award	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	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 Integrated Managed Care (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 or Rebid 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
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
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 Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

Company Announcements

MCG Health and Cadalys Offer New App on the Salesforce AppExchange, the World's Leading Enterprise Apps Marketplace. Read more

HMA News

Upcoming Webinar - Partnership Opportunities for Payers, Providers and States: Supportive Housing for High Utilizers on June 7, 1–2 EDT. Read More

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- NE Medicaid Managed Care Enrollment Rises 2.3%, Jun-18 Data
- MLRs at NV Medicaid MCOs Average 84.9%, 2017 Data
- MLRs Average 91.8% Among MO Medicaid MCOs, 2017 Data
- MLRs Average 93.5% Among MA Medicaid MCOs, 2017 Data
- MLRs Among KS Medicaid MCOs Average 88.1%, 2017 Data
- MLRs Average 97.5% at IL Medicaid MCOs, 2017 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- AK Medicaid Coordinated Care Demonstration Project RFP and Award, 2016-18
- FL Statewide Medicaid Prepaid Dental Health Program ITN, Respondents, and Rankings, 2017-18
- TX CHIP and Medicaid Managed Care Services for Serious Mental Illness RFI, Jun-18
- FL Statewide Medicaid Managed Care Re-procurement ITN Transcripts and Additional Awards for Regions 1, 9, and 11, May-18
- KY Health Data Analytics and Enterprise Data Warehouse (EDW) RFP, May-18

Medicaid Program Reports and Updates:

- PA DHS Electronic Visit Verification (EVV) Presentation, May-18
- NE HCBS Statewide Transition Plan Update Presentation, May-18
- CMS Medicaid Expenditures for Long-Term Services and Supports (LTSS) Report, FY 2016
- WV Enacted Budget, SFY 2018-19
- MD Enacted Budget, SFY 2018-19

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- Excel data packages
- RFP calendar

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