HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

HMA News

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IN FOCUS

MEDICAID AND EXCHANGE ENROLLMENT UPDATE – JANUARY 2019

This week, our *In Focus* section reviews updated information issued by the Department of Health & Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) on Medicaid expansion enrollment from the *"January 2019 Medicaid and CHIP Applications, Eligibility Determination, and Enrollment Report,"* published on April 25, 2019. Additionally, we review 2019 Exchange enrollment data from the *"Health Insurance Exchanges 2019 Open Enrollment*

Period: Final State-Level Public Use File," published by CMS on March 25, 2019. Combined, these reports present a picture of Medicaid and Exchange enrollment in 2019, representing 72.4 million Medicaid and CHIP enrollees and 11.4 million Exchange enrollees.

Key Takeaways from Medicaid Enrollment Report

- Across all 50 states and DC, Medicaid and CHIP enrolled nearly 72.4 million individuals as of January 2019.
- Medicaid and CHIP enrollment is down more than 1.6 million members since January 2018, a 2.2 percent decrease in enrollment.
- Since January 2018, 13 states saw positive percentage growth in Medicaid and CHIP. No states saw double digit growth. The highest growth was seen in Alaska (5.7 percent); Iowa (2.9 percent); Connecticut (2 percent); South Carolina (1.8 percent); and Georgia (1.5 percent). Maine and Virginia have since implemented Medicaid expansion in January 2019. Idaho, Nebraska, and Utah have passed ballot measures but have yet to implement expansion.
- Over that same period, 37 states and DC saw a net decline in Medicaid and CHIP enrollment.
- As of January 2019, national Medicaid and CHIP enrollment is up 14.7 million (25.5 percent) from the "Pre-Open Enrollment" period, defined as July 2013 through September 2013.
- The top five states in percentage growth of Medicaid and CHIP enrollment since the Pre-Open Enrollment period are Kentucky (101 percent), Nevada (91 percent), Montana (86.4 percent), Alaska (75.4 percent), and Colorado (65.7 percent). All five are Medicaid expansion states.
- The top five states in percentage growth of Medicaid and CHIP among states that did not expand Medicaid are North Carolina (27.7 percent), Georgia (17.1 percent), South Carolina (15.5 percent), Florida (13.2 percent), and Alabama (12.5 percent).
- The top five states in total enrollment growth of Medicaid and CHIP are California (4.1 million), New York (848,724), Washington (614,312), Kentucky (612,705), and Pennsylvania (552,361).

Table 1 – Overall U.S. Medicaid/CHIP Enrollment Growth – Pre-Open Enrollment Monthly Average through January 2019

	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (January 2019)	January 2019 % Change	January 2019 # Change
Expanded Medicaid	38,890,449	52,115,008	*34.0%*	*13,224,559*
Have Not Expanded	18,798,242	20,276,286	*7.9%*	*1,478,044*
Total - All States	**57,688,691**	**72,391,294**	***25.5%***	***14,702,603***

Key Takeaways from 2018 Exchange Enrollment Report

- Final Exchange enrollments for the 2019 plan year, published in March 2019, showed that Qualified Health Plan (QHP) plans have been selected by 11.4 million individuals across all 50 states and DC.

- 2019 QHP selections are down over 306,000 from 2018 QHP selections, a decline of 2.6 percent across all 50 states and DC.
- Only one state saw double-digit percentage growth in QHP selections – Massachusetts (13 percent), a State-Based Marketplace. Ten states saw increases between 0 percent to 10 percent.
- A total of 17 states saw declines in QHP selections between 0 percent and 5 percent. Another 16 states saw declines of 5 percent to 10 percent. A total of seven states saw double-digit percentage declines in QHP selections from 2018 to 2019.
- Overall, all Federally-Based administration models saw declines in enrollment, while State-Based Marketplaces saw an increase of 0.9 percent.

Table 2 – Overall U.S. Exchange QHP Selection Growth – 2018 through 2019

Marketplace Model (as of 2019)	Number of States	Selected Exchange QHP (2018)	Selected Exchange QHP (2019)	QHP % Change	QHP # Change
State-Based Marketplace (SBM)	12	3,006,533	3,032,527	*0.9%*	*25,994*
Federally Facilitated Marketplace (FFM)	28	7,505,455	7,257,661	*-3.3%*	*(247,794)*
State-Based, Federal Platform (SBM-FP)	5	454,569	428,663	*-5.7%*	*(25,906)*
Partnership	6	783,618	725,290	*-7.4%*	*(58,328)*
Total		**11,750,175**	**11,444,141**	***-2.6%***	*(306,034)*

The table on the following page (Table 3) provides state-level data on Medicaid and Exchange enrollment.

Medicaid and Exchange Enrollment Data Sources

Link to CMS Medicaid Expansion Enrollment Report:

"January 2019 Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report" (April 25, 2019)

Link to CMS Marketplace Open Enrollment Period Public Use Files:

"2019 Marketplace Open Enrollment Period Public Use Files" (March 2019)

State	Expanded Medicaid	Exchange Model	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (January 2019)	January 2019 % Change	January 2019 # Change	Selected Exchange QHP (2018)	Selected Exchange QHP (2019)	QHP % Change	QHP # Change
US Total			**57,688,691**	**72,391,294**	***25.5%***	***14,702,603***	**11,750,175**	**11,444,141**	***-2.6%***	***(306,034)***
Alabama	No	FFM	799,176	899,349	*12.5%*	*100,173*	170,211	166,128	*-2.4%*	*(4,083)*
Alaska	Yes	FFM	122,334	214,541	*75.4%*	*92,207*	18,313	17,805	*-2.8%*	*(508)*
Arizona	Yes	FFM	1,201,770	1,701,450	*41.6%*	*499,680*	165,758	160,456	*-3.2%*	*(5,302)*
Arkansas	Yes	SBM-FP	556,851	848,119	*52.3%*	*291,268*	68,100	67,413	*-1.0%*	*(687)*
California	Yes	SBM	7,755,381	11,823,859	*52.5%*	*4,068,478*	1,521,524	1,513,883	*-0.5%*	*(7,641)*
Colorado	Yes	SBM	783,420	1,297,913	*65.7%*	*514,493*	161,764	170,325	*5.3%*	*8,561*
Connecticut	Yes	SBM	618,700	861,977	*39.3%*	*243,277*	114,134	111,066	*-2.7%*	*(3,068)*
Delaware	Yes	Partnership	223,324	249,243	*11.6%*	*25,919*	24,500	22,562	*-7.9%*	*(1,938)*
District of Columbia	Yes	SBM	235,786	256,704	*8.9%*	*20,918*	19,289	18,035	*-6.5%*	*(1,254)*
Florida	No	FFM	3,695,306	4,184,636	*13.2%*	*489,330*	1,715,227	1,783,304	*4.0%*	*68,077*
Georgia	No	FFM	1,535,090	1,798,195	*17.1%*	*263,105*	480,912	458,437	*-4.7%*	*(22,475)*
Hawaii	Yes	FFM	288,357	330,244	*14.5%*	*41,887*	19,799	20,193	*2.0%*	*394*
Idaho	No	SBM	238,150	266,351	*11.8%*	*28,201*	94,507	94,430	*-0.1%*	*(77)*
Illinois	Yes	Partnership	2,626,943	2,817,556	*7.3%*	*190,613*	334,979	312,280	*-6.8%*	*(22,699)*
Indiana	Yes	FFM	1,120,674	1,443,002	*28.8%*	*322,328*	166,711	148,404	*-11.0%*	*(18,307)*
Iowa	Yes	Partnership	493,515	683,137	*38.4%*	*189,622*	53,217	49,210	*-7.5%*	*(4,007)*
Kansas	No	FFM	378,160	390,420	*3.2%*	*12,260*	98,238	89,993	*-8.4%*	*(8,245)*
Kentucky	Yes	SBM-FP	606,805	1,219,510	*101.0%*	*612,705*	89,569	84,620	*-5.5%*	*(4,949)*
Louisiana	Yes	FFM	1,019,787	1,475,255	*44.7%*	*455,468*	109,855	92,948	*-15.4%*	*(16,907)*
Maine	Yes	FFM	266,900	259,597	*-2.7%*	*(7,303)*	75,809	70,987	*-6.4%*	*(4,822)*
Maryland	Yes	SBM	856,297	1,298,973	*51.7%*	*442,676*	153,584	156,963	*2.2%*	*3,379*
Massachusetts	Yes	SBM	1,296,359	1,531,871	*18.2%*	*235,512*	267,260	301,879	*13.0%*	*34,619*
Michigan	Yes	Partnership	1,912,009	2,309,960	*20.8%*	*397,951*	293,940	274,058	*-6.8%*	*(19,882)*
Minnesota	Yes	SBM	873,040	1,037,867	*18.9%*	*164,827*	116,358	113,552	*-2.4%*	*(2,806)*
Mississippi	No	FFM	637,229	611,749	*-4.0%*	*(25,480)*	83,649	88,542	*5.8%*	*4,893*
Missouri	No	FFM	846,084	887,297	*4.9%*	*41,213*	243,382	220,461	*-9.4%*	*(22,921)*
Montana	Yes	FFM	148,974	277,633	*86.4%*	*128,659*	47,699	45,374	*-4.9%*	*(2,325)*
Nebraska	No	FFM	244,600	242,385	*-0.9%*	*(2,215)*	88,213	87,416	*-0.9%*	*(797)*
Nevada	Yes	SBM-FP	332,560	635,194	*91.0%*	*302,634*	91,003	83,449	*-8.3%*	*(7,554)*
New Hampshire	Yes	Partnership	127,082	181,293	*42.7%*	*54,211*	49,573	44,581	*-10.1%*	*(4,992)*
New Jersey	Yes	FFM	1,283,851	1,703,889	*32.7%*	*420,038*	274,782	255,246	*-7.1%*	*(19,536)*
New Mexico	Yes	SBM-FP	457,678	729,051	*59.3%*	*271,373*	49,792	45,001	*-9.6%*	*(4,791)*
New York	Yes	SBM	5,678,417	6,527,141	*14.9%*	*848,724*	253,102	271,873	*7.4%*	*18,771*
North Carolina	No	FFM	1,595,952	2,038,619	*27.7%*	*442,667*	519,803	501,271	*-3.6%*	*(18,532)*
North Dakota	Yes	FFM	69,980	91,060	*30.1%*	*21,080*	22,486	21,820	*-3.0%*	*(666)*
Ohio	Yes	FFM	2,161,785	2,650,867	*22.6%*	*489,082*	230,127	206,871	*-10.1%*	*(23,256)*
Oklahoma	No	FFM	790,051	776,208	*-1.8%*	*(13,843)*	140,184	150,759	*7.5%*	*10,575*
Oregon	Yes	SBM-FP	626,356	971,345	*55.1%*	*344,989*	156,105	148,180	*-5.1%*	*(7,925)*
Pennsylvania	Yes	FFM	2,386,046	2,938,407	*23.1%*	*552,361*	389,081	365,888	*-6.0%*	*(23,193)*
Rhode Island	Yes	SBM	190,833	308,844	*61.8%*	*118,011*	33,021	34,533	*4.6%*	*1,512*
South Carolina	No	FFM	889,744	1,028,077	*15.5%*	*138,333*	215,983	214,956	*-0.5%*	*(1,027)*
South Dakota	No	FFM	115,501	116,739	*1.1%*	*1,238*	29,652	29,069	*-2.0%*	*(583)*
Tennessee	No	FFM	1,244,516	1,396,023	*12.2%*	*151,507*	228,646	221,533	*-3.1%*	*(7,113)*
Texas	No	FFM	4,441,605	4,277,703	*-3.7%*	*(163,902)*	1,126,838	1,087,240	*-3.5%*	*(39,598)*
Utah	No	FFM	294,029	284,808	*-3.1%*	*(9,221)*	194,118	194,570	*0.2%*	*452*
Vermont	Yes	SBM	161,081	157,518	*-2.2%*	*(3,563)*	28,763	25,223	*-12.3%*	*(3,540)*
Virginia	Yes	FFM	935,434	1,017,764	*8.8%*	*82,330*	400,015	328,020	*-18.0%*	*(71,995)*
Washington	Yes	SBM	1,117,576	1,731,888	*55.0%*	*614,312*	243,227	220,765	*-9.2%*	*(22,462)*
West Virginia	Yes	Partnership	354,544	532,336	*50.1%*	*177,792*	27,409	22,599	*-17.5%*	*(4,810)*
Wisconsin	No	FFM	985,531	1,021,451	*3.6%*	*35,920*	225,435	205,118	*-9.0%*	*(20,317)*
Wyoming	No	FFM	67,518	56,276	*-16.7%*	*(11,242)*	24,529	24,852	*1.3%*	*323*

HMA Medicaid Roundup

Arkansas

Arkansas Reschedules PASSEs Open Enrollment to October. The Arkansas Department of Human Services (DHS) announced on April 30, 2019, that it has rescheduled open enrollment for the Provider-led Arkansas Shared Savings Entity (PASSE) program from May to October. Open enrollment will now run from October 1 to October 31 with an effective date of December 1. The state announced the delay to give PASSEs more time to develop their provider networks. Three PASSEs – Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care – have already begun receiving monthly payments from the state to manage the complete care of members. Read More

Delaware

Delaware Medicaid IDD Provider to Return $4.5 Million in State Overpayments. *The Washington Post/Associated Press* reported on May 2, 2019, that Chimes, a Maryland-based not-for-profit provider of services for individuals with intellectual and developmental disabilities (IDD), has agreed to return $4.5 million in Medicaid funds to Delaware. The state argued that Chimes was overpaid for its supported employment programs and Medicaid services provided from 2014 to 2016. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Political Committee Gathers 53,000 Signatures for Medicaid Expansion Ballot Measure. *Fox 35* reported on May 7, 2019, that a political committee called Florida Decides Healthcare has submitted 53,258 signatures for a Medicaid expansion ballot measure in November 2020. The measure calls for a constitutional amendment to expand Medicaid eligibility to low income adults. The committee needs to submit 76,632 signatures to trigger a Florida Supreme Court review and a total of 766,200 signatures to get the measure on the ballot. Read More

2019 Legislative Session Concludes. Florida lawmakers signed off on a $91.1 billion state budget ($34 billion general revenue (GR)) setting aside $3.4 billion in reserves, concluding the 61-day 2019 Legislative Session on May 4, 2019. The Legislature had to extend their session by one day in order to pass the budget.

The Health and Human Services portion of the budget totals $37.7 million (41 percent) of the total state budget.

The budget agreement shifts $9.6 million (3 percent) in Medicaid hospital automatic rate enhancements to inpatient and outpatient hospital base rates. The rate enhancements are currently used to supplement existing Medicaid reimbursements to 28 of the state's hospitals with the highest Medicaid caseloads. The Senate had proposed redistributing the $319 million enhancements to the base rates while the House had proposed reducing hospital rates by $111.1 million that included a 3 percent reduction to enhancements as well as a 3 percent reduction to hospital base rates.

The budget provides that Medicaid retroactive eligibility changes for non-pregnant adults will continue to begin the first day of the month in which a non-pregnant adult applies for Medicaid. The Legislature had agreed last year to reduce that period from three calendar months to one, to save the state about $100 million. Also, the Agency for Health Care Administration (AHCA) is required to submit a report to the Legislature, by January 10, 2020, regarding how the policy affects beneficiaries and providers.

Medicaid Budget Highlights FY 2019-20

• **Medicaid Price Level and Workload** – $94.4M Total; $173.8M GR – Fully funds the Medicaid program at $28.4 billion to serve an estimated 3.9 million Medicaid beneficiaries. (Includes an average rate increase in the MCO capitation payment of 3.2 percent for MMA and 1.5 percent for LTC managed care rates.)

• **KidCare Workload** – $91.4M Total; $51.9M GR – Fully funds the KidCare program at $598 million to serve an estimated 275,707 children.

• **Florida Healthy Kids Combined Risk Pool** – $6.9M Total; $1.1M GR – Provides funding for Florida Healthy Kids to implement a combined-risk premium model of Title XXI-subsidized and full-pay enrollments for medical insurance payments, effective January 1, 2020.

• **Florida Medicaid Management Information System (FMMIS)** – $34.0M Trust Fund (TF) Total – Provides nonrecurring funding for the Medicaid Enterprise System Procurement project.

• **Electronic Visit Verification (EVV) for Behavior Analysis** – $1.2M TF Total – Provides funding to implement EVV for behavioral analysis services statewide.

• **Nursing Home Rate Enhancements** – $15.5M TF Total– Provides nonrecurring funding for nursing home rate enhancements by increased quality incentive payments.

• **Redirect Hospital Rate Enhancements** – ($9.6M Total; $3.7M GR) – Reduces hospital rate enhancement funding by 3% for inpatient and outpatient services and redirects funds to increase hospital base rates.

  • **Increase Hospital Inpatient DRG Base Rate** – $8.0M Total; $3.1M GR
  • **Increase Hospital Outpatient EAPG Base Rate** – $1.6M Total; $0.6M GR

• **Rural Inpatient Hospital Inpatient Adjustment** – $9.6M Total; $3.8M GR – Provides nonrecurring funding for sole community hospitals that meet the

definition of rural hospitals in the DRG reimbursement methodology services for hospital inpatient services.

• **Graduate Medical Education Program Increase** – $4.4M TF Total; $1.7M IGTs – Provides funding to increase Graduate Medical Education Programs.

• **Increase Residential Habilitation Provider Rates** – $28.7M Total; $11.1M GR – Provides funding to increase salaries of direct care staff.

• **APD Resources for Persons with Unique Abilities** – $48.7M Total; $18.8M GR – Provides funding for the iBudget home and community-based services waiver.

• **Program of All-Inclusive Care for the Elderly (PACE)** – $4.7M Total; $1.8M GR – Provides funding to increase PACE by 150 slots in Orange County.

Healthcare 2019 Major Legislation (Passed Bills)

• **Prescription Drug Importation (HB 19)** – establishes two programs to import prescription drugs approved by the federal Food and Drug Administration (FDA) into the state, contingent on federal approval:

  • The Canadian Prescription Drug Importation Program established by AHCA and

  • The International Prescription Drug Importation Program established by the Department of Business and Professional Regulation in collaboration with the Department of Health.

• **Certificate of Need (HB 21)** – removes a requirement for CON for general hospitals and tertiary care on July 1 and for specialty hospitals in 2021. CON will remain for long-term care and hospice facilities.

• **Telehealth (HB 23)** – establishes a regulatory framework for telehealth in Florida and creates a registration process and requirements for out-of-state telehealth providers.

• **Nonemergency Medical Transportation Services (HB 411)** – authorizes a transportation network company, subject to compliance with state and federal Medicaid requirements, to provide nonemergency medical transportation services to a Medicaid recipient.

Illinois

Illinois Medicaid Eligibility Backlog Leaves Thousands Without Coverage. *The Chicago Sun Times* reported on May 3, 2019, that an Illinois Medicaid eligibility determinations backlog has left 112,000 applicants past the 45-day federal limit for receiving coverage determinations. The Centers for Medicare & Medicaid Services (CMS) has informed the state that it is non-compliant for making timely determinations. In February, 2,000 Medicaid applicants received temporary medical assistance cards. Read More

Iowa

Medicaid Officials to Meet with Beneficiaries, Providers Ahead of Health Plan Departure. *The Des Moines Register* reported on May 6, 2019, that Iowa Medicaid officials are scheduled to meet with beneficiaries and providers as UnitedHealthcare prepares for a July 1 departure from the program. UnitedHealthcare's 425,000 beneficiaries will be spread among Anthem/Amerigroup Iowa and Centene/Iowa Total Care. Officials have scheduled a total of seven public meetings. Read More

Kansas

Legislature Fails to Advance Medicaid Expansion This Year. *Modern Healthcare* reported on May 6, 2019, that a push for Medicaid expansion in Kansas this year has died in the state legislature. The Kansas House had been attempting to force a Senate vote on expansion by holding up the state's fiscal 2020 budget. However, the stalemate ended when the House approved an $18 billion budget blueprint, which now heads to the governor's desk for signature. Read More

House Blocks State Budget in Hopes of Forcing Medicaid Expansion Vote. *The New York Times* reported on May 3, 2019, that the Kansas House voted 63-61 against the state's proposed $18 billion budget in hopes of forcing a vote on Medicaid expansion in the Senate. The move comes after the Senate failed to advance an expansion bill to the main floor for a vote. Read More

Maine

Hospital Is Warned by CMS to Correct Quality Concerns or Lose Funding. *The Sun Journal* reported on May 6, 2019, that federal regulators have given Central Maine Medical Center until June 30 to address numerous care and quality problems or potentially lose Medicare and Medicaid funding. The Centers for Medicare & Medicaid Services (CMS) has cited numerous problems, including the improper treatment of a cervical fracture patient resulting in paralysis. Read More

Nebraska

Nebraska Releases RFQ For Families First Prevention Services Act Providers. The Nebraska Department of Health and Human Services (DHHS) on May 6, 2019, released a request for qualifications (RFQ) for potential providers of services funded through the Families First Prevention Services Act (FFPSA). The RFQ seeks agencies and organizations to provide in-home parenting skills, substance abuse treatment, and mental health services to families "at imminent risk" of having a child moved into foster care. Nebraska is one of 13 other states that plan to implement FFPSA by October 1. States will need to submit a five-year plan by July 1. Read more

New Hampshire

Lawmaker Proposes 12 Percent Raise in Medicaid Rates for Clinicians. *The Concord Monitor* reported on May 6, 2019, that a $116 million proposal by New Hampshire Senator Cindy Rosenwald (D-Nashua) would raise Medicaid clinician rates by 12 percent over two years, impacting health care workers at clinics, community centers, nursing homes, and home health agencies. Rosenwald's proposal, which has garnered bipartisan support, would also support workplace recruitment, telehealth, the streamlining of nursing background checks, and incentives to retain young health care workers. Read More

House Advances Bill that Could Eliminate Medicaid Work Requirements. *U.S News & World Report* reported on May 2, 2019 that the New Hampshire House gave preliminary approval to legislation that would end Medicaid work requirements in the state if 500 or more people lose coverage. The bill, which was sent to the House Finance Committee, would also broaden exemptions to the work requirements. The Senate approved the bill in March. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey DHS Provides Update on MLTSS, Nursing Facility 'Any Willing Qualified Provider' Reimbursement Model. According to the New Jersey Department of Human Services (DHS) SFY 2020 budget discussion points, when first implemented, the MLTSS program established a "default rate" for nursing facilities (NF) that had not otherwise negotiated a reimbursement rate with a resident's managed care organization (MCO). These reimbursement parameters, while still in effect, are intended to be transitioned to a new, quality-based Any Willing Qualified Provider (AWQP) reimbursement model. AWQP establishes a new framework for NFs serving MLTSS enrollees and MCOs to negotiate payment rates based on performance standards to improve the quality of care by linking provider reimbursement to performance and enabling consumers to select high-quality providers. DHS with the Division of Medical Assistance and Health Services (DMAHS) are implementing the AWQP initiative over a few years.

After collecting data and developing baselines in the first year, DHS intends to award AWQP designation status to NFs this spring and review it annually. AWQP designated NFs must meet or exceed the State benchmark for at least four of seven measures:

- rate of administered influenza vaccination
- rate of administered antipsychotic medication
- rate of pressure ulcers experienced by patients
- rate of patients physically restrained
- rate of falls with major injury
- family experience
- utilization of tools to measure 30-day hospitalizations and hospital utilization.

DHS and DMAHS intend to align compensation with quality metrics as the program matures. If a NF is unable to attain or retain AWQP designation, DHS and DMAHS may take progressive accountability actions ranging from issuing

notices informing MLTSS members that they may relocate to another facility, to stopping new MLTSS long-term custodial care admissions, to terminating the NF as an MCO network provider.

Under the AWQP redesign, each eligible NF may receive up to an additional $3.00 per day, per patient for meeting quality metrics.

There are currently 288 Medicaid Certified NFs participating in the AWQP initiative. About half are designated. Additionally, there are 30 Special Care NFs (stand-alone or attached to a NF) that will be included in the AWQP initiative going forward.

DHS and DMAHS continue to establish the baseline structure of this MLTSS VBP initiative as one component of NF reimbursement, and will evaluate the continued use of a default reimbursement rate. Network adequacy continues to be a consideration for future planning.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York City Moves to Implement Health Care Program for the Uninsured. New York City Mayor Bill de Blasio took the next step in implementing the NYC Care program, an initiative to provide health care to individuals without insurance. NYC Care will be launched in the Bronx on August 1, and will be fully implemented across the city by the end of 2020. The mayor has named Marielle Kress as Executive Director of the initiative. Bill de Blasio also unveiled the NYC Care Card, which will connect each member with a dedicated doctor and access to a 24-hour customer service line, and reported that NYC Health + Hospitals will be hiring an additional seven physicians in the Bronx as part of the roll-out. NYC H+H will be providing medical care for the initiative. Read More

CBC Releases Report on Enhancing Care Coordination for Dually Eligible Individuals in New York. On April 25, 2019, the Citizens Budget Commission, a nonpartisan, nonprofit organization, released a report describing a series of options for enhancing care coordination for dually eligible individuals in New York. The report is particularly timely as New York's duals integration demonstration program, Fully Integrated Duals Advantage (FIDA), comes to an end at the end of 2019. The report explores opportunities for care management within the Medicaid program, the Medicare program, and under a combined Medicaid-Medicare plan. The report goes on to articulate five strategies for improving care for the dually eligible population, noting that the population is growing, has extensive medical needs, and is an expensive population. The options, which are not mutually exclusive, are listed below:

1. Revitalize the FIDA model – improve marketing and consumer education; constrain competition from alternative care arrangements by not allowing plans that offer an integrated product to also offer a non-integrated Managed Long-Term Care (MLTC) product.
2. Build on Medicaid Advantage and Medicaid Advantage Plus – integrate enrollment and appeals processes; impose limits on competition from alternative plans by requiring that plans offering Medicaid Advantage Plus not also offer a MLTC option and that plans offering Medicaid Advantage Plus not also offer a D-SNP.

3. Expand partnerships between Medicare Advantage D-SNPs and Medicaid MLTC plans – align enrollment for individuals requiring long-term care services by requiring MLTC plans to also offer a companion D-SNP; limit contracting with D-SNPs to plans that also offer an MLTC; allow passive enrollment.
4. Target enrollment in health homes among eligible fee-for-service duals – target duals who do not need long-term care services yet have serious mental illness or other chronic conditions that require services beyond Medicare benefits for health home enrollment.
5. Support broader marketing of Medicare Advantage D-SNPs – encourage dually eligible individuals to enroll in Medicare Advantage in order to benefit from more coordinated care; allow passive enrollment of duals aging out of mainstream Medicaid managed care into the D-SNP sponsored by their current managed care plan. Read More

Senate Will Not Vote on Single Payor Bill. *City and State NY* reported on April 25, 2019, that the New York Chair of the Senate Committee on Health, Gustavo Rivera, will not bring the single payor bill, the New York Health Act, to a vote this year. Senator Rivera has indicated that he has scheduled a series of joint public hearings to gain input about the legislation. The state Senate has never before voted on the bill, as which was under Republican control until this year. City and State reports that Rivera has no intention to take action on the bill this year in order to allow the hearings to conclude and to give his colleagues a chance to closely examine it. The bill has passed the Assembly Health Committee, and while it has been approved by the Assembly every year for the last four years, it is not clear whether it will be brought to the full Assembly for a vote. Read More

NYU Expands Dental Care Options for Individuals with Disabilities. *The New York Times* reported on May 2, 2019, that the New York University College of Dentistry now offers expanded dental care options for individuals with special needs. The university's Oral Health Center for People with Disabilities serves adults and children across the spectrum of disabilities and has two operating rooms where patients who are unable to sit still for treatment can be sedated. Read More

North Carolina

North Carolina Audit Cites Inadequate Monitoring of Behavioral LME-MCOs. *The News & Observer* reported on May 7, 2019, that the North Carolina Department of Health and Human Services didn't properly monitor the performance of Local Management Entities-Managed Care Organizations (LME-MCOs), which manage care for mental health, developmental disabilities, and substance abuse among Medicaid members, according to a state auditor's report. The Office of the State Auditor recommended creating a centralized tracking system; formal policies and procedures for evaluation; and penalties and corrective actions to hold organizations accountable for their performance. Read More

Ohio

Ohio Proposed House Budget Would Revamp Medicaid Pharmacy Benefit Managers. *The Columbus Dispatch* reported on May 2, 2019, that the Ohio House has unveiled a plan to give the state greater control of Medicaid pharmacy benefits and no longer leave this benefit carved into private managed care companies. Under the new House proposal, the Department of Administrative Services would select and contract with a single pharmacy benefit manager (PBM) rather than allowing managed care plans to hire their own PBM. The state PBM cannot be owned by a managed care organization. The proposal would also require the PBM to submit quarterly pricing reports to the Department of Medicaid. Read More

Ohio Is Developing Plan to Address Medicaid Application Backlog at Request of Federal Regulators. *The Akron Beacon Journal/Columbus Dispatch* reported on May 6, 2019, that Ohio is developing a plan to address the state's Medicaid applications backlog at the request of federal regulators, according to Medicaid director Maureen Corcoran. The state has a backlog of 70,000 Medicaid applications, down from 88,000 in March. Under federal guidelines, Medicaid applications and renewals must be processed within 45 days for nondisability applications and 90 days for disability applications. Most Ohio Medicaid applications have been pending for 45 days or longer. Read More

Oklahoma

Oklahoma Medicaid Selects Telligen to Continue as SoonerCare Health Management Program Partner. The Oklahoma Health Care Authority announced on April 29, 2019, that Telligen has been selected to continue administering Oklahoma Medicaid's SoonerCare Health Management Program (HMP). Telligen will continue existing work while also undertaking new initiatives to expand outreach, improve quality and provider outcomes, as well as reduce costs to Medicaid beneficiaries at risk for complex or chronic conditions. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Counties Push Back Against Behavioral Health Integration Bill. *ITF* reported on May 3, 2019, that Pennsylvania county-elected officials, administrators, and advocates are pushing back against state Senate legislation that would combine Medicaid's physical and mental health services in Pennsylvania. The bill (SB 268) would eliminate the state's $4 billion behavioral health program, Behavioral HealthChoices, and merge it with the state's $12 billion physical health Medicaid program, HealthChoices. Critics fear that combining the two Medicaid systems will take money from county mental health programs and give too much control to managed care organizations. The bill is with the Senate Health and Human Services Committee. Read More

Tennessee

Tennessee to Seek Federal Approval for Medicaid Block Grant Waiver. *Politico* reported on May 3, 2019, that Tennessee Republican lawmakers passed a bill that would require the state to seek federal approval of a Medicaid block grant waiver within the next six months. The legislation, which would significantly overhaul the state's Medicaid program, now heads to Governor Bill Lee's desk. If approved, Tennessee would become the first state to fund its Medicaid program through a block grant. Read More

Tennessee Passes Budget with Full Funding of Katie Beckett Waiver. *The Tennessean* reported on April 30, 2019, that the Tennessee general assembly has passed the state's $38.5 billion budget for fiscal 2020, including $27.3 million to fully fund the state's share of the Katie Beckett waiver program. The program provides coverage to 3,000 Tennessee children with severe disabilities who do not qualify for Medicaid. Read More

West Virginia

Opioid Treatment Centers to Pay $17 Million Amid Medicaid Fraud Allegations. *Modern Healthcare* reported on May 6, 2019, that Acadia Healthcare, which owns seven drug addiction treatment centers in West Virginia, will pay $17 million to settle allegations of Medicaid fraud related to alleged false laboratory tests in the state. The tests in question generated $8.5 million in payments to Acadia centers from 2012 to 2018 in West Virginia, including $2.8 million in state and $6.3 million in federal funds. Read More

West Virginia Reaches Settlement in Opioid Lawsuit with McKesson for $37 Million.
The New York Times/Reuters reported on May 2, 2019, that West Virginia has settled an opioid lawsuit against drug distributor McKesson Corporation for $37 million. The lawsuit was filed by the state in Boone County Circuit Court in 2016 alleging that McKesson failed to identify suspicious opioid orders. The settlement is just one of hundreds of cases against McKesson across the country. Read More

Wisconsin

Lawmakers to Vote to Remove Medicaid Expansion from Budget. *The Milwaukee Journal Sentinel* reported on May 1, 2019, that Wisconsin Republican lawmakers of the Joint Finance Committee plan to vote to remove Medicaid expansion from the Governor's budget. Approximately 82,000 individuals would be eligible for coverage under expansion. Read More

National

CMS Takes Action to Further Rural Health Initiative. The Centers for Medicare & Medicaid Services (CMS) outlined on May 8, 2019, actions taken as part of the agency's Rural Health Initiative, which aims to strengthen the rural health care system. Actions have included expanded access to telehealth, proposals to address Medicare payment disparities impacting rural hospitals, and a new set of payment models for primacy care providers. Payment proposals could go into effect as early as October 1. Read More

CMS Reports Faster Approval Times for 1915 Waivers, State Plan Amendments. The Centers for Medicare & Medicaid Services (CMS) announced on May 7, 2019, that its making "great progress" in approval turnaround times for state Medicaid 1915 waivers and state plan amendments (SPAs). CMS reported a 16 percent decrease in median approval times for Medicaid SPAs between 2016 and 2018. Median approval times for 1915(b) waivers decreased by 11 percent over the same period. CMS also reported that 78 percent of SPAs were approved within 90 days in 2018. Read More

CMS Finalizes Rule Prohibiting Medicaid from Paying Home Health Union Dues. *Modern Healthcare* reported on May 2, 2019, that the Centers for Medicare & Medicaid Services (CMS) finalized a rule that prohibits states from using Medicaid funds to pay home health union dues. CMS Administrator Seema Verma stated that the rule aims to ensure that providers receive their complete payment. The rule does not prohibit workers from joining a union. Read More

AHA Urges DOJ to Block Centene Acquisition of WellCare. *Modern Healthcare* reported on May 1, 2019, that the American Hospital Association (AHA) is urging the U.S. Department of Justice to block the proposed merger of Centene and WellCare Health Plans. AHA argues that the deal could reduce competition in Medicaid Managed Care and Medicare Advantage markets. Together, Centene and WellCare cover almost 22 million people. Read More

CBO Outlines Challenges of Designing, Implementing Medicare-for-all. *Kaiser Health News* reported on May 1, 2019, that lawmakers would need to address a "laundry list" of benefit options, funding issues, and technicalities in designing and implementing a Medicare-for-all health care system, according to a Congressional Budget Office report. Among the key issues are what constitutes medical necessity, what type of new taxes would fund the program, and how to set payment levels to hospitals and other providers. Read More

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness: Additional Data Sources. On May 16, 2019 from 2:00 pm-3:30 pm ET, the Medicaid Innovation Accelerator Program (IAP) will provide Medicaid agencies with an overview of a new technical resource, Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness: Additional Data Sources. This Technical Resource describes approaches to combining Medicaid data with additional data sources that can assist state Medicaid agencies with developing data analytics to better understand their population with serious mental illness. Data analyses related to housing, corrections/justice involvement and food insecurity are highlighted as examples of the approaches described in the resource. The webinar will feature an overview of the technical resource, example analyses, and a discussion with state Medicaid leaders from Arizona and Minnesota who will share insights based on their experience conducting similar analyses. This resource builds on the Medicaid claims and encounters data analytics described in the IAP resource, Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness.

HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program. HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates. To participate in this webinar, register here.

Industry News

Hedge Funds May Challenge Centene, WellCare Deal, Sources Say. *Reuters* reported on May 6, 2019, that Centene shareholders Corvex Management LP and Sachem Head Capital Management LP may challenge the company's proposed $17.3 billion acquisition of WellCare, according to unnamed sources. The funds would like to see Centene do more to explore selling itself, the sources said. Centene has stated that it is "committed" to completing the WellCare deal. Read More

Ensign Group to Spin Off Home Health, Hospice Assets Into Public Company. Publicly traded Ensign Group announced on May 6, 2019, that it will spin off its wholly owned Pennant Group subsidiary into a separate publicly traded company, which will include about 60 home health and hospice agencies and 51 senior living facilities among other assets. Shares of Pennant common stock, which are expected to be traded on Nasdaq under the symbol PNTG, will be distributed to Ensign shareholders on a pro rata basis. Daniel Walker, who is currently president of Ensign's Cornerstone Healthcare, will become chairman and chief executive of Pennant. The spinoff is expected to be completed in the fourth quarter of 2019. Read More

Arsenal Capital Partners Acquires Behavioral Health Service Provider Hopebridge. Arsenal Capital Partners announced on May 6, 2019, the acquisition of Hopebridge, LLC, which provides outpatient behavioral health services for children with autism spectrum disorder or other behavioral challenges. Terms were not disclosed. Read More

Ensign Group Completes Acquisition of Several Post-Acute, Rehab, SNF Operations. The Ensign Group announced on May 2, 2019, that it has completed the acquisition of two Arizona post-acute and rehabilitation campuses as well as four skilled nursing facilities in California, effective May 1, 2019. In addition, Ensign subsidiary Cornerstone Healthcare has acquired the assets of Resolutions Hospice in Austin and Houston, TX. Financial terms of the transactions were not disclosed. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
May 17, 2019	Minnesota MA Families and Children; MinnesotaCare	Proposals Due	679,000
May 17, 2019	Minnesota Senior Health Options; Senior Care Plus	Proposals Due	55,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
June 28, 2019	Louisiana	Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
July 1, 2019	Washington Integrated Managed Care - North Sound (Island, San Juan, Skagit, Snohomish, and Whatcom Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
July 9, 2019	Oregon CCO 2.0	Awards	840,000
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
January 1, 2020	Washington Integrated Managed Care - Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum Counties); Salish (Clallam, Jefferson, and Kitsap Counties); Thurston-Mason (Mason and Thurston Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	315,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	960,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	148,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	265,500
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

HMA News

Medicaid Directors from 5 States, Plus Other State Medicaid Officials to Address Opportunities, Pitfalls of Medicaid Innovation. State Medicaid directors will be among the dozens of featured speakers at HMA's annual conference on *The Next Wave of Medicaid Growth and Opportunity: How Payers, Providers, and States Are Positioning Themselves for Success*, September 9-10, at the Chicago Marriott Downtown Magnificent Mile.

At least five Medicaid directors from states including Arizona, California, Illinois, Kentucky and North Carolina, along with the commissioner of the New Jersey Department of Human Services and Medicaid officials from Indiana, Maryland, and Virginia will outline a wide variety of state innovation efforts and provide a roadmap for Medicaid opportunities going forward.

Early Bird registration is now open. Last year's conference attracted more than 450 attendees. Visit the conference website for complete details: 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

- Medicaid Managed Care Accounts for 52% of Total Medicaid Spending, 2018 Data
- Medicaid Plan Profit Margin Dips to 0.5% In 2018
- Bed Days per 1000 Members at 664 for Kentucky Medicaid MCOs, 2018 Data
- Bed Days Per 1000 Members Average 1152 at Pennsylvania Medicaid MCOs, 2018 Data
- Bed Days per 1000 Members Average 880 for Massachusetts Medicaid MCOs, 2018 Data
- MLRs at Kansas Medicaid MCOs Average 84.4%, 2018 Data
- MLRs at Pennsylvania Medicaid MCOs Average 87.8%, 2018 Data
- MLRs Average 86.8% Among Missouri Medicaid MCOs, 2018 Data
- MLRs Average 93.9% Among Massachusetts Medicaid MCOs, 2018 Data
- Massachusetts Medicaid Managed Care Enrollment is 996,847, Jan-19 Data
- Minnesota Medicaid Managed Care Enrollment is Down 2.1%, May-19 Data
- New Mexico Medicaid Managed Care Enrollment is Flat, Apr-19 Data
- Oklahoma Medicaid Enrollment is Flat, Mar-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Flat, Mar-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alabama MMIS Takeover RFB, Mar-19
- Arkansas Expanded Medicaid Evaluation IFB, Apr-19
- Arizona AHCCCS Contract Amendments, 2018-19
- Georgia Department of Behavioral Health and Developmental Disabilities Fiscal Intermediary Services RFP, May-19

- Missouri Medicaid Organization Assessment and Recommendations RFP, Apr-19
- South Dakota Medicaid Enterprise Prior Authorization, Utilization Management and Care Management Information System RFP, May-19

Medicaid Program Reports, Data and Updates:

- Arizona LTC Home and Community Based Services Annual Reports, 2012-18
- DC Medical Care Advisory Committee Meeting Materials, Apr-19
- Pennsylvania HealthChoices Databooks, 2018-20
- Pennsylvania HealthChoices HEDIS Performance Measures Rate Charts, 2015-18
- Pennsylvania Managed Care External Quality Review Reports, 2018
- Virginia Medicaid Recipients by Eligibility Category, May-19

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

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

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