HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*February 21, 2018*




RFP Calendar

HMA News

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## THIS WEEK



## IN FOCUS

### WASHINGTON RELEASES 2019/2020 INTEGRATED MANAGED CARE RFP

This week's *In Focus* section reviews Washington's 2019/2020 Integrated Managed Care (IMC) request for proposals (RFP) issued by the Washington State Health Care Authority (HCA) on February 15, 2018 to provide 1.6 million Medicaid enrollees with both physical and behavioral health services. The

procurement will expand Washington's Apple Health – IMC program (formerly known as Fully Integrated Managed Care (FIMC)) to eight additional Regional Service Areas (RSAs) and add an additional managed care organization to the Southwest RSA. It will also add one county to the Southwest RSA and one county to the North Central RSA.

## Services and Populations Covered

Selected Medicaid Managed Care Organizations (MCOs) will provide the full continuum of physical and behavioral health, including primary care, pharmacy, mental health, and SUD treatment, to Medicaid enrollees. Most Medicaid enrollees will be enrolled in the IMC program, including current Apple Health managed care beneficiaries. Apple Health covers most populations, including individuals who are aged, blind, and disabled (ABD) and HCBS waiver beneficiaries. Those who are not eligible for managed care will receive Behavioral Health Services Only (BHSO) through the IMC contracts and will continue to receive their medical services through the state's fee-for-service system. These include dual eligibles, individuals residing in an IMD (Institution for Mental Disease), medically needy spenddown enrollees, and pregnant women who are not citizens of the U.S.

Incumbent Behavioral Health Organizations (BHOs) will either cease operations or convert to a Behavioral Health Administrative Service Organization (BH-ASO) in regions where IMC is implemented. MCOs will be required to subcontract with BH-ASOs under the contract.

Foster care beneficiaries will remain enrolled in the current statewide foster care plan for physical health. Beginning on October 1, 2018, all behavioral health services will also be provided through that MCO. American Indian/Alaska Native (AI/AN) individuals may voluntarily opt into IMC. If they are not eligible for IMC, they can select BHSO with one of the IMC-contracted MCOs.

## RFP Requirements

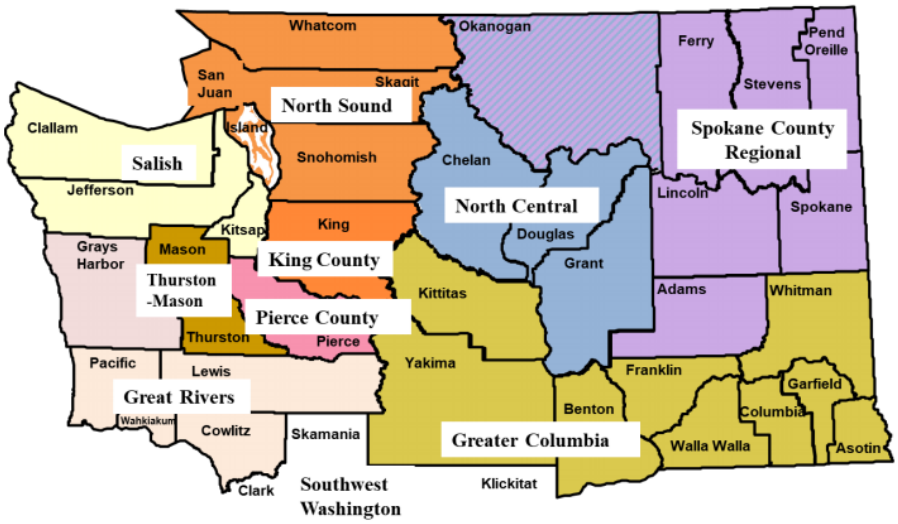
HCA is accepting bids only from MCOs with current Apple Health Medicaid Managed Care contracts.

## Contract Awards

HCA anticipates awarding multiple contracts per RSA:

| Region | Number of MCOs |
|---|---|
| Greater Columbia | 5 |
| King | 5 |
| North Sound | 5 |
| Pierce | 4 |
| Spokane | 4 |
| Thurston-Mason | 3 |
| Great Rivers | 3 |
| Salish | 3 |

Additionally, HCA will select a third MCO to operate in the Southwest RSA. This region is already in the IMC program. Molina Healthcare and Community Health Plan of Washington are currently serving the Southwest RSA. In the Southwest region, the service area will also be expanded to include Klickitat County and in the North Central region, the service area will be expanded to include Okanogan County.




*Source: Washington State Health Care Authority*

For regions choosing to implement IMC in 2019, contracts are set to begin on or about January 1, 2019 and end December 31, 2020. For regions choosing to implement IMC in 2020, contracts are set to begin on or about January 1, 2020 and to end on December 31, 2020. HCA can extend the contracts for up to two (2) additional one (1)-year periods.

## Evaluation Criteria

MCOs will be evaluated based on combined scores on statewide and regionally-specific questions. Under some service areas, specific issues are identified in addition to general requirements. For example, a rural county may ask how a bidder will ensure clients have access to specific services. Counties with high homelessness rates can ask the bidder how they can develop affordable housing. Mandatory requirements, including medical and behavioral health networks, will be evaluated on a pass/fail basis.

| Evaluation Criteria | Maximum Points |
|---|---|
| RFP Compliance | N/A |
| Mandatory Management Review<br>Letter of Submittal and Certification and Assurances | N/A |
| Statewide Evaluation Questions | 650 |
| (Management and Administration) | (105) |
| (Behavioral Health Network and Access) | (210) |
| (Quality and Utilization Management) | (105) |
| (Care Coordination) | (230) |
| 2019 Regional Questions | |
| Greater Columbia | 250 |
| King | 250 |
| North Sound | 250 |
| Pierce | 250 |
| Spokane | 250 |
| Provider Network | Pass/Fail |

## RFP Timeline

MCOs are required to submit a mandatory letter of intent to propose by March 1. Proposals are due on April 12, with "Apparently Successful Bidders" selected on May 22, 2018. Contracts run for one year, with renewal options for two (2) one (1)-year periods.

| RFP Activity | Date |
|---|---|
| RFP Issued | February 15, 2018 |
| Mandatory LOI Due | March 1, 2018 |
| Proposals Due | April 12, 2018 |
| Awards | May 22, 2018 |
| 2019 Implementation | January 1, 2019 |
| 2020 Implementation | January 1, 2020 |

## Current Medicaid Managed Care Market

Washington's total managed care enrollment is 1.6 million. Molina Healthcare is the largest MCO, with over 45 percent of the market share.

| MCO | 2017 Enrollment | Market Share |
|---|---|---|
| Molina Health Care | 730,752 | 45.4% |
| Community Health Plan of WA | 278,038 | 17.3% |
| UnitedHealth/Optum Total | 234,774 | 14.6% |
| Coordinated Care Corp./Centene | 203,107 | 12.6% |
| Anthem/Amerigroup | 145,303 | 9.0% |
| Various Tribal/County Orgs | 16,057 | 1.0% |
| **Total Managed Care** | **1,608,031** | |

## WAIVERS

Washington's Section 1115 Waiver, Medicaid Transformation Project (MTP), was approved by the Centers for Medicare & Medicaid Services (CMS) on January 9, 2017. The five-year waiver, worth $1.5 billion, integrates physical and behavioral health purchasing and service delivery, converts 90 percent of Medicaid provider payments to reward outcomes instead of volume, supports providers to adopt new payment and care models, implements population health strategies, and addresses key determinants of health.

## LINK TO RFP/BIDDERS' LIBRARY

RFP #2567 Integrated Managed Care (IMC) can be found in the Request for Proposals section.
https://www.hca.wa.gov/about-hca/bids-and-contracts

HMA Medicaid Roundup

## Alaska

**State Senators Introduce Medicaid Work Requirements Bill.** *SitNews* reported on February 20, 2018, that Alaska state Senators introduced legislation to implement Medicaid work requirements. The bill, sponsored by Senate President Pete Kelly (R-Fairbanks) among others, was sent to the Senate Health and Social Services Committee and the Senate Finance Committee for review. Read More

## Florida

**Florida Medicaid Plans, Providers Join Class Action Lawsuit Against Opioid Makers.** *The Daily Business Review* reported on February 20, 2018, that Florida Medicaid managed care plans and providers have joined a statewide class action lawsuit filed against opioid manufacturers, distributors, and marketers. The suit seeks to hold the pharmaceutical industry accountable for health care costs related to the opioid crisis and recoup losses. The lawsuit claims that the defendants misled doctors, patients, and insurers about the risks of opioid addiction and caused $2 billion in opioid-related Medicaid health care costs since 2011. Read More

## Kansas

**Kansas Hit With Lawsuit Over Medicaid Denials of Hepatitis C Drugs**. *The Kansas City Star* reported on February 15, 2018, that the American Civil Liberties Union filed a federal class action lawsuit, arguing that the Kansas Medicaid program is improperly denying hepatitis C medication to members until they are severely ill. The suit names Kansas Department of Health and Environment (KDHE) Secretary Jeff Andersen and KDHE Division of Health Care Finance Director Jon Hamdorf. Medicaid managed care plans in the state either require "severe liver damage" before covering the drugs or allow some coverage before that point. Read More

**Maximus Institutes Compliance Plan in Kansas.** *KNSS* reported on February 18, 2018, that Maximus has instituted a compliance plan and is committed to reaching a June 1 deadline to deal with Kansas state concerns over the company's processing of Medicaid applications. Maximus is required to reach certain performance standards or face fines and the potential loss of its contract. Read More

## Kentucky

**Governor Files Lawsuit to Uphold Medicaid Work Requirements.** *The Louisville Courier Journal* reported on February 19, 2018, that Kentucky Governor Matt Bevin has filed a federal lawsuit aimed at upholding the state's plan to implement Medicaid work requirements. The suit, filed in U.S. District Court in Frankfort, Kentucky, is meant to counter a class action lawsuit arguing that the Trump administration violated federal law in approving the Kentucky work requirements earlier this year. Read More

**Kentucky Reveals Waiver Implementation Will Result in Higher Medicaid Spending.** The *Courier Journal* reported on February 14, 2018, that a plan to revamp the Kentucky Medicaid program, including the implementation of work requirements, will increase total Medicaid spending by close to $374 million over the next two years, according to projections from the administration of Governor Matt Bevin. Broader savings projected by the administration come from the assumption that 100,000 individuals will drop out of Medicaid over five years. Those remaining are expected to be sicker and have higher administrative costs, including the cost of new technology to track compliance with work requirements. The revamp is scheduled to launch on July 1, 2018. Read More

**Kentucky Senator Says State Should Administer Medicaid Pharmacy Benefits, Rather than PBMs.** *U.S. News/AP* reported on February 14, 2018, that Kentucky Senator Max Wise (R-Frankfort) has proposed a bill that would transition administration of Medicaid pharmacy benefits back to the state. Kentucky currently uses several pharmacy benefit management (PBM) companies. Wise said that drug reimbursement rates are too low and pharmacies in rural districts are in danger of closing. Read More

## Michigan

**Michigan to Consider Transitioning Long-Term Care into Managed Care.** *Crain's Detroit Business* reported on February 18, 2018, that Michigan will consider a proposal to transition the state's $2.8 billion Medicaid nursing home and long-term care services programs into managed care. An initial review by the state Department of Health and Human Services is expected to begin by July 1. Read More

## Nebraska

**Nebraska Begins Implementation of New Data Management Analytics System.** The Nebraska Department of Health and Human Services announced on February 20, 2018, that it has begun implementing a new Medicaid data management analytics system, aimed at replacing the state's 35-year-old Medicaid Management Information System. Implementation is slated to take approximately 20 months. Read More

**Nebraska Names Matthew Van Patton Medicaid Director**. *Live Well Nebraska* reported on February 17, 2018, that Matthew Van Patton will replace Calder Lynch as director of the Nebraska Division of Medicaid and Long-Term Care effective March 1. Van Patton is currently chief executive of Cadre Medical Technologies and has worked for Spartanburg Regional Healthcare System. Read More

# *New Hampshire*

**Republicans Outline Proposed Changes to Medicaid Expansion.** *The Concord Monitor* reported on February 15, 2018, that New Hampshire Senate Republicans have released a bill outlining potential changes to the state Medicaid expansion program, including moving members into managed care and imposing work requirements and assets tests. As previously reported, a state commission recommended reauthorizing the state's Medicaid expansion program for five years and transitioning the program to managed care in 2019. The current expansion program, New Hampshire Health Protection Program, covers about 50,000 individuals. Read More

# *New Jersey*

## HMA Roundup – Karen Brodsky (Email Karen)

**New Jersey State Fiscal Year Revenues Exceeding Projections.** In January, the New Jersey Department of the Treasury reported an increase in state revenues as of December 2017 when compared to revenues in December 2016. Major revenue sources are up 8.7 percent year to date. Revenues are up for the largest revenue sources:

- Gross Income Tax is up 30.5 percent
- Sales and Use Tax is up 4.1 percent
- Corporation Business Tax is up 15 percent
- Realty Transfer collections are up 36.7 percent. Read More

**New Jersey Medicaid Program Examines Homeless Service Use and Medicaid Spending.** On January 26, 2018, Rutgers University, Center for State Health Policy met with housing experts and Medicaid officials to begin a project that would identify opportunities to generate Medicaid savings and improve patient outcomes among Medicaid enrollees who use homeless services. The study is also supported by The Nicholson Foundation. Researchers will link data from the Homeless Management Information System (HMIS) and the Medicaid Management Information System (MMIS). Read More

**New Jersey Lawmaker Proposes Bill to Establish an Individual Mandate.** On February 12, 2018, New Jersey Assemblyman John McKeon introduced a bill, A3380, that would establish an individual mandate beginning in 2019 whereby taxpayers and their dependents would be required to have coverage under a health insurance policy with minimum essential coverage. A financial penalty would be applied to individuals who do not meet the requirement. Rules and regulations would be adopted by the Commissioner of Banking and Insurance and the State Treasurer. A second measure, A3379 would create a health insurance reinsurance plan for individual claims costs that exceed $50,000 in a benefit year with a cap of $250,000. Both bills have gone to the Senate Budget Committee for review.

**CMS Approves New Jersey State Plan Amendment (SPA) to Update PACE Rates.** On January 25, 2018, The Centers for Medicare & Medicaid Services approved a State Plan Amendment (SPA) to update the methodology New Jersey Medicaid uses to calculate the amounts that would otherwise have paid (AWOP) for Program for All-Inclusive Care for the Elderly (PACE) rates. The state sought to revise the PACE rate-setting methodology to comply with the transition to managed long term services and supports. The AWOP be used to reset PACE rates annually each state fiscal year based on the estimated amounts payable for alternative managed care programs (MLTSS). Read More

**New Jersey Releases State Innovation Model Project Report.** Rutgers Center for State Health Policy published a report on the results of the State Health Innovation Plan for the New Jersey State Innovation Model (SIM) project, a $3 million design grant from the Center for Medicare & Medicaid Innovation. The researchers credit the SIM project for advancing the integration of physical and behavioral health care. According to the report, the state's SIM Design project set forth to:

1. Advance physical and behavioral health integration strategies
2. Address Medicaid cost/value, especially for high-cost, complex patients
3. Improve birth outcomes through smoking cessation

Researchers documented a variety of activities that were performed to support the project goals:

1. Development of a set of 31 "core" quality metrics to ease existing state measurement reporting requirements
2. Support for critical Medicaid ACO activities
3. A statewide survey of primary care practices for input on the three respective SIM Design goals
4. Policy decisions to transfer mental health and addiction functions from the Department of Human Services to the Department of Health
5. Expansion of a Pediatric Behavioral Health Collaborative
6. Advancement of the state's Population Health Improvement Plan, *Healthy New Jersey 2020*

The report describes a sustainability strategy for delivery system transformation and population health improvement goals. Read More

# New Mexico

**New Mexico Responds To Lawsuit Protesting Medicaid Managed Care Awards.** The *Associated Press/Albuquerque Journal* reported on February 16, 2018, that New Mexico said an injunction filed to block implementation of the state Medicaid managed care awards wasn't necessary, adding that legal action is premature because the state is still reviewing protests to the award. The comments were made in the state's response to a lawsuit filed by Molina Healthcare of New Mexico, which is seeking an injunction after the company lost its bid to retain its Medicaid contract with the state. Molina also filed a protest with the state. Read More

**Molina, United Allege Bias in New Mexico Medicaid Contract Awards.** *The New Mexican* reported on February 14, 2018, that Molina Healthcare and UnitedHealthcare are alleging that New Mexico was biased in its recent Medicaid managed care contract awards. Molina and United state that Western Sky Community Care (Centene), a contract winner, had business ties to Mercer Health & Benefits, which helped the department evaluate bids. An internal memo indicates that the New Mexico Human Services Department was aware of the potential conflict. New Mexico says that the contracting process was competitive and fair. Read More

# New York

## HMA Roundup – Denise Soffel (Email Denise)

**New York Medicaid Director Jason Helgerson to Step Down.** *The Albany Times Union* reported on February 20, 2018, that New York's Medicaid Director Jason Helgerson will step down from his post once the 2018-19 state budget is finalized. Helgerson was appointed by Governor Andrew Cuomo in 2011 to undertake a redesign of NY's Medicaid program, which provides coverage to 6.1 million people at an annual budget of $68 billion. Helgerson oversaw the Medicaid program as it began operating under a global budget cap, which has limited the growth in Medicaid spending to the Medical Consumer Price Index, and had led to an actual reduction in per capita spending. He has also been the driving force behind New York's Delivery System Reform Incentive Payment program, an $8 billion five-year effort to redesign the health care delivery system in NY, moving away from reliance on hospital-based care and building up the community-based health care infrastructure. DSRIP is also moving New York's health care system into value-based payment methods. The program is completing its third year. Read More

**New York Releases Medicaid-Specific Fiscal 2019 Budget Presentation.** The New York Department of Health, Medicaid Redesign Team, released in February 2018, a Medicaid-specific presentation regarding the fiscal 2019 proposed budget from Governor Andrew Cuomo. The presentation covers Medicaid spending through November 2017, Global Cap Projections for 2018-19, MRT Phase VIII recommendations, and other topics. A recording of the presentation can be found here. Read More

**New York Proposes Reducing Incentive Payments to Patient Centered Medical Home Providers.** New York has proposed a temporary reduction in payments to primary care providers under its Patient Centered Medical Home (PCMH) Incentive Program, as well as raising the standards for eligibility. The reductions are in response to the fiscal constraints of the Medicaid Global Spending Cap. NY established a statewide Patient-Centered Medical Home program in 2010 whereby providers who are recognized as PCMHs by the National Committee for Quality Assurance (NCQA) are eligible to receive additional payments for services provided to Medicaid enrollees. The state is changing the reimbursement amounts for providers working at practices that are recognized as a PCMH for May and June of 2018. The reduction in payments applies to both Medicaid Managed Care (MMC) and Medicaid Fee-For-Service (FFS). Practices recognized under the NCQA 2014 Level 3 or NCQA 2017 standards will receive a temporarily reduced MMC incentive payment of $2.00 PMPM for two months. The PCMH FFS incentive add-on amounts will remain unchanged, and will be $29.00 and $25.25 for professional and institutional claims, respectively. In addition, as part of on-going efforts to raise the bar on provider performance, all incentive payments for PCMH-recognized providers under NCQA's 2014 Level 2 standards will be permanently eliminated for both MMC and FFS. Beginning July 1, 2018, the PCMH incentive payments will be modified (increased from the temporary two-month reduction) to align with the principles of Value Based Payments (VBP). NYS Medicaid will engage key stakeholders to focus on making sustainable fiscal recommendations that are in line with the Medicaid global spending cap for the PCMH program, and to explore options to tie the incentive to VBP participation, and quality. Read More

**New York Announces Regulatory Reform Initiatives.** The New York Department of Health has announced a package of regulatory reform initiatives that are the result of its Regulatory Modernization Initiative. The initiative was established last year to provide the state an opportunity to review a whole host of regulations governing licensure and oversight of health care facilities with the goal of streamlining and updating existing policies and regulations. The recommendations can be found in a new report, "Spurring Health Care Innovation through Regulatory Modernization: Putting Patients First." Some of the reforms include:

- Integrating primary and behavioral health services. NY will propose regulations to allow for a new licensure category in order to allow providers to more readily offer integrated services.
- Allowing patients to access care more conveniently by expanding the use of telehealth services. NY will expand access to telehealth services through a series of measures, including expanding the list of eligible originating sites so that patients can receive telehealth services in any setting.
- Putting patients at the center of a coordinated, cohesive health care system by easing care transitions. NY will reform the post-acute regulatory landscape, including legislation to expand the scope of practice of certified Emergency Management Technicians in order to expand access to care. Read More

**New York Develops New Video Series on Adult Behavioral Health Medicaid Managed Care.** The New York State Office of Mental Health in partnership with the Office of Alcohol and Substance Abuse Services, the NYC Department of Health and Mental Hygiene, and the Center for Practice Innovations have developed a series of educational videos intended to familiarize individuals with Medicaid managed care options and the home and community based services available to Medicaid beneficiaries with serious mental illness and/or substance use disorder. The brief videos describe:

- Medicaid Managed Care Health and Recovery Plans (HARPs);
- Adult Behavioral Health Home and Community Based Services (BH HCBS); and
- Health Home Care Management

The series also walks through the process of accessing Behavioral Health Home and Community Based Services, including the role of Care Managers, the Eligibility Assessment, and the Person-Centered Plan of Care. While HARPS have been available since 2015, the use of BH HCBS services remains low. These videos are intended to increase awareness of benefits available to HARP enrollees. To view this video, click here.

**New York Catholic Diocese Opposes Governor's Proposal for Fidelis Proceeds.** *The Albany Times Union* reported on February 14, 2018, that the Roman Catholic Diocese of Albany is opposing a proposal from New York Governor Andrew Cuomo, which would direct to the state 90 percent of the proceeds from the sale of Catholic health plan Fidelis Care. Centene is currently planning to buy Fidelis Care and announced that it would set up a Catholic charitable fund. Cuomo's plan would alter state law regarding the sale of not-for-profit plans to for-profit plans, allowing the state to receive most of the proceeds. Read More

## *Ohio*

**Department of Medicaid Releases Draft Work Requirements 1115 Waiver for Review and Comment.** On February 16, 2018, the Ohio Department of Medicaid released the draft Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver for review and comment. The waiver application, mandated by the legislature with the passage of House Bill 49, will require Medicaid beneficiaries between the ages 22 to 64 to meet work and community engagement requirements as a condition of eligibility. The following beneficiaries will be exempt from the work/community engagement requirements: those 50 years of age or older, people physically or mentally unfit for employment, participants in the Specialized Recovery Services Program, those caring for a disabled/incapacitated household member, pregnant women, Parent/caretaker residing in same house with minor child, those that have applied for or receiving Unemployment Compensation, people in school at least half-time, people participating in drug or alcohol treatment, an assistance group member subject to and complying with any work requirement under the Ohio Works First (OWF) program, or an applicant for or recipient of Supplemental Security Income (SSI). Comments are due by March 18, 2018. Read More

**Ohio EVV Rollout Criticized for Glitches, Privacy Violations.** *The Alliance Review* reported on February 19, 2018, that Ohio's rollout of an electronic visit verification (EVV) system to log patient visits by Medicaid home-health workers and personal-care aides has been met with criticism over glitches, a lack of training, and privacy violations. The system, which launched January 8, relies on cell-phone based GPS monitoring. Read More

## *Pennsylvania*

**Pennsylvania Announces Proposed Funding for Seniors.** On February 16, 2018, the Pennsylvania Department of Human Services (DHS) highlighted an initiative focused on seniors and individuals with physical disabilities as part of Governor Tom Wolf's proposed budget for fiscal year (FY) 2018-2019. The continued rollout and implementation of Community HealthChoices, DHS' managed care program for long term services and supports, will be supported with proposed funding of over $69 million in FY 2018-2019. CHC was implemented in the Southwest region on January 1, 2018, and phased rollout will continue throughout the Commonwealth through January 1, 2020. Read More

## *Rhode Island*

**Inmate Program Reduces Opioid Overdose Deaths.** *Stat News* reported on February 14, 2018, that the number of recently released inmates in Rhode Island who died from an opioid overdose decreased between 2016 and 2017. The study attributed the decrease to the availability of medication assisted treatment in correctional facilities starting in 2016. Rhode Island was the first state to offer inmates methadone, buprenorphine, and naltrexone. Read More

## *Virginia*

**Virginia House Budget Plan Includes Medicaid Expansion With Work Requirements.** The *Associated Press/Delmarva Now* reported on February 19, 2018, that the Virginia House Appropriations Committee cleared a fiscal 2019 budget proposal that includes Medicaid expansion with work requirements, a dramatic shift for the Republican-led legislature. A proposed Virginia Senate budget didn't include expansion. The House plan, which would be effective January 2019, is projected to enroll about 300,000 adults up to 138 percent of the poverty level. Read More

**Delegate Terry Kilmore Announces Support for Medicaid Expansion with Work Requirements.** The *Richmond Times-Dispatch* reported on February 16, 2018, that Virginia Delegate Terry Kilgore (R-Scott), a high-ranking Republican in the House of Delegates, has announced his support for Medicaid expansion as long as work requirements are included. He called it "a conservative approach to expanding Medicaid." House Speaker Kirk Cox (R-Colonial Heights) has been negotiating with Governor Ralph Northam over the conditions for expansion, which would require able-bodied recipients to seek work, job training or education, or participate in public service. Read More

## Washington

**Washington Accountable Communities of Health Receive Approval for Medicaid Transformation Project Plans.** The Washington State Health Care Authority announced on February 20, 2018, that it has approved all nine Accountable Communities of Health (ACH) Medicaid Transformation Project Plans. The Medicaid Transformation Project is the state's Section 1115 waiver, approved by the Centers for Medicare & Medicaid Services (CMS) in 2017. Under the waiver, the first initiative involves transforming Medicaid delivery in each Regional Service Area through ACHs. The newly approved Project Plans look to improve the overall health of Medicaid beneficiaries by tackling the opioid crisis and integrating behavioral health, among other plans. Read More

## Wyoming

**Senate Introduces Bill Requiring Work Requirements; House Fails to Pass Mirroring Bill.** The *Wyoming Tribune Eagle* reported on February 17, 2018, that the Wyoming Senate introduced a bill that would introduce work requirements for Medicaid and the Supplemental Nutrition Assistance Program. The Wyoming House failed to introduce a bill mirroring the Senate version. The Senate bill calls for the Wyoming Department of Health to apply for a waiver to implement work requirements, with certain exemptions. An estimated 3,300 enrollees would be affected. Read More

## National

**Trump Administration Proposes Rule Aimed at Expanding Short-Term Exchange Plan Availability.** *Modern Healthcare* reported on February 20, 2018, that the Trump administration released a proposed rule that would allow insurers to offer short-term Exchange plans that last up to 12 months. Currently, short-term plans have a maximum term of three months. While the plans would likely be cheaper than existing Exchange plans, they wouldn't be required to cover pre-existing conditions or offer the 10 essential health benefits mandated by the Affordable Care Act. Read More

**GAO Says Medicaid Demonstrations Yield Limited Results Despite $109 Billion in Federal Funding.** *Healthcare Analytics News* reported on February 20, 2018, that Medicaid demonstration projects have yielded "limited results" despite $109 billion in federal funding, according to a report from the Government Accountability Office. GAO said demonstrations suffer from a lack of reporting standards, making it difficult to prove efficacy and inform policy. A contractor hired by the Centers for Medicare & Medicaid Services (CMS) also found that demonstrations had insufficient control groups, if any. GAO recommends that CMS change federal procedures, encourage transparency, and institute written procedures that require submission of a final evaluation. Read More

**Medicaid Work Requirements Will Have High Administrative Costs, Experts Say.** *Governing* reported on February 19, 2018, that health policy experts are warning that Medicaid work requirements and other eligibility rules will have high administrative costs. The two largest costs will be information technology and hiring personnel to track compliance and appeals. The Centers for Medicare & Medicaid Services (CMS) indicated in a letter to state Medicaid directors in January that it would provide additional financial support for "job training or other employment services, child care assistance, transportation, or other work supports to help beneficiaries prepare for work or increase their earnings." Read More

**HHS Secretary Azar Looks to Ease Restrictions on Physician-Owned Hospitals**. *Modern Healthcare* reported on February 14, 2018, that U.S. Health and Human Services (HHS) Secretary Alex Azar is looking to ease Affordable Care Act restrictions on physician-owned hospitals. The ACA effectively blocks the establishment of new physician-own hospitals and requires that existing physician-owned hospitals meet certain requirements and gain HHS approval to expand their facilities. Read More

**CMS Projects 8 Million Additional Uninsured By 2026.** *Modern Healthcare* reported on February 14, 2018, that repeal of the individual mandate will increase the number of uninsured from 30 million in 2018 to nearly 38 million in 2026, according to the Centers for Medicare & Medicaid Services (CMS). CMS attributes the increase to younger and healthier people choosing to be uninsured. Last year, the Congressional Budget Office projected 13 million more people would become uninsured because of the repeal of the mandate. Read More


## Industry News

**Community Health Systems to Sell Louisiana Hospital to Allegiance Health Management.** Tennessee-based Community Health Systems announced on February 14, 2018, that it has entered into a definitive agreement to sell Byrd Regional Hospital in Leesville, Louisiana to Allegiance Health Management. The transaction is expected to close in the second quarter of 2018. Read More

**Federal, Illinois Regulators Approve Advocate-Aurora Merger; Wisconsin Decision Pending.** *Modern Healthcare* reported on February 15, 2018, that the proposed merger of Advocate Health Care and Aurora Health Care has received approval from Illinois and federal regulators. The deal still awaits approval from the state of Wisconsin, where Aurora is based. The merged entity would be the tenth largest not-for-profit hospital system. Read More

# RFP CALENDAR

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| 2018 (Delayed from 2017) | Alaska Coordinated Care Demonstration | Contract Awards | TBD |
| 2018 | Massachusetts One Care (Duals Demo) | RFP Release | TBD |
| Spring 2018 | North Carolina | RFP Release | 1,500,000 |
| March 2018 | Alabama ICN (MLTSS) | RFP Release | 25,000 |
| March 1, 2018 | Pennsylvania HealthChoices (Delay Likely) | Implementation (NE Zone) | 315,000 |
| March 1, 2018 | Massachusetts | Implementation | 850,000 |
| March 6, 2018 | Iowa | Proposals Due | 600,000 |
| March 6, 2018 | Texas STAR+PLUS Statewide | Proposals Due | 530,000 |
| March 8, 2018 | Arizona | Contract Awards | 1,600,000 |
| April or May 2018 | Alabama ICN (MLTSS) | Contract Award | 25,000 |
| April 1, 2018 | New Hampshire | RFP Release | 160,000 |
| April 6, 2018 | Texas STAR and CHIP | RFP Release | 3,342,530 |
| April 6, 2018 | Puerto Rico | Proposals Due | ~1,300,000 |
| April 16, 2018 | Florida Statewide Medicaid Managed Care (SMMC) | Contract Awards | 3,100,000 |
| April 24, 2018 | Iowa | Contract Awards | 600,000 |
| April 27, 2018 | Florida Children's Medical Services | Responses Due | 50,000 |
| April 12, 2018 | Washington FIMC (Remaining Counties) | Proposals Due | ~1,600,000 |
| May 2018 | Puerto Rico | Contract Awards | ~1,300,000 |
| May 22, 2018 | Washington FIMC (Remaining Counties) | Contract Awards | ~1,600,000 |
| June 2018 | North Carolina | Proposals Due | 1,500,000 |
| June 2018 | Kansas KanCare | Contract Awards | 380,000 |
| June 26, 2018 | Florida Children's Medical Services | Contract Award | 50,000 |
| July 2018 | Texas STAR and CHIP | Proposals Due | 3,342,530 |
| July 1, 2018 | Pennsylvania HealthChoices (Delay Likely) | Implementation (SE Zone) | 830,000 |
| July 1, 2018 | MississippiCAN | Implementation | 500,000 |
| August 1, 2018 | Virginia Medallion 4.0 | Implementation | 700,000 |
| September 1, 2018 | Texas CHIP (Rural, Hidalgo Service Areas) | Implementation | 85,000 |
| September 2018 | North Carolina | Contract awards | 1,500,000 |
| September 26, 2018 | Texas STAR and CHIP | Evaluation Period Ends | 3,342,530 |
| October 2018 | Puerto Rico | Implementation | ~1,300,000 |
| October 2018 | Alabama ICN (MLTSS) | Implementation | 25,000 |
| October 1, 2018 | Arizona | Implementation | 1,600,000 |
| October 1, 2018 | Texas STAR+PLUS Statewide | Contract Start | 530,000 |
| November 1, 2018 | New Hampshire | Proposals Due | 160,000 |
| January 2019 | Kansas KanCare | Implementation | 380,000 |
| January 1, 2019 | Washington FIMC (Remaining Counties) | Implementation for RSAs Opting for 2019 Start | ~1,600,000 |
| January 1, 2019 | Florida Children's Medical Services | Contract Start | 50,000 |
| January 1, 2019 | Pennsylvania MLTSS/Duals | Implementation (SE Zone) | 145,000 |
| January 1, 2019 | Florida Statewide Medicaid Managed Care (SMMC) | Implementation | 3,100,000 |
| January 1, 2019 | Pennsylvania HealthChoices (Delay Likely) | Implementation (Lehigh/Capital Zone) | 490,000 |
| January 1, 2019 | New Mexico | Implementation | 700,000 |
| January 1, 2019 | New Hampshire | Contract Awards | 160,000 |
| January 24, 2019 | Texas STAR and CHIP | Contract Start | 3,400,000 |
| July 1, 2019 | North Carolina | Implementation | 1,500,000 |
| July 1, 2019 | New Hampshire | Implementation | 160,000 |
| July 1, 2019 | Iowa | Implementation | 600,000 |
| January 1, 2020 | Texas STAR+PLUS, STAR, and CHIP | Operational Start Date | 530,000 |
| January 1, 2020 | Pennsylvania MLTSS/Duals | Implementation (Remaining Zones) | 175,000 |
| January 1, 2020 | Washington FIMC (Remaining Counties) | Implementation for RSAs Opting for 2020 Start | ~1,600,000 |
| January 1, 2020 | Massachusetts One Care (Duals Demo) | Implementation | TBD |

# HMA News

**Preliminary Look at Key Healthcare Proposals in 32 States from Governors' Proposed Budgets for SFY 2019.** Kaiser Family Foundation and HMA Principal Kathy Gifford present a preliminary look at key healthcare proposals in governors' proposed budgets for SFY 2019. Read more

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

# HMA WELCOMES…

**Rachel Post – Senior Consultant**

Rachel Post joins HMA from Central City Concern (CCC) where she most recently served as public policy director. In this role, Rachel was responsible for collaboration with city, county, state, and federal government officials, community alliances, and community and state agencies to advance policy initiatives in support of CCC's mission to end homelessness. Rachel's work included contributions to a Department of Housing and Urban Development (HUD) issued policy brief on supportive housing for those with substance use disorders, serving as a Substance Abuse and Mental Health Services Administration (SAMHSA) technical assistant consultant on supportive housing and supportive employment, presenting in a congressional briefing on supportive housing and employment and working with the USDA to secure funding for employment services. She was a member of the governor appointed Family Services Review Commission, which advised the Department of Human Services (DHS) director. She was also a member of Oregon Health Authority and Oregon Housing Community Services Supportive Housing Work Group tasked with looking at new revenue to expand capacity across the state. In addition, Rachel served as co-chair of the Oregon Temporary Assistance for Needy Families (TANF) Alliance and co-chair of the Joint Office on Homelessness Workforce and Economic Opportunity Subcommittee

While at CCC, Rachel also served as director of supportive housing and employment and project director. As project director, Rachel designed and oversaw implementation and supervision of a nationally awarded chronic homeless housing first team. She developed and implemented innovative homeless service programming and was the lead author for federal grant applications, including the $4.2 million awarded United States Interagency Council on Homelessness (USICH) Chronic Homeless grant.

Additional roles Rachel has held include psychiatric security review board coordinator at State Office of Mental Health and project coordinator at Regional Research Institute at Portland State University.

Rachel earned her Master of Science in Social Work from the University of Wisconsin School of Social Work and her bachelor's degree in psychology from New England College.

**Laura Zaremba – Principal**

Laura Zaremba joins HMA most recently from Trexin Consulting where she served as senior principal, healthcare practice. In this role, Laura provided strategic account management and oversight for projects with healthcare clients engaged in health transformation, Affordable Care Act implementation, and regulatory compliance. She led projects and developed services to support payer and provider clients with new business models, information technology projects, and organizational changes related to the transition from volume-based to value-based and accountable care.

Prior to Trexin Consulting, Laura served as health data and technology director at the Illinois Governor's Office of Health Innovation and Transformation. In this role, Laura led a project team to develop a four-year, $100 million proposal for federal innovation funding through the State Innovation Model Initiative to achieve better health outcomes, improve healthcare quality, and control costs across multiple payers. Laura chaired the Data and Technology Work Group, comprising more than 100 health industry and public health representatives, to develop specifications for care coordination and analytics IT infrastructure to be used by integrated delivery systems participating in the state innovation model.

Laura earned her master's degree and bachelor's degree in political science from Southern Illinois University at Carbondale.

Health Management Associates (HMA) is an independent health care research and consulting

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

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.