HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 15, 2017

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THIS WEEK

IN FOCUS

New CMS Guidelines to Expedite Approval of 1115 Waivers and State Plan Amendments

This week, our *In Focus* section reviews the new guidelines issued by the Centers for Medicare & Medicaid Services (CMS) on expediting the approval

process for Medicaid waivers and state plan amendments (SPAs) and improving quality, accessibility, outcomes, and transparency. The guidelines, titled *Section 1115 Demonstration Process Improvements* and *State Plan Amendment and 1915 Waiver Process Improvements to Improve Transparency and Efficiency and Reduce Burden* were released on November 6, 2017.

1115 Waivers

CMS is seeking to improve the 1115 Medicaid demonstration waiver process to facilitate expedited approval of demonstrations. Under the Trump administration, which promised increased flexibility to states, states have submitted applications to expand Medicaid, many including work requirements, premiums, and other conditions. However, most of the waivers have not been acted on, while others have been left to expire or have been withdrawn. Currently, there are 38 submitted 1115 waivers pending CMS approval. To expedite the waiver process, CMS will employ the following strategies:

Reduce Burden

- Streamline and simplify the Demonstration Application
- Work with states to develop a timeline for the approval process
- Standardize approved Special Terms and Conditions (STC) language across similar demos, focusing on specific milestones, performance metrics, benchmarks, and anticipated outcomes

Increase Efficiency

- Develop parameters for expedited approval of demonstrations similar to those approved in other states
- Provide technical assistance to states
- Approve the extension of routine, successful, non-complex section 1115(a) waiver
- Offer virtual working meetings with states to review and clarify STC language
- Support states to use fast track process through a streamlined review process for demonstration extension requests in timeframes similar to Medicaid section 1915 waivers or State Plan Amendments with an abbreviated application template
    - Remove the requirement that states must have had at least one full extension cycle without substantial program changes

Promote Transparency

- Offer technical assistance to states considering changes to their Medicaid programs
- Share a working list of open issues with states during demonstration review process
- Work with states to determine whether waivers may be available instead of or in combination with section 1115

- Help states identify any other federal funding sources
- Clarify expectations and provide guidance on policy and methodology for demonstrating budget neutrality
- Standardize budget neutrality STCs

Monitoring and Evaluation

- Improve and standardize measurement sets to facilitate state data development, collection, and reporting capacity
- Strengthen state evaluation designs
- Implement a State Technical Advisory Group (TAG) of experts to advice CMS on monitoring and evaluation processes
- Reduce the number of monitoring reports for all demonstrations by combining the fourth quarterly reports with annual reports
- Generate general evaluation design and evaluation report guidance for all section 1115 demonstrations

State Plan Amendments and 1915 Waivers

State plan amendments (SPAs) describe how a state administers its Medicaid and CHIP programs, including details such as eligible individuals, services, methodologies for provider reimbursement, and administrative activities. As with the 1115 waivers, CMS currently has a backlog of 350 SPAs and 1915 waivers due to unanswered requests for additional information (RAIs). The average pending time of SPAs is two years. CMS conducted an extensive review of SPA standard operating procedures to better understand the factors impacting the processing time and identify areas for increased consistency and enhanced efficiency. CMS will implement the following strategies for SPA and 1915 waiver process improvements:

- Contact states within 15 days of receipt of each new SPA or section 1915 waiver submission to discuss the intent of the submission and any critical timelines
- Provide states with an SPA and 1915 waiver toolkit consisting of preprints, templates, checklists and other guidance
- Reduce the current backlog by providing states a comprehensive list of their SPAs and work to resolve the amendments
- Expand MACPro, a web-based system for the submission, review, and disposition of SPAs, to additional SPA authorities
- Review the proposed changes and provisions as soon as an SPA is submitted
- Develop other short and long-term strategies in the future

Link to CMS Informational Bulletin on 1115 Waivers

Link to CMS Informational Bulletin on SPAs, 1915 Waivers

HMA Medicaid Roundup

Connecticut

Connecticut Senate Approves Hospital Provider Tax Fix. *The CT Mirror* reported on November 14, 2017, that the Connecticut Senate voted to fix a technical flaw in the state's hospital provider tax increase. A spokesperson for Connecticut Governor Dannel Malloy stated the original language adopted in the state budget concerning the tax increase was "fundamentally flawed and violated federal law." The new hospital taxing arrangement will still need approval from the Centers for Medicare & Medicaid Services. Read More

Iowa

Iowa to Auto-Assign AmeriHealth Medicaid Members to United, Unless They Choose Anthem. The *Des Moines Register* reported on November 8, 2017, that Iowa will auto-assign the Medicaid membership of AmeriHealth Caritas to UnitedHealthcare on December 1, 2017, unless members opt to enroll in a plan from Anthem/Amerigroup. AmeriHealth is withdrawing from the Iowa Medicaid market after disagreeing with the state on the cost of providing care to members. The Iowa Department of Health Services waited 30 days to disclose AmeriHealth's withdrawal from the state's Medicaid program. Iowa released a request for proposals (RFP) to add one or more Medicaid managed care organizations to its Medicaid program. Read More

Massachusetts

Massachusetts Senate Passes Health Care Reform Bill. *WBUR* reported on November 10, 2017, that the Massachusetts Senate approved a health care reform bill aimed at reducing hospital admissions, increasing oversight of the pharmaceutical industry, increasing telemedicine access, and lowering unexpected consumer costs. The bill also preserves passive enrollment for the Senior Care Options program, while adding protections and specifics regarding the opt-out process. Additionally, the bill would raise rates for lower-paid hospitals to 90 percent of the statewide average for the previous year. The bill is expected to generate MassHealth savings of $114 million and commercial market savings of $475 million to $525 million. Read More

Minnesota

Minnesota Nursing Home Involuntary Discharges, Transfers Complaints Rise. The *Star Tribune* reported on November 15, 2017, that Minnesota nursing

home patients who bring maltreatment complaints directly to the home's management may face retaliation. According to a review of public documents by Star Tribune, the number of complaints concerning involuntary discharges and transfers rose 50 percent statewide between 2012 and 2016. The senior care industry argues that discharges are often for legitimate reasons, including residents who put others at risk or are too difficult to handle. A spokeswoman for LeadingAge Minnesota, an industry trade group, said that discharges should never be abrupt or unexpected. Read More

Montana

HMA Roundup – Rebecca Kellenberg (Email Rebecca)

Montana Committee Blocks Medicaid Reimbursement Rate Reductions. *U.S. News* reported on November 10, 2017, that the Montana Children, Families, Health and Human Services Committee, a joint legislative committee, has voted to block a 3 percent Medicaid provider rate reduction until January 2019. The state Department of Public Health & Human Services had proposed the reduction to comply with a law that requires budget cuts if state revenues come in lower than predicted. Read More

Nebraska

Nebraska Lawmaker to Propose Medicaid Expansion Ballot Measure. *U.S. News/Associated Press* reported on November 8, 2017, that Nebraska Senator Adam Morfeld (D-Lincoln) hopes to include Medicaid expansion on the state's November 2018 general election ballot. A ballot measure would need the approval of 30 of the state's 49 senators to move forward. Nebraska lawmakers have rejected expansion five times. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Governor-Elect Names Members of Health Care and Human and Children Services Transition Teams. *Return on Information – New Jersey* reported on November 13, 2017, that Governor-elect Phil Murphy released the list of individuals that will be on his health care and human and children services transition teams.

The Health Care transition team will include:

- Dr. Omar Baker, co-president, chief quality and safety officer and director of performance improvement at Riverside Medical Group/ProHealthCare of New Jersey
- Dr. Shereef Elnahal, assistant deputy undersecretary for health, Veterans Health Administration
- Balpreet Grewal-Virk, director of community engagement, Department of Population Health at Hackensack Meridian Health
- Valerie Harr, former director, Division of Medical Assistance and Health Services

- Heather Howard, former commissioner, New Jersey Department of Health and Senior Services
- Linda Schwimmer, CEO and president, New Jersey Health Care Quality Institute
- Maria Vizcarrondo, former CEO and president, United Way of West Essex and West Hudson

The Human and Children Services transition team will include:

- Zillehuma Hasan, founding member and executive director, Wafa House Inc.
- Trish Morris-Yamba, executive director emerita, Newark Day Center
- Kevin Ryan, CEO and president, Covenant House International
- Jennifer Velez, senior vice president of community and behavioral health, RWJBarnabas Health
- Joseph Youngblood II, vice provost and dean, John S. Watson School of Public Service at Thomas Edison State University
- Cecilia Zalkind, CEO and president, Advocates for Children of New Jersey

Governor-elect Murphy has named Joseph Fernandez, former assistant secretary of state for economic, energy and business affairs, as the director of transition policy committees and Carl Van Horn, director of the John J. Heldrich Center for Workforce Development at Rutgers University, as the senior advisor to the transition for strategy and policy. Read More

New Jersey Governor Chris Christie Names Christopher Rinn as Acting Commissioner of the Department of Health. *NJ.com* reported on November 8, 2017, that Governor Chris Christie (R-NJ) named Christopher Rinn, the assistant commissioner of the Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness, as the acting commissioner of the Department of Health. Mr. Rinn will be replacing Cathleen Bennet. Read More

New Jersey DHS Expands Behavioral Health Benefits Covered Under NJ FamilyCare. The New Jersey Department of Human Services (DHS) announced in November 2017 that it has expanded the list of covered health benefits available to align behavioral health coverage for Medicaid Long Term Services and Supports (MLTSS), Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), and Division of Developmentally Disabled (DDD) MCO members participating in the New Jersey FamilyCare (NJFC) Medicaid managed care program. The expanded NJFC health plan benefit coverage will include, with some exceptions regardless of age, all mental health benefits, substance used disorder (SUD) services, general acute care hospital and psychiatric unit admissions, and air emergency ambulance transports. Several behavioral health services will remain in fee-for-service (FFS), including targeted case management (TCM), integrated case management services (ICMS), behavioral health homes (BHH), and community support services (CSS). A comprehensive list of services that will remain in fee-for-services and services that have been expanded can be found here. In a separate newsletter, DHS also announced that it will provide NJFC FFS coverage for Ambulatory

Drug Withdrawal Management (AWM) services. These changes will become effective January 1, 2018.

Good Care Collaborative Provides Recommendations to the Murphy Administration on Advancing Complex Care. The Good Care Collaborative, a coalition launched by the Camden Coalition of Healthcare Providers consisting of a diverse, statewide coalition of consumer advocates, providers, payers, policy makers in New Jersey, released a set of recommendations to the next gubernatorial administration in New Jersey to guide their strategies for advancing complex care. These recommendations include advancing the community-based, data-driven models of care, such as the Accountable Care Organizations (ACOs), supporting community-based care management services, developing a coordinated statewide approach to providing supportive housing for homeless individuals, implementing and engaging with the Integrated Population Health Data (iPHD) Project, improving the oversight and quality of non-emergency medical transportation, and improving oversight and accountability of the state's Medicaid system. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Releases Value Based Payment Reporting Requirements. The New York State Department of Health has released the 2018 Value Based Payment (VBP) Reporting Requirements Technical Specifications Manual. The document describes the quality measure reporting requirements for Medicaid managed care organizations participating in the Medicaid VBP program. It includes an overview of the specific reporting requirements for Category 1 measures for each VBP arrangement and a description of the changes to the measure sets from 2017 to 2018. Five different types of VBP arrangements are possible under the VBP program:

- Total Care for General Population (TCGP)/ Integrated Primary Care (IPC)
- Health and Recovery Plan (HARP)
- HIV/AIDS
- Maternity
- Managed Long Term Care (MLTC)

The document can be found on the VBP Resource Library under the VBP Quality Measures tab.

New York Announces Regulatory Modernization Initiative. The New York Department of Health has announced a comprehensive Regulatory Modernization Initiative 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 across a range of areas to best meet the needs of payers, providers, and consumers in the years ahead.

The state has scheduled the first meeting of the Long Term Care Need Methodologies and Innovative Models Workgroup for Monday, November 20, 2017, from 11:30 a.m. to 1:30 p.m. in Meeting Room 6 at Empire State Plaza.

The Long Term Care workgroup will provide feedback to the Department on regulatory reforms to facilitate provision of innovative models of care to meet the needs of communities, including rural communities. To attend the meeting, RSVP at RegulatoryModernization@health.ny.gov. Written comments can also be submitted to that address. The meeting will also be webcast here.

New York Releases Report on Engaging Community Based Organizations in the Delivery System Reform Incentive Payment Program. The Citizens Budget Commission has released a report that explores issues that have arisen as Performing Provider Systems participating in the Delivery System Reform Incentive Payment Program have developed networks of community-based providers and organizations to implement the program. DSRIP requires that PPSs implement a series of projects designed to improve the quality of care, with an emphasis on reducing unnecessary inpatient and emergency room hospital care. The report notes that in the first two years of the program, the bulk of the funding went to relatively few organizations. Despite the DSRIP emphasis on population health and the state's emphasis on social determinants of health as keys to improving health outcomes, community-based organizations were not integrated into most PPS activities, and only a small number received financial compensation for their efforts. The report identifies four challenges that the PPSs have encountered that help explain these findings:

1. limited evidence for selecting appropriate roles for CBOs in addressing health delivery needs;
2. difficulties designing suitable business models for contracting for non-clinical services from CBOs;
3. uncertainty about the future governance and sustainability of PPS entities; and
4. leadership skepticism among some CBOs and some lead organizations. Read More

New York Cited for Inadequate Follow-Up to Nursing Home Deficiencies. The Office of the Inspector General conducted an audit of New York's follow-up of nursing homes that had been cited for deficiencies during surveys. CMS requires that the state follow up on all deficiencies that result in a corrective action plan. The audit looked at 100 cases out of a total of 4,361 deficiencies that had been identified during 2014. The state did not always verify nursing homes' correction of deficiencies in accordance with federal requirements: of the 100 sampled deficiencies, the state agency verified the nursing homes' correction of 43 deficiencies but did not have documentation supporting that it had verified the nursing homes' correction of the remaining 57 deficiencies. According to the audit, the Department of Health did not ensure that its surveyors followed CMS guidance when verifying and documenting the correction of nursing home deficiencies. As a result of the state's noncompliance, the health and safety of a significant number of nursing home residents may have been at risk. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Overwhelmingly Rejects Controversial Drug-Price Ballot Issue. The *Columbus Dispatch* reported on November 7, 2017, that voters have rejected

Issue 2, the Ohio Drug Price Relief Act, by a margin of 80% to 20%. The citizen-led initiative sought to limit what the state pays for prescription drugs to the amount the Veterans Administration pays for drugs. Advocates claimed this would save the state $400 million per year. Opponents asserted the law was flawed and would be difficult to implement. Drug prices are not always public and discounts and rebates can further affect pricing. Additionally, a key clause in the proposed statute would hold the state liable for the proponents' legal fees if the law was challenged. Issue 2 set a record as the most expensive ballot initiative in Ohio's history. Proponents spending of $16 million was dwarfed by the opposition that spent $60 million. Read More

Ohio Medicaid Delays Hospital Rate Cut for Six Months. The Ohio Governor's Office of Health Transformation announced on November 13, 2017, that the state will delay a 5 percent Medicaid rate cut for hospital inpatient and outpatient services for six months. The Ohio Department of Medicaid had originally proposed the cut to help with the state's $1.1 billion fiscal 2019 budget gap; however, the state appears to have addressed the budget shortfall through other initiatives, including shifting $139 million in reductions from hospitals to managed care plans as well as other providers. Crain's Cleveland Business reported on November 12, 2017, that the rate cut could have resulted in in up to 2,500 fewer health care jobs in Northeast Ohio. Read More

Cleveland Clinic to Remain in CareSource Network. *Cleveland.com* reported on November 8, 2017, that CareSource members will continue to have access to the Cleveland Clinic, after the two organizations signed a new long-term contract. An existing pact expired on August 31 but was extended through November. Read More

Oregon

Oregon Braces for Additional Medicaid Processing Problems. The *Portland Tribune* reported on November 13, 2017, Oregon may face additional federal recoupments related to its Medicaid claims processing problems, according to Pat Allen, director of the Oregon Health Authority. The revelation comes after news surfaced that the state overpaid Medicaid coordinated care organizations by $74 million from 2014-16, a number that Allen now says could be up to $56 million higher. Allen attributed some of the overpayments to the misclassification of certain Medicaid patients who were also eligible for Medicare as well as other eligibility-related payment errors. Governor Kate Brown has ordered OHA to recoup $64 million from the CCOs. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Receives $11.7 Million Federal Grant for MIECHV Program. Pennsylvania's Department of Human Services (DHS) received an $11.7 million federal grant for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. The MIECHV Program provides home-based support for at-risk pregnant women and families. Pennsylvania's evidence-based home visiting programs are Nurse Family Partnership, Early Head Start, Parents as Teachers, and Health Families America. Home visits may include supporting preventive health and prenatal practices, assisting parents on how

best to breastfeed and care for their babies, and working with parents to set goals for their future, continue their education, find employment and child-care solutions, and access other resources in their community. Read More

Pennsylvania Insurance Department Warns of Noncompliant Health Plans. Jessica Altman, Pennsylvania's Acting Insurance Commissioner, issued a consumer alert about buying individual health insurance plans outside the federal website. The Insurance Department has taken action against seven agents who were offering limited-benefits plans that were not compliant with the Affordable Care Act. These non-ACA-compliant plans potentially leave consumers liable for a tax penalty, ineligible for tax credits, or without minimum essential benefits as defined by the ACA. Read More

Texas

Texas Names Muth as New Medicaid Director. The Texas Health and Human Services Commission announced on November 3, 2017, that deputy executive commissioner Stephanie Muth will be the state's next Medicaid director effective November 27. Read More

Utah

Utah to Receive Additional Medicaid Funding for Opioid Treatment. Utah Public Radio reported on November 14, 2017, that the Centers for Medicare & Medicaid Services approved a waiver request from Utah for additional Medicaid funds to expand opioid treatment to even more patients. The waiver lifts the 16-bed restriction on Medicaid funding per residential treatment center. Read More

Virginia

Virginia Announces Medallion 4.0 Medicaid Managed Care Notices of Intent to Negotiate. The Virginia Department of Medical Assistance Services announced on November 9, 2017, that the state intends to enter into contract negotiations with Aetna Better Health, Anthem HealthKeepers Plus, Magellan Complete Care, Optima Health, United Healthcare, and Virginia Premier Health Plan for statewide Medicaid managed care contracts to participate in the Medallion 4.0 program. If awarded, contracts will be effective August 1, 2017, for Tidewater, September 1, 2018, for Central, October 1, 2018, for Northern/Winchester, November 1, 2018, for Charlottesville/Western, and December 1, 2018, for Roanoke/Alleghany and the Southwest regions. Notices can be found here.

Magellan Complete Care is the only plan selected that is not a Medallion 3.0 incumbent. United Healthcare entered the market earlier this year through its acquisition of INTotal Health.There are approximately 737,000 Medicaid and FAMIS members enrolled in managed care in Virginia.

West Virginia

West Virginia Considers Medicaid Work Requirements for Expansion Population. The *Charleston Gazette-Mail* reported on November 13, 2017, that

West Virginia is considering work requirements for able-bodied Medicaid expansion members. The state Department of Health and Human Resources plans to submit a waiver application in 2018. The state has about 170,000 expansion members. About 70 percent of expansion households already have a working adult; the new requirement would be aimed at the remaining 30 percent. Read More

West Virginia CHIP Could End as Early as February. *CQ* reported on November 9, 2017, that the West Virginia Children's Health Insurance Program (CHIP) could end as early as February 2018 unless Congress reauthorizes funding for the program. The Medicaid and CHIP Payment and Access Commission originally predicted that the state would have enough funding to keep the program going until April. Read More

National

Exchange Plans Are Still Owed $12.3 Billion in Risk-Corridor Payments. ***Modern Healthcare*** reported on November 14, 2017, that the federal government owes health plans $12.3 billion in risk-corridor payments for losses incurred on the insurance Exchanges from 2014 and 2016. The Centers for Medicare & Medicaid Services faces 36 lawsuits over risk payments, including a class action lawsuit representing 150 health plans. Among the plans owed the most money are Blue Cross Blue Shield of Texas, Kaiser Foundation Health Plan and Select Health. Read More

Senate Finance Committee Adds Repeal of Individual Mandate to Tax Bill. *The Washington Post* reported on November 14, 2017, that the Senate Finance Committee has added repeal of the Affordable Care Act individual mandate to a proposed tax reform bill. Senators who opposed previous ACA repeal efforts have yet to comment on whether they support the tax bill, which could move to the Senate floor this week. Meanwhile, the House also expects to vote this week on its version of tax reform, which does not include the repeal of the individual mandate. Read More

Uwe Reinhardt Dies at Age 80. *Modern Healthcare* reported on November 14, 2017, that Uwe Reinhardt, healthcare economist and professor at Princeton University, died at age 80. The German-born Reinhardt served on the governing council of the Institution of Medicine and on the Physician Payment Review Committee. Read More

Hospitals File Federal Lawsuit Over 340B Drug Payment Cuts. *Modern Healthcare* reported on November 13, 2017, that hospitals have filed a federal lawsuit against the U.S. Department of Health and Human Services over planned cuts to 340B drug payments. Hospitals could lose $1.6 billion in payments as a result of the cuts. Plaintiffs in the lawsuit include the American Hospital Association, the Association of American Medical Colleges, America's Essential Hospitals, Eastern Maine Healthcare Systems, Henry Ford Health System, and Park Ridge Health. The lawsuit argues that HHS doesn't have the authority to implement the cuts. Read More

States Reconsider Retroactive Medicaid Coverage. *Kaiser Health News* reported on November 14, 2017, that a growing number of states are eliminating retroactive Medicaid coverage for certain members. For example, Arkansas, Indiana, and New Hampshire have eliminated retroactive coverage for expansion populations. Iowa has eliminated retroactive coverage for

everyone except pregnant women and children under age one, and Kentucky has a similar proposal awaiting federal approval. Other states looking to eliminate retroactive Medicaid coverage for certain populations include Delaware, Maryland, Massachusetts, and Utah. Read More

Trump Nominates Alex Azar as Health and Human Services Secretary. *Politico* reported on November 13, 2017, that President Trump has nominated Alex Azar as Secretary of the U.S. Department of Health and Human Services (HHS), filling a position left vacant by Tom Price's departure. Azar was most recently president of Eli Lilly and previously served as HHS general counsel and deputy secretary during the Bush Administration. Read More

CMS Reports Early ACA Open Enrollment Membership. The Centers for Medicare & Medicaid Services released on November 9, 2017, data on the first week of open enrollment through HealthCare.gov. A total of 601,462 individuals selected plans in the week of November 1-4. Of these, 137,322 were new consumers. Read More

Bill Would Allow Governors to Implement Section 1332 Waivers without State Legislative Approval. *Roll Call* reported on November 8, 2017, that Senators Orrin Hatch (R-UT) and Michael Crapo (R-ID) have proposed a bill that would allow state governors to implement Section 1332 Innovation Waivers without approval from state legislatures. The bill would also mandate that the U.S. Department of Health and Human Services decide on 1332 waiver applications within 100 days. The bill also provides protections to individuals with pre-existing conditions. Read More

CBO Projects 13 Million Additional Uninsured Following Repeal of Individual Mandate. *Politico* reported on November 8, 2017, that repeal of the individual insurance mandate would result in 13 million additional uninsured by 2027, according the Congressional Budget Office (CBO). CBO released the scoring as Republicans in Congress consider inserting repeal of the individual mandate into tax reform legislation. CBO also projected that repeal would generate $338 billion in savings to the federal budget deficit over 10 years. Read More

Industry News

Justice Department to Drop Medicare Fraud Case Against Ohio-based Nursing Chain HCR ManorCare. *The New York Times* reported on November 9, 2017, that Justice Department lawyers are moving to drop a Medicare fraud lawsuit against Ohio-based HCR ManorCare, a nursing chain operating more than 270 skilled nursing facilities across the United States. The move comes after a federal magistrate ruled that the government's key witness could not testify. The lawsuit, filed in 2009, alleged that ManorCare billed Medicare for unnecessary services, including rehabilitation programs for certain elderly and frail patients. Read More

Catholic Health Initiatives Cuts 3Q17 Operating Loss by Nearly 57 Percent. *Modern Healthcare* reported on November 10, 2017, that Catholic Health Initiatives (CHI) reduced its operating loss by nearly 57 percent in the quarter ended Sept. 30, 2017, compared to a year earlier. The not-for-profit health system reported earnings before interest, depreciation, and amortization of $222.8 million in the quarter, more than double the previous year. Read More

Genesis Health May File for Bankruptcy, Seeks Relief from Creditors. *The Inquirer* reported on November 8, 2017, that Genesis Health Inc. warned that unless it receives relief from creditors, the company may file for bankruptcy protection in the face of debt-service and rent obligations. Genesis, which recently took a $360 million write-down of goodwill assets, is the largest nursing home operator with 450 facilities in Pennsylvania, New Jersey, and New York. Read More

Caring People Inc. Is Acquired by Private Equity Firm. *Crain's Health Pulse* reported on November 15, 2017, that private-equity firm Silver Oaks Services Partner has agreed to acquire Caring People Inc., a home health company with offices in New York, New Jersey, Connecticut, and Florida. The transaction requires regulatory approval. Steven East, founder and chief executive of Caring People, will retain a stake in the company and remain in his current position. Read More

SynerMed to Shut Down Amidst Increased Scrutiny from State Regulators, Health Plans. ***Kaiser Health News*** reported on November 15, 2017, that SynerMed, a California-based firm that manages physician practices, plans to shut down all operations. The decision comes after audits by health plans found "several system and control failures within medical management and other departments." The company is also under investigation by the California Department of Managed Health Care. SynerMed will work to transfer clients to another management firm within 180 days. Read More

Personal Touch Home Care Owes State $4.51 Million in Medicaid Overpayments. *Cincinnati.com* reported on November 14, 2017, that Personal

Touch Home Care of Ohio will need to pay back the state approximately $4.5 million in Medicaid overpayments. The overpayments are largely attributed to the state wrongly paying for Medicaid services rendered by 80 uncertified home health agency employees. Read More

Corizon Health Names Stephen Rector CEO. Corizon Health, a correctional healthcare services provider, named Stephen Rector chief executive officer effective December 1, 2017. Rector is currently division vice president for Tennessee-based Community Health Systems, Inc., an acute care hospital operator. Corizon Health completed a recapitalization earlier this year. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
November 17, 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 5, 2018	Iowa	Proposals Due	600,000
January 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 1, 2018	Iowa	Implementation	600,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
November 1, 2018	New Hampshire	Proposals Due	160,000
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	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000

HMA News

HHS Releases Report on Fragile Blood Supply. *HealthAffairs* reported on November 9, 2017, that the nation's ability to provide reliable access to safe blood products is reaching a critical point, according to a report from the U.S. Department of Health and Human Services. The blood collection industry faces declining demand, flat-to-declining compensation, a deteriorating infrastructure, loss of research and development capacity, and limited use of new blood safety technology. The report includes recommends improved data collection, support for technology adoption, and subsidies to help blood centers maintain surge capacity. A blog post covering the HHS report was co-written by Karen Scott, M.D., Principal, Health Management Associates, and former chief medical officer in the Office of Assistant Secretary for Health at HHS. Read More

AARP Public Policy Institute and HMA Publish Report on Innovations in MLTSS. A paper titled *Emerging Innovations for Supporting Family Caregivers in Managed Long-Term Services and Supports*, co-written by the AARP Public Policy Institute and Health Management Associates, highlights examples of how progressive managed care plans are supporting family caregivers who are caring for plan members with long-term services and supports (LTSS) needs. The purpose of this paper is for plan administrators, policymakers, and community-based organizations to learn from one another and ultimately adopt these practices, resulting in better care for members and their family caregivers.

Understanding and addressing family caregivers' roles and their needs is a key element of a high-performing LTSS system, because the family provides the lion's share of LTSS to people who need help, given their limitations in carrying out daily living activities. Although not all family caregivers need help, many do.

This emerging innovations paper is part of a new series of the 2017 LTSS State Scorecard that highlights what LTSS innovations states and organizations are developing, piloting, or testing. This newly released paper and the CARE Act Summit build upon AARP's history and ongoing commitment to supporting family caregivers.

The Scorecard and this paper—produced in collaboration with AARP Foundation, The Commonwealth Fund, and The SCAN Foundation—are located here.

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HMA WELCOMES…

Dr. James Cruz – Costa Mesa, California Office

Dr. James Cruz joins HMA from Molina Healthcare of California where he most recently served as Senior Medical Director/Chief Medical Officer (CMO). In this role, Dr. Cruz restructured Molina's Quality Improvement Department, implemented a practice facilitation program in collaboration with key medical groups, augmented Molina's pay-for-performance incentives, and supervised the reorganization of Healthcare Effectiveness Data and Information Set (HEDIS) data collection processes. As a result, Molina received two Awards of Quality for HEDIS Performance from the California Department of Health Care Services. Dr. Cruz led a multidisciplinary team that developed and implemented performance improvement initiatives targeting dual eligible members, resulting in a 15 percent reduction in the total cost of care. Additionally, he established Molina's first telepsychiatry program targeting custodial and skilled nursing care members with one or more behavioral health diagnoses. Less than one year into the program, the total cost of care for its members decreased by 30 percent.

Prior to Senior Medical Director/CMO, Dr. Cruz served as Medical Director at Molina Healthcare of California. In this role, he collaborated with contracted medical groups to improve clinical processes to meet both quality and cost benchmarks for various product lines. He reviewed contracted medical group performance reports of ambulatory and inpatient utilization metrics and identified opportunities for improvement. Additionally, Dr. Cruz reviewed ambulatory and acute care authorization requests from contracted medical groups and facilities.

Prior to Molina Healthcare, Dr. Cruz served as Associate Vice President of Health Services/Medical Director at Arcadian Management Services. In this role, he oversaw all utilization management nursing functions, case management, utilization data analysis, and the quality improvement program. Dr. Cruz developed and managed a $3 million departmental budget and was responsible for ambulatory and acute care authorization review, claims review, and review of provider appeal and grievances. He reviewed medical group performance reports and identified opportunities for focused improvement. He also collaborated with contracted medical groups to educate, modify, and recommend medial group adjustments and physician practice behavior.

Dr. Cruz earned his Doctor of Medicine from the University of California, San Diego School of Medicine. He completed his residency in Family Medicine at

White Memorial Medical Center in Los Angeles and is board certified by the American Board of Family Medicine.

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.

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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.