HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 13, 2018

Edited by:
Greg Nersessian, CFA
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

THIS WEEK

IN FOCUS

ALTERNATIVE BENEFIT PLANS FOR THE MEDICAID EXPANSION POPULATION

This week, our *In Focus* section highlights HMA Medicaid Market Solutions' (MMS) efforts to support state flexibility in designing and implementing Section 1115 Demonstration Waivers promoting member engagement and personal responsibility. Over the coming weeks, HMA MMS will present a series of articles providing in-depth analyses of the many facets of these new Medicaid models. This week, we look at Alternative Benefit Plan (ABP) options available to states for the Medicaid expansion population.

Health benefits offered to the expansion population are required to be provided through an ABP. States may elect to align these benefits with the Medicaid State Plan or may choose to base them on a different set of benefits. ABPs were an option for states prior to the Affordable Care Act and were updated following its passage to reference the Essential Health Benefits (EHB) options that are available to states in the commercial market while maintaining the exemption for the medically frail.

To date, 34 states, including Washington D.C., have elected to offer Medicaid to childless adults with income under 138% of the poverty level. Among these states, 14 have implemented or are in the processing of implementing the option to base the benefits for the expansion population on a package other than the Medicaid State Plan. Unlike other personal responsibility initiatives targeted at the expansion population, ABPs can be structured without the implementation of a Section 1115 waiver. In addition, the recently finalized (April 17, 2018) Notice of Benefit and Payment Parameters for 2019 will allow states additional flexibility in selecting EHB benchmarks beginning in 2020. This flexibility will carry over to ABPs, providing more options on which states can base their Medicaid expansion coverage.

Current ABP Options

States developing benefit packages targeted to Medicaid expansion adults have the option to develop a benchmark or benchmark equivalent coverage ABP. A benchmark plan is a benefit design that is indexed to the benefits offered on a reference plan, and a benchmark equivalent plan is a benefit design that provides benefits of equivalent value to a reference plan. Many of the requirements for ABPs are linked to the commercial market definition of EHB. Benchmark coverage must offer benefits in the ten EHB categories[1] and offer benefits of equal value to those in the benchmark plan. "Equal to" does not indicate that the same benefits must be offered, as benefits may be removed or substituted within an EHB category following the methodology for benefit substitution available in the commercial market. Plans that can serve as the base-benchmark include all of those plans available to serve as commercial market EHBs.[2]

---

[1] Includes: ambulatory patient services (outpatient services), emergency services, hospitalization (inpatient), maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. Note: For the purposes of offering benefits to the adult population in Medicaid, Early Periodic Screening Diagnostic, and Treatment services do not apply as these are a required *pediatric* benefit.

[2] Includes: Federal Employee Coverage (Blue Cross Blue Shield PPO), State Employee Coverage, Largest Commercial Non-Medicaid HMO by enrollment in the State, Secretary Approved Coverage (Medicaid State Plan) AND all of the options available in the state for the commercial market EHB, encompassing the three small group insurance plans by enrollment in the state).

The benchmarking process for ABPs contains more flexibility than allowed for the definition of a state's EHB in the commercial market. Within the ten required benefit categories, benefits may be removed, replaced, modified, and substituted, provided that the entire actuarial value of the category does not fall below the original value in the reference plan. Any EHB category may be duplicated from the Medicaid State Plan, provided it is of at least the same value, while continuing to base the remaining EHB categories on the selected benchmark plan. In addition, benefits may be added to the ABP that are not included in the benchmark option, without the requirements that the cost of the benefit be defrayed as exists in the commercial market.

States may also leverage benchmark equivalent coverage when targeting benefits that require more flexibility than allowed under the benchmark process. Benchmark equivalent coverage requires the same coverage of the ten EHB categories but allows for a package that is on aggregate of equal value to one of the benchmark options instead of equal value in every category. Prescription drugs, mental health, vision and hearing services must be provided at least at 75 percent of the actuarial value of the benchmark plan. However, provided the total value of the plan is at least equal to the reference plan, there are no such restrictions on variation in the other categories under the benchmark equivalent option.

Future ABP Options

The Notice of Benefit and Payment Parameters for 2019 adds benchmark options for states to leverage from the commercial market in 2020. As the ABP benchmark plan options are based on those plans available in the commercial market, this will allow for additional flexibility for states in defining benefit packages via ABPs beginning in 2020. The requirement to offer all 10 EHB benefit categories and the existing benchmark options remain. Additional benchmark plan options include:

- The EHB benchmark plan for 2017 from any state
- Any of the existing benchmarks, with any EHB category replaced by a benchmark plan from another state
- Otherwise selecting or developing a benchmark, provided it is equivalent to a typical employer plan.[3]

This increased flexibility will allow for further targeting and development of innovative benefit designs in Medicaid.

[3] Defined as equal to one of the existing benchmark options, one of the five largest benchmarks by enrollment for large group health insurer plans.

State Examples of Benefit Variation via ABPs

Arkansas	Indiana	North Dakota
• ABP based on commercial market small group plan that is the State's EHB. • Allows for alignment of Medicaid expansion benefits with Marketplace coverage. • Supports 1115 waiver program that enrolls non-exempt individuals eligible for the Medicaid expansion into Marketplace plans.	• Two distinct ABPs both based on the largest commercial HMO. • Allows for a Basic benefit package with some lower service limits that does not include vision and dental and a Plus benefit package with increased service limits including vision and dental. • Supports the Healthy Indiana Plan 1115 waiver program HIP Plus and HIP Basic design.	• Bases benefits on the largest commercial HMO. • Provides a benefit design for the expansion population that excludes benefits not commonly offered on health plans in the commercial market, such as long term care and routine dental. • Benefit variation for Medicaid expansion implemented without a corresponding 1115 waiver.

Identifying and Enrolling the Medically Frail

States utilizing an ABP distinct from the Medicaid State Plan must also identify medically frail expansion beneficiaries and offer these individuals the opportunity to select the Medicaid State Plan.[4] In states where the ABP is the state plan, the medically frail identification and opt-out process is not required. In states with community engagement requirements, however, identification of medically frail expansion beneficiaries is required (even where there is not a benefit difference) since they are exempt from those requirements.

The federal definition of medically frail as applicable to the Medicaid Expansion population includes:

- individuals with disabling mental disorders
- individuals with chronic substance use disorders
- individuals with serious and complex medical conditions;
- individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, and
- individuals with a disability determination based on Social Security criteria or in states that apply more restrictive criteria than the Supplemental Security Income program, the state plan criteria.

[4] Since enrollment of the newly eligible adult or Medicaid expansion population is required to be into ABPs, CMS refers to the Medicaid State Plan option as 'the ABP that is the state plan' for medically frail individuals.

Within these criteria, states have substantial flexibility in how they define the medically frail and what process they leverage to identify them. State definitions of medically frail may be based on diagnosis codes, past health care utilization, or general member medical need. Once medically frail is defined, the state must develop a method to identify medically frail individuals. This may include member screening tools or surveys, provider attestations and/or documentation, or tools that perform claims analysis to identify individuals that meet the state's criteria.

For individuals determined to be medically frail, these individuals may be enrolled by default into the Medicaid State Plan option and then provided, if required, the opportunity to change to the ABP option. Providing the opportunity to change coverage options requires that the state inform the enrollee of the difference in benefits between the two options.

Example of State Variations in Medically Frail Processes

Arkansas	Indiana	North Dakota
• Individuals screened on application for medically frail or may self-attest post eligibility • Health plans may identify individuals via claims • Medically frail enrolled by default into the Medicaid State Plan equivalent benefit package • Provided with a choice counseling notice to opt into an ABP equivalent benefit package • Not eligible for enrollment in Marketplace QHP allowed under the 1115 waiver, must remain in Medicaid FFS	• Medically frail based on diagnosis codes linked to high-cost and debilitating conditions • Medically frail status determined by member's health plan leveraging member claims, or submitted records and a claims analysis tool • Medically frail members receive Medicaid State Plan benefits, no option to opt into ABPs	• Expansion adults informed of option to seek medically frail status via self-report • Individuals requesting medically frail status complete a screening questionnaire. Those who are determined potentially medically frail must provide documentation. • The ABP is the default enrollment plan. Individuals that qualify as medically frail may request to change enrollment from the ABP to the State Plan.

Outlook for ABPs

Leveraging the options to target benefit design, specifically to the Medicaid expansion population, provides the ability to develop benefits appropriate to the needs of the target population. Analyzing the benchmark plan options to select the most appropriate benefit starting point, and developing medically frail definitions and methodology are key considerations when implementing targeted benefits for the Medicaid expansion. In addition, where benefits vary between populations, ensuring transparency for members, providers and other stakeholders regarding what benefits are covered is a critical factor to success.

HMA Medicaid Roundup

Arkansas

Arkansas Medicaid Director to Resign. *The Northwest Arkansas Democrat Gazette* reported on June 12, 2018, that Rose Murray Naff will resign her position as director of the Arkansas Medical Services Division effective July 13. Naff has served in the post for 11 months. Deputy director Tami Harlan will serve as interim director. Read More

Colorado

Colorado Releases RFI for Non-Risk Medicaid, CHIP Dental Services. Colorado, on June 12, 2018, released a Request for Information for a single, non-risk dental managed care contract for the state's Medicaid program and Children's Health Insurance Program (CHIP). The state currently has a risk contract with Colorado Dental Service, Inc., for CHIP and an administrative services organization contract with DentaQuest for Medicaid. Responses are due July 12, 2018.

Florida

Florida Announces Additional Medicaid Managed Care Awards. On June 12, 2018, the Florida Agency for Health Care Administration announced additional awards for the Statewide Medicaid Managed Care Program, Regions 3-7 and 9-11. All plans are Managed Medical Assistance (MMA) Plans with the exception of Simply Healthcare in Region 10, which is a Comprehensive Plan.

Region 3: UnitedHealthcare of Florida, Inc.
Region 4: UnitedHealthcare of Florida, Inc.
Region 5: Simply Healthcare Plans, Inc. (Anthem)
Region 6: Coventry Health Care of Florida, Inc. D/B/A Aetna Better Health of Florida
Region 7: Coventry Health Care of Florida, Inc. D/B/A Aetna Better Health of Florida
Region 9: Florida True Health, Inc. D/B/A Prestige Health Choice
Region 10: Simply Healthcare Plans, Inc.
Region 11: Florida True Health, Inc. D/B/A Prestige Health Choice. Read More

Florida Program Cuts Increase Scrutiny on Prison Health Contract. *The Palm Beach Post* reported on June 8, 2018, that Florida's recent cuts to drug treatment, mental health and community re-entry programs in the state have increased stakeholder scrutiny on the Centurion's prison health services contract. Centurion of Florida, which was the only company that agreed to negotiate with the state, administers a $375 million prison health care contract that allows for an 11.5 percent administrative fee. Centurion first began treating 97,000 inmates in the Florida Corrections system two years ago. The contract is set to take effect July 1. Read More

Florida CHIP Costs to Rise as ACA Match Decreases. *Health News Florida* reported on June 7, 2018, that Florida's share of costs for the Children's Health Insurance Program (CHIP) are expected to rise as federal matching funds drop to 84 percent in 2020 and 72 percent in 2021. Florida costs are projected to be about $75 million in 2020, according to a report by Georgetown University's Center for Children and Families. Read More

Florida to Face Legal Challenge from Molina Healthcare Over Medicaid Contracts. *Health News Florida* reported on June 7, 2018, that Molina Healthcare announced plans to challenge the Florida Agency for Health Care Administration's decision last week to award additional Medicaid contracts to Miami Children's Health and Lighthouse Health Plan. In April, the agency announced five-year awards to nine managed care plans in 11 regions, worth more than $90 billion. Molina has 10 days to file a legal petition with the state. Read More

Iowa

Iowa to Cap Adult Medicaid Dental Wellness Plan Benefits at $1000 PMPY. *The Gazette* reported on June 11, 2018, that Iowa intends to cap benefits in its Medicaid Dental Wellness Plan at $1,000 per member per year for beneficiaries over 21 effective July 1. The Iowa Department of Human Services is accepting public comments through June 29. The limit doesn't include annual checkups, cleanings, X-rays, fluoride treatments, and other preventive, diagnostic or emergency dental services. The Dental Wellness Plan is a Medicaid managed care program with coverage contracted out to Delta Dental and MCNA Dental. Read More

Iowa Auditor to Examine Medicaid Managed Care Savings Projections. *The Des Moines Register* reported on June 8, 2018, that Iowa auditor Mary Mosiman will investigate why the state Department of Human Services tripled its Medicaid managed care savings projection to $140.9 million annually. The audit was requested by Iowa Senator Pam Jochum (D-Dubuque), a critic of managed care, who believes savings will come from cuts to services and shorted payments. Read More

Kentucky

Kentucky Opponents of Medicaid Work Requirements to Get Day in Federal Court. *WKMS* reported on June 12, 2018, that a U.S. District Court Judge in Washington, DC, will hear arguments in a lawsuit filed by 16 Kentucky Medicaid beneficiaries challenging the state's plan to implement Medicaid work requirements. A decision could come as soon as this week. Kentucky was the first state to receive approval for a waiver to implement work requirements, which are scheduled to roll out beginning July 1 on a county-by-county basis. Read More

Maine

Maine Appeals Medicaid Expansion Court Order. *The Seattle Times* reported on June 7, 2018, that Maine Governor Paul LePage continues to oppose implementation of the state's voter-approved Medicaid expansion, with his administration appealing a recent court order to carry out the law. As previously reported, Maine Superior Court Justice Michaela 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. Read More

Michigan

Michigan Medicaid Work Requirement Bill Includes Provision That Could End Expansion. *The Detroit Free Press* reported on June 8, 2018, that a Michigan Medicaid work requirements bill includes a provision that could end the state's Medicaid expansion program altogether. Under the bill, Michigan would need to apply for a waiver that limits expansion benefits to 48 months. If recipients exceed that time, they will need to pay 5 percent of their income and prove they are practicing healthy behaviors. If the federal government does not approve the waiver within 12 months, expansion would end. Governor Rick Snyder is expected to sign the bill, which has already passed the state House and Senate. Read More

House Passes Medicaid Work Requirement Bill. *Crain's Detroit Business* reported on June 6, 2018, that the Michigan House passed a revised work requirements bill for the state's Medicaid expansion population. Under the bill, beneficiaries aged 18-64 would need 80 hours of work, school, job training, internship, substance abuse treatment, or community service monthly. A prior version of the bill would have applied to all adults on Medicaid. Approximately 27,000 to 54,000 could lose coverage because of the requirement. Read More

Michigan Medicaid Hepatitis C Treatment Would Expand Under Settlement. *The Associated Press* reported on June 6, 2018, that a federal judge has given preliminary approval to a settlement that would result in expanded access to hepatitis C treatment to all Michigan Medicaid beneficiaries effective fall 2019. A lawsuit had claimed that Michigan was limiting new antiviral medicine only to the most severe hepatitis C cases. A fairness hearing for final approval of the settlement is set for August 8. Read More

Minnesota

Dental Association Renews Campaign to Raise Medicaid Reimbursement Rates. The Minnesota Dental Association said it has renewed a public affairs campaign on June 11, 2018, to increase support for higher Medicaid reimbursement rates for dental services, especially for children. Minnesota ranks 49th out of the 50 states for pediatric Medicaid dental reimbursement rates. Read More

Mississippi

Mississippi Releases CHIP Managed Care RFQ; Letters of Intent Due June 29. The Mississippi Division of Medicaid on June 8, 2018, released a Children's Health Insurance Program (CHIP) request for qualifications (RFQ). Bidding managed care organizations (MCOs) must submit letters of intent by June 29, 2018. Proposals will be due July 27, 2018, and contracts will be effective July 1, 2019 through June 30, 2022, with two optional years. The Mississippi CHIP Program operates statewide. UnitedHealthcare and Magnolia Health Plan are the incumbent plans. The current contracts expire on June 30, 2019. Mississippi did not state how many new contracts will be awarded. Read More

Montana

Nursing Homes, Assisted Living Facilities File Lawsuit to Stop Medicaid Cuts. *The News & Observer/Associated Press* reported on June 11, 2018, that the Montana Health Care Association and six other nursing homes and assisted-living facilities filed a lawsuit against the Montana Department of Public Health and Human Services to stop cuts to Medicaid reimbursements. The 2.99 percent cut is expected to extend through the next fiscal year beginning on July 1. Read More

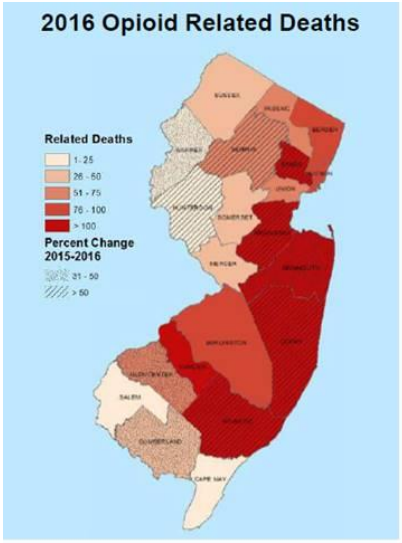
New Hampshire

New Hampshire Awards Centene Correctional Healthcare Contract. Centene announced on June 12, 2018, that the New Hampshire Department of Corrections has awarded its Centurion subsidiary the state's correctional health care contract, effective July 1, 2018, for four years, plus two optional years. Centurion is the incumbent vendor. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Health Annual Summit Addresses Opioid Addiction Through Population Health. *NJ Spotlight* reported on June 6, 2018, that the New Jersey Department of Health held its third annual population health summit on June 5, 2018, which made opioid addiction a centerpiece. Speakers stressed the need to address prevention and wellness through population health in efforts to combat the opioid epidemic. More than 2,000 New Jersey residents died of drug-related problems in 2017 and the number of state newborns born with addictions has doubled in recent years. The following map from the Department of Health shows the distribution of opioid related deaths in New Jersey in 2016. Read more.



Data Presented at New Jersey Association of Mental Health and Addiction Agencies Annual Conference; April 10, 2018, by Shereef Elnahal, M.D., M.B.A., Commissioner, New Jersey Department of Health.

New Jersey DSRIP Program Offers Behavioral Health Measurement Guidance. The New Jersey Department of Health conducted a webinar on June 4, 2018, for DSRIP participants to introduce DSRIP Years 7 to 8 Stage 1 measure guidance for behavioral health. Specifically, the guidance addresses screenings and appropriate follow-up for potential substance use disorder and depression by primary care and behavioral health providers. The state introduced this new measure to improve hospitals' ability to know whether they are screening their population, the burden on the population and to track whether providers are documenting guideline-based follow-up plans when someone screens positive. The measure is further described below. The webinar slides and a link to watch the webinar presentation can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Insurers Propose 2019 Health Insurance Rates in Individual Market. Health insurers in New York have submitted rate requests for 2019. Under New York's prior approval law, rates have to be approved by the Department of Financial Services (DFS), which typically reduces rate increase requests. DFS reviews all of the submissions to ensure that rate increases are fully and actuarially justified by appropriate medical cost increases and are not inadequate, excessive or unfairly discriminatory, in accordance with New York law. In the individual market, rate increase requests averaged 24 percent, ranging from a high of 38.6 percent (Fidelis) to a rate decrease of 3.2 percent (HealthNow, serving the Buffalo area). Fidelis, which currently has the lowest premiums in the state, is being acquired by Centene Corporation. The individual market in New York insures 317,000 people; Fidelis currently has 32 percent of the market.

The rate increase requests separate out a specific percentage of the increase that they attribute to the repeal of the individual mandate penalty, which required most Americans to buy coverage or pay a tax penalty. The individual mandate, a key component of the Affordable Care Act, helped mitigate against dramatic price increases by ensuring healthier insurance pools. Insurers have attributed approximately half of their requested rate increases to the risks they see resulting from its repeal. Read More

INDIVIDUAL MARKET

Company Name	2019 Requested Rate Change without the Individual Mandate Repeal	Additional Percentage Associated with the Individual Mandate Repeal	Total 2019 Requested Rate Change
CDPHP*	5.1%	0.0%	5.1%
Crystal Run Health Plan, LLC	12.0%	3.7%	15.7%
Emblem*	19.5%	12.0%	31.5%
Empire Healthchoice Assurance*	19.8%	4.2%	24.0%
Excellus*	1.6%	7.3%	8.9%
Fidelis (New York Quality Healthcare Corp)*	12.7%	25.9%	38.6%
Healthfirst Insurance Company, Inc.	8.5%	6.5%	15.0%
Healthfirst PHSP, Inc.*	8.5%	6.5%	15.0%
Healthnow New York*	-3.2%	0.0%	-3.2%
IHBC*	4.7%	16.6%	21.3%
MetroPlus*	12.3%	1.1%	13.5%
MVP Health Plan*	1.8%	4.7%	6.5%
Oscar*	17.0%	8.2%	25.2%
UnitedHealthcare of New York Inc*	17.7%	5.9%	23.6%
Weighted averages:	**12.1%**	**11.9%**	**24.0%**

* Indicates the Company offers products on the NY State of Health Marketplace.

Health and Recovery Plans Now Offered Through New York State of Health. Individuals eligible to enroll in Health and Recovery Plans (HARPs), designed for individuals with serious mental illness and/or substance use disorders, will now have the option to select a HARP on New York State's official health plan marketplace, New York State of Health (NYSOH). HARP-eligible individuals will be automatically moved into the HARP associated with their current health plan. Before enrollment, they will receive a notification letter about this move. HARP-eligible individuals wishing to opt out of a HARP will need to opt out within 30 days after receiving their notification letter to avoid being automatically moved.

Academy of Medicine Announces its Annual Albany Update. The New York Academy of Medicine hosts an annual session on the status of health reform efforts in Albany. Paul Francis, the Deputy Secretary for Health and Human Services, will present on the progress of state health reform initiatives and what's next for New York State health reform efforts, including Medicaid reform, the State Innovation Model program, the New York Prevention Agenda, and payment and delivery system innovations. Neil Calman, President of the Institute for Family Health, and Benjamin Chu, Managing Director at Manatt Health, will add their perspectives from practice and policy advocacy. The event will be held on Wednesday, June 27, from 5:15 – 7:30. The event is free, but registration is required. Read More

New York Extends Deadline for Social Determinants of Health Initiative. The New York State Department of Health (DOH) is launching a new initiative to identify innovative ideas to effectively address the Social Determinants of Health (SDH) for Medicaid members across New York State. DOH recently posted a Call for Innovations to solicit input from organizations across the state, as well as across the country. Selected innovations will be announced in August 2018; organizations selected will have an opportunity to present their ideas at a Social Determinants of Health Innovations Summit, planned for the fall of 2018. No funding from the state is available for the initiative, but it provides an opportunity for organizations to receive exposure to the larger health care community, including providers, managed care organizations, and DSRIP Performing Provider Systems. The Call for Social Determinants of Health Innovation application is available here. The deadline for applications has been extended to June 29th, 2018 at 5:00 PM.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Awards $8 Million in Grants to Improve Electronic Health Information Exchange for Medicaid Patients. The Pennsylvania Department of Human Services (DHS), with the Pennsylvania eHealth Partnership Program, awarded almost $8 million in onboarding grant funds. This funding will help connect hospitals, nursing homes, and ambulatory practices to the Pennsylvania Patient & Provider Network enabling electronic health information exchange across the commonwealth. The four health information organization (HIO) awardees will use these funds to connect to over 190 entities. This program is made possible through a grant from the federal Centers of Medicare & Medicaid Services (CMS). Under the terms of the federal grant, CMS provides 90 percent of the onboarding grant, with the remaining 10 percent funded by the commonwealth. Read More

Pennsylvania Health Insurance Plan Rates Stabilize. Pennsylvania health insurance rates will have modest increases for 2019, particularly as compared to national trends. Health insurers currently in Pennsylvania's individual market will all stay in the market in 2019 and have requested aggregate statewide increases of 4.9 percent. In neighboring states, insurers are asking for average rate increases above 20 percent for 2019 coverage. Rate filings for 2019 health insurance plans were submitted to the Insurance Department on May 21. Proposed rate changes vary by plan and region and are subject to change by the Department as part of the review process. Complete rate filing requests, including plan-specific information, will be available on July 23 at www.insurance.pa.gov and final rates, as approved by the Commissioner, will be made available this fall. Read More

Rhode Island

Nursing Homes to Receive 2.5 Percent Medicaid Funding Increase in Lawsuit Settlement. *The Westerly Sun/Associated Press* reported on June 12, 2018, that Rhode Island nursing homes will receive a 2.5 percent increase in Medicaid funding in fiscal 2019, as part of a settlement with the state. The settlement comes after a Superior Court judge found that the state acted improperly by proposing certain Medicaid funding cuts in a recent budget proposal. A group of 59 nursing homes had brought the initial lawsuit. Read More

Virginia

Governor Signs Budget Expanding Medicaid. *The Hill* reported on June 7, 2018, that Virginia Governor Ralph Northam signed into law a state budget that includes Medicaid expansion for up to 400,000 individuals, after years of strong opposition from Republicans. The expansion will include Medicaid work requirements. Virginia will be the 33rd state to expand Medicaid under the Affordable Care Act. Read More

National

HHS Secretary Tells Congress to Pass Drug Pricing Legislation. *CQ News* reported on June 12, 2018, that U.S. Health and Human Services Secretary Alex Azar is urging Congress to pass legislation based on the Trump Administration's drug pricing blueprint. The blueprint would allow HHS to require drug companies to advertise prices of medications, require pharmacist to inform patients when it's cheaper to buy drugs without insurance, prevent companies from abusing generic 180-day patent protection periods, and target caps on rebates. Read More

Medicaid Work Requirements to Impact Just 6 Percent of Able-Body Adult Beneficiaries, Kaiser Says. The Kaiser Family Foundation issued a brief on June 12, 2018, finding that Medicaid work requirements will impact only six percent of able-bodied adult beneficiaries. The remainder already work (62 percent), will be eligible for an exemption because of health status (15 percent), are a caregiver (11 percent), or because they are in school (6 percent). The brief also notes that 30 percent of Medicaid adults never use a computer or the Internet, which could impact their ability to meet reporting requirements. Read More

CMS Releases Guidance on Combating Opioid Epidemic. *The Hill* reported on June 11, 2018, that the Centers for Medicare & Medicaid Services (CMS) released guidance to help state Medicaid directors combat the opioid epidemic. The guidance focuses on how Medicaid programs can enhance federal funding for telemedicine to monitor patient prescriptions and provides information on services for infants born dependent on opioids. States may also cover addiction treatment services to eligible parents of the infants being treated. Read More

Medicaid Reimbursement Rates for Autism Treatment Are Too Low, Lawsuits Claim. *The PEW Charitable Trusts* reported on June 12, 2018, that lawsuits in South Carolina and California claim that Medicaid reimbursement rates for applied behavior analysis (ABA), the most common and effective treatment for autism, are too low and are limiting children's access to required treatment. The lawsuits claim that states are violating the law by not providing treatment. According to a survey of 33 states conducted by Autism Speaks, South Carolina paid the lowest ABA rate at $17 an hour. Neighboring North Carolina and Georgia paid more than $70 an hour. Read More

DOJ Refuses to Defend ACA in Lawsuit Targeting Guaranteed Issue, Community Rating. *Modern Healthcare* reported on June 7, 2018, that the U.S. Department of Justice (DOJ) has refused to defend the Affordable Care Act (ACA) in a lawsuit filed in February by 20 Republican-governed states attempting to repeal key portions of the law. The lawsuit argues for overturning ACA provisions guaranteeing coverage for individuals with preexisting conditions and requiring community ratings. DOJ concluded that after the repeal of the individual mandate tax penalty, guaranteed issue and community can no longer stand. Read More

GAO Urges CMS to Address Risk of Overpayments to Medicaid Managed Care Plans. The U.S. Government Accountability Office (GAO) on May 7, 2018, urged federal regulators to address the risk of improper capitated payments to Medicaid managed care plans. A GAO report found that the rate of improper capitated payments to Medicaid plans was just 0.3 percent, compared to 12.9 percent for fee-for-service, which GAO says suggests that the rate of overpayments to Medicaid plans may not be accurately measured. Read More

Industry News

CD&R to Acquire 55 Percent Stake in naviHealth from Cardinal Health. Cardinal Health, Inc. announced on June 13, 2018, that investment firm Clayton, Dubilier & Rice (CD&R) will acquire a 55 percent stake in post-acute benefit manager naviHealth. Cardinal will retain a 45 percent stake and an option to reacquire the business. CD&R advisor Ron Williams, who formerly served as chief executive of Aetna, will become chairman of naviHealth. Clay Richards will remain chief executive of naviHealth. The transaction is expected to close in the third quarter of 2018. Read More

LA-Based Peoples Health to Be Acquired by United Healthcare. *The New Orleans Advocate* reported on June 7, 2018, that United Healthcare has reached a deal to acquire physician-owned Peoples Health, one of the first companies to offer Medicare Advantage plans in Louisiana. The transaction will make UnitedHealthcare the second-largest Medicare Advantage provider in Louisiana. Peoples Health has more than 63,000 enrollees statewide. The financial terms were not disclosed. Read More

KKR & Co. to Acquire Envision Healthcare for $9.9 Billion. *The Wall Street Journal* reported on June 11, 2018, that private-equity firm KKR & Co. will acquire Envision Healthcare Corp. in a deal valued at $9.9 billion in cash, stock, and assumed debt. Envision is a Nashville-based provider of physician services to health care facilities. The transaction is expected to close in the fourth quarter of 2018. Read More

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 8, 2018	Mississippi CHIP	RFP Release	47,000
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
July 1, 2019	Mississippi CHIP	Implementation	47,000
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

HMA News

Navigating the Recent Changes in Medicare Advantage and Engaging Your Nonskilled Business

HMA Managing Principal Mary Hsieh will join Mark Heaney, Principal, at DTRT Health Advisors for the webinar, "Navigating the Recent Changes in Medicare Advantage and Engaging Your Nonskilled Business," hosted by Home Health Care News and sponsored by Complia Health. Topics covered will include the recent changes in the approved services for Medicare Advantage, the reasoning behind these changes and how they can affect your home care agency, and how to develop a plan to engage your nonskilled business. This webinar will be held on Wednesday, June 20, 2-3 EDT. Register here

Medicaid Directors from 7 States to Address Innovation, Waivers, Shared Responsibility, Value-Based Payments, Care for Chronically Ill, and More at HMA Medicaid Conference

State Medicaid directors will be among dozens of featured speakers at HMA's annual conference on *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers, and States*, October 1-2, 2018, at The Palmer House in Chicago.

At least seven Medicaid directors from states including California, Florida, Idaho, Indiana, North Carolina, Texas, and Washington as well as the commissioner of the New York State Office of Mental Health will discuss the future of Medicaid innovation, waivers, shared responsibility, value-based payments, care for the chronically ill, and other important initiatives.

Early Bird registration is now open. Last year's conference attracted more than 400 attendees. Visit the conference website for complete details: https://conference.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- LA Medicaid Managed Care Enrollment is Up 0.4%, Apr-18 Data
- MI Medicaid Managed Care Enrollment is Flat, May-18 Data
- MS Medicaid Managed Care Enrollment is Down 4.6%, Apr-18 Data
- OH Medicaid Managed Care Enrollment is Down 0.5%, May-18 Data
- PA Medicaid Managed Care Enrollment is Up 0.8%, Mar-18 Data
- TN Medicaid Managed Care Enrollment is Down 2.1%, Apr-18 Data
- WA Medicaid Managed Care Enrollment is Down 1.2%, May-18 Data
- WI Medicaid Managed Care Enrollment is Up 3.2%, May-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- MS Children's Health Insurance Program (CHIP) RFQ, Jun-18
- CO Dental Services RFI, Jun-18
- FL Statewide Medicaid Managed Care Re-procurement ITN Awards, 2018
- MN RFP for Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through IHP Demo, Jun-18
- AK Medicaid Coordinated Care Demonstration Project RFP, Proposals, and Award, 2016-18
- NC Managed Care Ombudsman Program RFI, Jun-18

Medicaid Program Reports and Updates:

- NY DSRIP 1115 Quarterly Reports, 2017-18
- FL Medicaid Enterprise System Program, AHCA Vendor Forum Presentation, May-18
- NJ Medicaid and Managed Care Presentation on Adult Day Health Services, Jun-17

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.