

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... July 31, 2019



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IN FOCUS

CMS MEDICARE FEE-FOR-SERVICE FY2020 PROPOSED RULES: HOSPITAL OUTPATIENT DEPARTMENT AND END-STAGE RENAL DISEASE

This week, our *In Focus* section reviews the new Centers for Medicare & Medicaid Services (CMS) Medicare Fee-For-Service FY 2020 proposed rules. On July 29, 2019, CMS issued the Calendar Year (CY) 2020 proposed rules for the Physician Fee Schedule (PFS), the hospital outpatient department (HOPD) and ambulatory surgical center (ASC) prospective payment systems (PPS), and

the End-Stage Renal Disease (ESRD) PPS. These proposed regulations include payment rate and policy changes for the upcoming calendar year. The comment deadline for all three of these proposed rules is September 27, 2019.

In addition, on July 11, 2019, CMS issued the FY 2020 proposed rule for the Home Health prospective payment system. This rule regulation includes annual payment changes and other proposed policy changes. The comment deadline for the Home Health proposed rule is September 9, 2019.

Overall, these four Medicare Part B proposed rules include favorable payment rate updates across each of the provider types impacted by these regulations. Among the most notable policy changes are proposals to: require price transparency, employ prior authorization for some procedures, and permit knee replacements in the ASCs setting in the hospital outpatient proposed rule; implement a new Medicare Part B benefit which provides coverage and reimbursement for opioid treatment centers, develop and implement a cost reporting process for ambulance suppliers and providers in the physician fee schedule proposed rule; and reintroduce a competitive bidding program for Durable Medical Equipment (DME) in the ESRD/DMEPOS proposed rule. In addition, across many of the regulations CMS demonstrated a continued interest in creating bundled payments.

This week we review the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule and the End-Stage Renal Disease (ESRD) and Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) proposed rule. Next week, on July 7, 2019, our *In Focus* will review the Physician Fee Schedule (PFS) proposed rule and the Medicare Home Health proposed rule.

2020 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule Highlights

Hospital outpatient and ambulatory surgical center payment provisions

CMS proposed to update the Hospital Outpatient Prospective Payment System (OPPS) payment rates by 2.7 percent, which is projected to increase OPPS payments to providers by more than \$6 billion. This is a larger increase than the 1.35 percent update implemented for CY 2019.

CMS also proposed to update ASC payment rates by 2.7 percent, which is projected to increase ASC payments by \$200 million. This increase is larger than the 2.1 percent update implemented in 2019.

Price transparency for hospitals

CMS proposed to implement the President's executive order requiring each hospital to establish and update publicly a yearly list of the hospital's standard charges for inpatient and outpatient items and services furnished. CMS solicits comments on how charges should be defined. As it applies to this provision, CMS proposed to define a hospital as any institution licensed by a state as a hospital, which would include acute care hospitals, critical access hospitals, long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, and sole community hospitals. CMS proposed that hospitals must make their charges for all items and services available online in a machine-readable format. CMS also proposed that, for 70 services CMS selects and another 230 services the hospital may select (referred to as "shoppable items"), hospitals must provide charge data in a consumer-friendly format which enables patients to compare charges across hospitals. Hospitals would be held accountable for non-compliance with this requirement through application of civil monetary penalties of \$300 per day.

Prior Authorization Requirements

In a departure from current Medicare FFS policy, CMS proposed to implement prior authorization requirements for certain outpatient services. As proposed, prior authorization would be required for five outpatient procedures: Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation. CMS asserts that prior authorization policy for these services will be effective for controlling increases in volume in instances when these cases are not medically necessary. CMS proposed that providers must submit the prior authorization request to CMS, and CMS would have 10 business days to issue a decision. The five procedures for which prior authorization would be required specifically implicated 40 different procedures typically paid for under the OPSS. Prior authorization requirements would not apply to these five procedures in the inpatient setting.

ASC-covered procedures list modifications

CMS proposed to add total knee arthroplasty, knee mosaicplasty, and three coronary intervention procedures to the ASC-covered procedures list, which enables procedures to be conducted in ASCs. The coronary procedures include percutaneous transcatheter placement of intracoronary stents as well as drug-eluting stents, and percutaneous transluminal coronary angioplasty. In addition, CMS seeks comment on how the agency could redesign the role of the ASC-covered procedures list to improve physicians' ability to determine the setting of care as appropriate for a given beneficiary.

340B Drugs

For drugs acquired through the 340B Program, CMS proposed to continue to pay an adjusted amount of the Average Sales Price (ASP) minus 22.5 percent in CY 2020 for certain separately payable drugs or biologicals acquired through the 340B Program. CMS is also seeking comment on alternative payment options and potential remedies for both CY 2020 payments and the ongoing legal dispute regarding CY 2018 and CY 2019 340B payments. CMS specifically requests comment of the alternative payment option of using average sales price (ASP) plus 3 percent for OPSS payment for 340B-acquired drugs.

Inpatient-only procedures list modifications

CMS proposed to remove total hip arthroplasty from the inpatient-only list, making it eligible to be paid by Medicare in both the hospital inpatient and outpatient settings. In addition, CMS proposed that procedures removed from the inpatient-only list will be excluded from CMS' audit of short inpatient stays for the first year following exclusion. During this time period, these procedures will also not be subject to the 2-midnight rule, which requires that cases be in the hospital for at least two midnights in order to be deemed by auditors as an appropriate inpatient case.

Rural health policies

As in prior years, CMS proposed to apply the post-reclassification wage index changes proposed (and not finalized as of August 1, 2019) as a part of the FY 2020 Hospital Inpatient Prospective Payment System (IPPS) to OPSS payment rates and the OPSS copayment standardized amount. The inpatient policy proposal included increasing the wage index for hospitals with a wage index value below the 25th percentile, removing urban to rural hospital reclassifications from the calculation of the IPPS rural floor wage index value, and implementing a five-percent cap on any decrease in a hospital's wage index from its final wage index for FY 2019. HMA's summary of the FY 2020 IPPS proposed rule is available [here](#).

CMS is also proposing to change the level of supervision of outpatient therapeutic services in hospitals and Critical Access Hospitals (CAHs) from direct supervision to general supervision, which means that a procedure must be furnished under a physician's overall direction and control, but that physician's presence is not required during the procedure.

Hospital outpatient device pass-through payments

Similar to CMS's proposed modifications to the inpatient PPS new technology add-on payments (NTAP), CMS proposed to reduce the requirement that new technologies applying for outpatient PPS pass-through payments demonstrate "substantial clinical improvement" in order to yield the additional payment.

Organ Procurement and Transplant Center Regulations

In an effort to provide clarity to providers and improve accuracy of performance measurement for Organ Procurement Organizations (OPOs), CMS proposed to revise the definition of "expected donation rate" to match the definition set forth by the Scientific Registry of Transplant Recipients and to provide OPOs with additional time to comply with the change. CMS is also seeking public comment on potential revisions to the OPO Conditions for Coverage and transplant center Conditions of Participation, as well as the validity, reliability, and appropriateness of two potential outcome measures for OPOs.

Hospital outpatient and ambulatory surgical center quality reporting programs

Under the Hospital Outpatient Quality Reporting (OQR) program, CMS proposed removing one web-based measure for Calendar Year (CY) 2022 (External Beam Radiotherapy for Bone Metastases, OP-33) because the costs associated with the measure outweigh the benefit of its use. CMS also requested comment on the concept of integrating 4 patient safety measures used as a part of the ASC Quality Reporting Program (ASCQR) into the OQR. Under the ASCQR, CMS also requested input on the future use of these 4 patient safety measures in the ASCQR.

2020 End-Stage Renal Disease (ESRD) and Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Proposed Rule Highlights

ESRD payment provisions

CMS proposed a 2 percent increase to the FY 2020 ESRD PPS bundled base rate, increasing the per dialysis treatment rate by \$5 to \$240.27. Including the base rate increase and the various payment adjustments, net payments will increase 1.6 percent for all ESRD facilities and 1.9 percent for hospital-based ESRD facilities. This increase accounts for standard annual updates to the wage index and outlier calculations. Updates made to the outlier calculations will likely increase payments for ESRD beneficiaries requiring higher resource utilization.

Changes to ESRD add-on payment adjustment policies

- *Transitional Drug Add-on Payment Adjustment (TDAPA)*: CMS proposed to exclude certain drugs approved by the FDA from being eligible for the TDAPA in an effort to reduce spending related to the TDAPA. Specifically, CMS proposed to exclude generic drugs from the TDAPA as well as drugs in the following FDA classifications: Type 3 (drugs with new dosage instructions), Type 5 (drugs with new formulations or other differences), Type 7 (drugs previously marketed but without an approved NDA), Type 8 (drugs that have transitioned to over-the-counter), and other combinations of FDA classification types. CMS also proposed to reduce the basis of TDAPA payment for calcimimetics from the average sales price (ASP) plus 6 percent to 100 percent of ASP. In addition, CMS proposed to no longer apply the TDAPA for a new renal dialysis drug or biological product if the ASP data they possess from the manufacturer does not represent a full calendar quarter of data and is more than two calendar quarters from the date payment.
- *New add-on for renal dialysis equipment and supplies*: CMS proposed to create a new add-on payment for new renal and dialysis equipment and supplies, called the transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES). To be eligible for this add-on CMS proposed that the equipment and supplies must 1) possess FDA marketing authorization on or after January 1, 2020, 2) demonstrate substantial clinical improvement, 3) be commercially available, and 4) have an active application for a Healthcare Common Procedure Code System (HCPCS) code. CMS proposed that the payment made to providers for TPNIES would be based on 65 percent of the price established by the Medicare

Administrative Contractor (MAC). Technologies approved for the TPNIES would be eligible for the add-on payments for two calendar years.

- *Termination of the erythropoiesis-stimulating agent (ESA) monitoring policy:* CMS proposed to terminate the ESA add-on payments because ESAs are now bundled into the per treatment payment and the agency believes the incentive for overutilization are eliminated for these services.

ESRD quality incentive program

CMS proposed no changes to the ESRD quality incentive program for CY 2020 or 2021, but proposed several updates to the program for 2022 and 2023. Specifically, CMS proposed process improvements to enable new ESRD facilities to participate in the ESRD QIP sooner, converting certain clinical measures into a reporting measure, and codifying certain data submission requirements for ESRD facilities and requirements for the Extraordinary Circumstances Exception to reporting data.

Acute kidney injury (AKI) payment provisions

CMS proposed a two percent increase to the AKI PPS bundled base rate to \$240.27, equal to the update to ESRD payment rates.

DMEPOS payment provisions

CMS proposed the reintroduction of competitive bidding into the DMEPOS for CY 2020. The agency asserts this proposal will improve the framework and basis for identifying comparable items and will improve the transparency and predictability of Medicare payments for new DMEPOS items. Specifically, CMS proposed to create a structure for comparing new and existing DMEPOS items. Items would be compared using five categories: physical components, mechanical components, electrical components, function and intended use, and additional attributes and features. CMS proposed that new items identified as similar to existing items, would be paid using the fee schedule amounts of the existing items. Payment rates for items identified as original would be determined either by assessing commercial pricing data or through technology assessments that evaluate the relative costs of the newer DMEPOS items. In addition, CMS proposed to make a one-time adjustment to the fee schedule amounts determined through technology assessments if the item's price declined by 15 percent or more over 5 years. CMS did not propose a corresponding payment increase when payment amounts established through technology assessments prove too low over time.

DMEPOS conditions of payment

CMS proposed to streamline the requirements for ordering DMEPOS items and consolidate three existing DMEPOS item conditions-of-payment lists into one Master List of items that could be subject to face-to-face encounters and written orders and/or prior authorization requirements.

HMA continues to analyze these proposed rules and will provide more detailed analyses evaluating the impacts of key CMS Part B proposals in the coming weeks. For more information or questions about these proposed Part B rules and HMA's Medicare Practice, please contact [Mary Hsieh](#) or [Jon Blum](#).



HMA MEDICAID ROUNDUP

Colorado

Colorado Holds Stakeholder Meeting on Design of Public Option Health Plan. *The Colorado Sun* reported on July 30, 2019, that Colorado officials held a stakeholder meeting concerning the design of a public option health plan, an initiative passed by state lawmakers this year. Insurance Commissioner Michael Conway and Medicaid department head Kim Bimestefer led the meeting, which was the fifth of 11 scheduled across the state. Key themes from stakeholders included sustainability, simple benefit designs, cost transparency, and continued choice of private insurance options. Conway and Bimestefer will hold stakeholder meetings through August, with draft recommendations expected in September and a final plan due in November. [Read More](#)

Florida

Agency Disagrees With Audit Alleging Improper Medicaid Payments. *Sayfie Review* reported on July 29, 2019, that the Florida Agency for Health Care Administration (AHCA) Secretary Mary Mayhew disagreed with a federal audit that found the state made \$436 million in improper Medicaid payments to Jackson Memorial Hospital, the country's largest public hospital. Mayhew said that Jackson Memorial Hospital's ability to serve the poor and uninsured will be impacted if it has to refund the money. [Read More](#)

Another MCO Withdraws Healthy Kids Award Protest. On July 26, 2019, WellCare/Staywell Kids withdrew its protest against the Florida Healthy Kids (FHK) awards, days after Centene/Sunshine State Health Plan withdrew its own protest. The state had awarded incumbent plans Coventry/Aetna and Anthem/Simply Healthcare Plans statewide awards and South Florida Community Care Network/Community Care Plan an award for Regions nine, 10, and 11.

Florida May Be Called to Repay \$436 Million in Medicaid Funds. *Politico* reported on July 26, 2019, that the Health and Human Services (HHS) inspector general could call on Florida to refund \$436 million in improper Medicaid payments made to Jackson Memorial, the country's largest public hospital, according to a draft audit report. State officials warn that the consequences to the state and Jackson Memorial Hospital could be devastating. The HHS inspector general's office is preparing the report on the matter, but it is unclear when a final report will be issued. [Read More](#)

Medicaid Ballot Initiative May Be Delayed Until 2022. *Health News Florida* reported on July 25, 2019, that the Florida Medicaid expansion ballot initiative may be delayed until 2022 as advocacy organizations determine if they have enough resources to make it on the 2020 ballot. Getting an amendment on the ballot can cost millions of dollars and advocates would need to secure about 700,000 more signatures. Florida Decides Healthcare, Inc., a political committee backing the proposed constitutional amendment, has said the proposed amendment is not being withdrawn. [Read More](#)

Illinois

Governor Vetoes Bill Aimed at Limiting His Administration's Ability to Seek Medicaid Waivers. *Crain's Chicago Business* reported on July 26, 2019, that Illinois Governor J.B. Pritzker vetoed a bill (SB 2026) that would have limited his administration's ability to seek federal waivers that could reduce access to Medicaid. Pritzker cited the need for flexibility. [Read More](#)

Kentucky

Kentucky AG Clears Evolent Health Acquisition of Passport Health Plan. *WDRB* reported on July 29, 2019, that Kentucky Attorney General Andy Beshear has approved publicly-traded Evolent Health's proposed acquisition of not-for-profit Passport Health Plan for \$70 million. The deal, which would give Evolent a 70 percent controlling stake in Passport, still requires approval from the Kentucky Finance and Administration Cabinet, Department of Insurance and federal regulators. [Read More](#)

Missouri

Governor Names Chief of Medicaid Transformation. *The St. Louis Post-Dispatch* reported on July 31, 2019, that Missouri Governor Mike Parson has named former Republican representative Kirk Mathews as the state's Medicaid chief transformation officer. The newly created position will oversee a recommended overhaul of the state's Medicaid program, aimed at realizing projected savings of \$1 billion annually. [Read More](#)

New Hampshire

Medicaid Work Requirements Are Blocked by Federal Judge. *WMUR/Associated Press* reported on July 29, 2019, that a federal judge blocked a Medicaid waiver request that would impose work requirements on Medicaid expansion beneficiaries in New Hampshire, again citing concerns over potential loss of coverage. U.S. District Judge James E. Boasberg in Washington made similar rulings in cases involving Kentucky and Arkansas, decisions the Trump administration has appealed. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

New York-based Oscar and Montefiore Health System Team Up to Offer Medicare Advantage Plan. New York-based health insurer Oscar and Montefiore Health System announced on July 17, 2019, that they will launch a co-branded Medicare Advantage plan beginning in 2020. Oscar is a technology-driven health insurance startup founded in 2012. Oscar currently operates in the individual and small group markets in New York. Montefiore Health System is an academic health system in New York comprised of 10 hospitals and more than 200 outpatient ambulatory care sites, as well as its medical school, Albert Einstein College of Medicine. Montefiore is a fully integrated healthcare delivery system.

Oscar first announced that it would be entering the Medicare Advantage Market in August 2018. Plans beginning January 1, 2020, pending regulatory approval, will be available during the Medicare Advantage Annual Election Period, from October 15 to December 7, 2019. Oscar will also offer a new Medicare Advantage plan in Houston, TX. [Read More](#)

New York Comptroller Releases Audit of OMH Performance on Incidence Reporting. New York enacted a law in 2007 to expand parents', guardians', and other qualified persons' access to records relating to incidents involving family members residing in facilities operated by the Office for People with Developmental Disabilities, the Office of Mental Health (OMH), or the Office of Alcoholism and Substance Abuse Services. The law was enacted in response to the death of a resident in a state facility. The law requires that state facilities provide telephone notification within 24 hours of an incident report; provide written copies of the incident report; provide a meeting with family members; and provide a written report of actions taken to address the incident.

A recent audit by the New York State Comptroller's office found that OMH has not implemented processes to effectively monitor whether facilities are complying with the law's requirements. The audit also found that facilities do not always provide all records to qualified persons when requested and are not providing them within the required time frame. The report recommends that OMH provide updated guidance on facility responsibility to share information on incidents and require that facilities implement them. [Read More](#)

NYS Health Foundation Releases Report on Health Care Spending. The NYS Health Foundation released a report in July 2019, examining health care spending in New York. The report finds that per person spending in New York State was higher than the national average in each year from 2013 to 2017. Per-person spending also grew faster in New York during the five-year period than almost all other states. The report notes that New York spends more money on professional services (such as doctors visits), inpatient services, and prescription drugs, but less on outpatient services relative to national spending. The report concludes that price growth was the primary driving factor in health care spending. Inpatient prices increased twice as much in New York than across the U.S., on average. Increases in drug prices were substantially higher in New York, even though there was also a larger shift from brand name to generic drugs in New York. [Read More](#)

Medicare Rights Center Releases Toolkit for New York Dual Eligibles. The Medicare Rights Center has posted a new toolkit on its website explaining the various coverage options available for New York beneficiaries eligible for both Medicare and Medicaid (dual-eligibles). The toolkit covers the following topics:

- Transitions for beneficiaries currently enrolled in New York's Fully Integrated Duals Advantage (FIDA) program, which is ending December 31, 2019
- Dual-eligible Special Needs Plans (D-SNPs) and Medicaid Advantage
- Options for beneficiaries who need long-term care, such as Medicaid Advantage Plus (MAP) and the Program of All-Inclusive Care for the Elderly (PACE)
- Decision-making for special populations [Read More](#)

New York Announces Statewide Health Care Facility Transformation Program Awards. New York Governor Cuomo announced on July 31, 2019, a new round of awards under the Statewide Health Care Facility Transformation Program. This round of funding was awarded pursuant to a 2019 amendment to the Statewide Health Care Facility Transformation Program, which authorized the Department of Health to allocate up to \$300 million of the \$525 million of Health Care Facility Transformation Program funds authorized in the fiscal 2018-19 budget to support project applications that were not awarded grants during the previous round of funding announced in February 2019. Awards totaling \$187 million were made to 25 health care providers across the state. The largest award, for \$29 million, went to St. John's Riverside Hospital, for debt retirement "to better position the organization for long-term sustainability." In fact, the five largest grants were all provided for debt retirement, part of the state's effort to downsize and consolidate the hospital sector. Only four New York City facilities were awarded, representing eight percent of the awards. Additional awards from this funding cycle will be announced in coming months. A Requests for applications for the next round of Health Care Facility Transformation Program awards will be issued later this year. [Read More](#)

Ohio

Medicaid Enrollment Declines, Uninsured Rate Rises. *The Columbus Dispatch* reported on July 30, 2019, that enrollment in Ohio Medicaid has dropped 8 percent, or 250,000, over the past two years. An improving economy and a time-consuming, automated Medicaid enrollment and renewal process drove the decline, according to Medicaid director Maureen Corcoran. Meanwhile, the state's uninsured rate for adults age 18 to 64 with incomes under 138 percent of poverty has reached 14.4 percent. [Read More](#)

Oklahoma

Medicaid Director Announces Retirement. Oklahoma Health Care Authority (OHCA) chief executive and state Medicaid director Rebecca Pasternik-Ikard announced on July 30, 2019, that she will be retiring, effective October 1, 2019. Previously, Pasternik-Ikard served as an assistant attorney general for Oklahoma. She joined OHCA as chief executive in October 2016. [Read More](#)

Lawmakers Are Expected to Reconsider Medicaid Expansion. *The Tahlequah Daily Press* reported on July 26, 2019, that Oklahoma lawmakers are expected to reconsider Medicaid expansion during the next legislative session. The issue has gained urgency as advocacy group Oklahomans Decide Healthcare will begin collecting signatures for a Medicaid expansion ballot measure in 2020. Acknowledging that a ballot initiative would have a good chance of passing, some Oklahoma lawmakers expressed concern that their ability to impose conditions on participation through a Medicaid expansion waiver might be limited if the measure passes through a ballot initiative. [Read More](#)

Oklahoma Signature Gathering for Medicaid Expansion Ballot Initiative Starts July 31. *The Tulsa World* reported on July 23, 2019, that Oklahoma Secretary of State Michael Rogers has announced July 31 as the start date for gathering signatures for a Medicaid expansion initiative petition. A total of 178,000 valid signatures need to be submitted in a 90-day window in order for Medicaid expansion to get on the ballot in 2020. [Read More](#)

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

Medical Assistance Advisory Committee Held on July 25. At the Pennsylvania Medical Assistance Advisory Committee (MAAC) meeting held on July 25, 2019, the Pennsylvania Department of Human Services (DHS) provided status updates on the following:

Office of Medical Assistance Programs (OMAP) Updates: Due to the passage of Senate Bill 695, the request for applications (RFA) for the Medical Assistance Transportation Program is on hold pending an analysis to be completed in 180 days. Additionally, the recently passed state budget requires an evaluation of the financial impact of the Preferred Drug List (PDL), but that will not stop the recommended PDL process. The PDL evaluation is expected by the end of August.

Office of Long-Term Living (OLTL) Update: A draft enrollment services RFA was release for public comment. The final RFA will incorporate comments and be published in September for a 45-day bidding period.

Office of Mental Health and Substance Abuse Services (OMHSAS) Update: The Pennsylvania demonstration for Certified Community Behavioral Health Clinics (CCBHCs) ended in June and to date there has been no federal extension of the program.

Utah

Partial Medicaid Expansion Rejection Disappoints Conservative States. *The Associated Press* reported on July 29, 2019, that some conservative states are disappointed by the Trump administration's rejection of a proposed Utah Medicaid waiver, which would have given the state a 90 percent federal funding match for expanding Medicaid eligibility up to 100 percent of poverty. Some conservative states had considered the Utah waiver a compromise alternative to full expansion. [Read More](#)

Utah Faces Rejection of Partial Medicaid Expansion Waiver Proposal. *The Salt Lake Tribune* reported on July 27, 2019, that the Trump administration is expected to reject a waiver proposal that would have allowed Utah to expand Medicaid up to 100 percent of the federal poverty level and still receive a 90 percent federal funding match. A rejection would trigger state legislation requiring Utah to pursue a full expansion. [Read More](#)

National

CMS Says Average Medicare Part D Premiums Will Continue to Decline in 2020. The Centers for Medicare & Medicaid Services (CMS) announced on July 30, 2019, that the average basic premium for Medicare Part D prescription drug plans is projected to decline to \$30 in 2020, down for the third consecutive year from \$34.70 in 2017. Enrollment has increased 12.2 percent since 2017. [Read More](#)

Congress Sends Short-Term Medicaid Funding Bill to President. CQ reported on July 31, 2019, that Congress cleared a bill to temporarily extend funding for a variety of Medicaid programs, including the Certified Community Behavioral Health Clinics Demonstration and programs involving spousal impoverishment, substance abuse treatment, Money Follows the Person, and health information centers for families with complex medical conditions. The bill now heads to President Trump.

Democratic Presidential Hopefuls Debate Medicare For All. *The New York Times* reported on July 30, 2019, that the Democratic presidential primary debate highlighted political divisions among candidates over health care. Senators Bernie Sanders (D-VT) and Elizabeth Warren (D-MA) defended their versions of Medicare for All, which includes replacing private health plans with a single-payer system. [Read More](#)

GAO Report Highlights Disparities in DSH Payments. *Modern Healthcare* reported on July 29, 2019, that the Government Accountability Office has released a report detailing funding disparities in the Medicaid disproportionate share hospital (DSH) payment program. The report noted, for example, that DSH payments account for 0.7 percent of Medicaid funding in Tennessee, but make up nearly 97 percent of funding in Maine. Of the \$18 billion of federal and state DSH payments, approximately 51 percent go toward offsetting uncompensated care costs incurred by hospitals. [Read More](#)

Trump Administration Issues Proposal for Increased Transparency in Hospital Prices. *The Hill* reported on July 29, 2019, that the Trump administration is moving to implement an executive order that would force hospitals to reveal prices they charge for all supplies, tests, and procedures, including rates negotiated with insurance companies. The proposed rule, issued by the Centers for Medicare & Medicaid Services, would take effect in 2020 and impact more than 6,000 hospitals. President Trump signed the executive order in June. [Read More](#)

Senate Passes Short-Term Extension of Medicaid Behavioral Health Clinic Demonstration. *Modern Healthcare* reported on July 26, 2019, that the U.S. Senate has approved a \$60 million, two-month extension of the Medicaid-certified community behavioral health clinic (CCBHC) demonstration program, which funds innovative mental health and substance abuse treatment centers in eight states. Initial funding of \$1 billion ran out on July 14. [Read More](#)

Senate Republicans Back Away From Drug Pricing Legislation. *Kaiser Health News* reported on July 25, 2019, that Republican lawmakers in the Senate Finance Committee are backtracking on bipartisan legislation to curb rising prices of prescription drugs. Although the Committee passed the proposal on a 19-9 vote, Senate Republicans fear the bill transfers too much power to the federal government, too harshly imposes caps on drug costs, and establishes protections on pre-existing conditions. [Read More](#)

Senate Passes Short-term Funding for Mental Health Pilot. *Politico* reported on July 26, 2019, that the Senate passed an amendment to HR 3253 to provide \$60 million in funding to keep a Medicaid mental health and addiction services pilot operating through September 13. The \$1 billion pilot program provides additional Medicaid funding to nearly 80 clinics across eight states that integrate mental health and addiction treatment into primary care. The National Council for Behavioral Health, the organization that provides technical assistance to the centers, estimates 300,000 people could lose access to services without the program. [Read More](#)

House Sees First Bill on Social Determinants of Health. *Modern Healthcare* reported on July 25, 2019, that a bipartisan group of lawmakers, led by House Representatives Cheri Bustos (D-Illinois) and Tom Cole (R-Oklahoma), introduced the first bill targeting social determinants of health. The bill aims to establish a multi-agency council and fund \$25 million in grants for "Social Determinants Accelerator Plans." The plans would target specific Medicaid populations, such as the homeless population, elderly nursing home residents, and women with postpartum depression. [Read More](#)

Kamala Harris Unveils Medicare-for-All Plan With Both Public, Private Options. *Politico* reported on July 29, 2019, that U.S. Senator Kamala Harris (D-CA) unveiled a Medicare-for-All proposal, which would allow individuals to choose between buying into traditional Medicare or purchasing a Medicare Advantage plan offered by a private insurance company. The plan would be phased in over a decade. Detailed cost projections were not included in the plan's announcement. [Read More](#)

Home-Delivered Meals Can Save Medicare Millions, Report Finds. *The Associated Press* reported on July 25, 2019, that Medicare could save nearly \$57 million if it offered free home-delivered meals to beneficiaries recently discharged from hospitalization, according to a report released by the Bipartisan Policy Center. The report demonstrated that providing home-delivered meals could avoid about 10,000 costly hospital re-admissions. Although Medicare Advantage plans have already implemented similar supplemental support services to select patients, two out of three beneficiaries do not have such access in traditional plans. [Read More](#)

Trump Administration Considering Executive Order to Slash Prescription Drug Prices. *Reuters* reported on July 24, 2019, that the Trump administration is preparing an executive order to implement pricing controls on prescription drugs sold to Medicare and other government health programs, according to industry sources. In 2016, the United States spent nearly \$29 billion on Part B drug expenses and around \$100 billion in Part D. The White House declined to comment upon the progress of the order, but the administration could delay an announcement if the Senate Finance Committee's recent drug pricing proposal garners enough bipartisan support. [Read More](#)

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Widening the Lens: Treatment for Alcohol and Stimulant Use Disorders. On August 8, 2019, from 3:00 PM - 4:30 PM EDT, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program's (IAP) Reducing Substance Use Disorder (SUD) program area is holding a webinar on the topic of broadening the national focus from opioid use disorder (OUD) to address alcohol and stimulant use disorders. In this webinar, participating states will learn about strategies for the treatment of alcohol use disorder (AUD), including medication-assisted treatment and AUD treatment coordinated with primary care. The webinar speakers will also provide an overview of treatment issues regarding stimulant use disorder such as patient retention and evidence-based models. Lastly, the webinar will walk participants through California Medicaid program's efforts to build a robust treatment delivery system to broadly address substance use disorders. *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 (IAP). 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](#).

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Demonstrating the Impact of Supportive Housing. On August 7, 2019, from 2:00 PM - 3:30 PM EDT, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program (IAP) is hosting a national learning webinar. During this webinar, a framework and measures to demonstrate the impact of supportive housing will be presented. The webinar includes a discussion on the benefits of undertaking this type of work, as well as specific measures used across the country to assess the impact that providing supportive housing can have on health care utilization costs, homelessness, criminal justice, and other systems. Participants will also learn about tips to get started measuring supportive housing impact and considerations for working with outcomes data. Two state Medicaid directors will serve as webinar respondents and will share information about their states' work in measuring the impact of supportive housing and the importance of state Medicaid-housing partnerships in developing supportive housing options for Medicaid beneficiaries. *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 (IAP). 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

UHS Reaches Behavioral Health Civil Settlement for \$127 Million. *Modern Healthcare* reported on July 25, 2019, that hospital management firm Universal Health Services (UHS) has agreed to pay \$127 million as part of a civil settlement against its behavioral health facilities. The settlement is subject to federal approval and a corporate integrity agreement with the Office of Inspector General for the United States Department of Health and Human Services. [Read More](#)

Active Day Acquires Bridges Rehabilitation Services in Ohio. Active Day announced on July 1, 2019, the acquisition of Ohio-based Bridges Rehabilitation Services, including four rehabilitation centers and fifteen community sites in the Cuyahoga and Summit counties, as well as certain non-emergency transportation (NEMT) services. Active Day, a provider of personalized care to seniors and adults with special needs, already had seven centers in the state.

LHC Group to Acquire VNA Home Health of Maryland. LHC Group announced on July 30, 2019, that it has entered into an agreement to acquire a Baltimore-based home health and home and community-based services (HCBS) provider from VNA of Maryland and Elite Home Care Services. The home health provider will continue to operate as VNA of Maryland and the HCBS provider will operate as Maryland Private Care. The deal is expected to close on September 1, 2019. [Read More](#)

High Medicaid Costs Impact Anthem Shares. *Reuters* reported on July 24, 2019, that Anthem shares fell by about 4 percent as a result of higher medical costs in its Medicaid health plans across certain states. [Read More](#)

Home Care Solutions Leader Sandata Secures Significant Investment from Silicon Valley Private Equity Firm. Silicon Valley-based investment firm Accel-KKR announced on July 24, 2019, that it has provided a significant growth equity investment to Sandata Technologies, LLC, a provider of home health technology solutions and Electronic Visit Verification. With the investment, Sandata aims to grow within the U.S. home care market while investing in product innovation and customer support. [Read More](#)

Five Arrows Capital Partners Announces Partnership with Averhealth. Averhealth, a leading provider of substance use disorder treatment monitoring, care management, and related support services, announced on July 25, 2019, that it has partnered with private equity firm Five Arrows Capital Partners (FACP) to provide access to capital and opportunities for growth. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
July 2019	Louisiana	Awards	1,500,000
July 19, 2019 (delayed)	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019 (delayed)	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 2019	Ohio	RFI #2 Release	2,360,000
August 30, 2019	Texas STAR+PLUS	Awards	530,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
September 1, 2019	New Hampshire	Implementation	181,380
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Implementation	~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 - March 2020	Ohio	RFP Release	2,360,000
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
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	85,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
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

COMPANY ANNOUNCEMENTS

How Can Artificial Intelligence Be Applied to Healthcare in the Future?

HMA NEWS

MAT Issue Brief Addresses Objections and Misconceptions. A new issue brief authored by HMA Principal Donna Strugar-Fritsch, MPA, BSN, dispels myths about, and objections to, the use of medication-assisted treatments (MAT) to treat opioid addiction. The brief is a clear and concise look at MAT, how and why it works, and what its use can mean for those impacted by opioid use disorder. [Read More](#)

[New this week on HMA Information Services \(HMAIS\):](#)

Medicaid Data

- Medicaid MLTSS Activity Map, Jul-19
- Arizona Medicaid Managed Care Enrollment is Up 0.6%, Jul-19 Data
- Iowa Medicaid Managed Care Enrollment is Up 5.3%, Jul-19 Data
- Indiana Medicaid Managed Care Enrollment is Down 0.5%, Jun-19 Data
- Maryland Medicaid Managed Care Enrollment Is Up 0.9%, May-19 Data
- Nebraska Medicaid Managed Care Enrollment Is Down 0.6%, Jun-19 Data
- Washington Medicaid Managed Care Enrollment is Up 1.4%, Jun-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- California Medicaid Pharmacy Services (Medi-Cal Rx) Draft RFP, Jul-19
- Florida Healthy Kids Medical Services and Coverage ITN, Awards, Protests, and Related Documents, 2018-19
- Florida Medicaid Managed Care Alternative Automatic Assignment Methodology RFI, Jul-19
- Idaho Project Management Office for a Modular MMIS RFP, Jul-19
- Louisiana Health Information Technology (HIT) Innovation RFI and Responses, 2019
- Ohio Transition Coordination for HOME Choice Program RFGA, Mar-19
- Rhode Island Medicaid RItE Smiles Program LOI and Awards, 2014

Medicaid Program Reports, Data and Updates:

- Idaho Dual Eligibles Stakeholder Presentations, Apr-19
- Idaho Medicaid Strategic Plan and Annual Key Initiatives, 2019
- Illinois Medicaid Annual Reports, 2013-18
- Indiana Division of Aging HCBS Waiver Rate Review Stakeholder Meeting Materials, Jun-19
- Louisiana Managed Care External Quality Review Technical Reports, 2017-18
- Missouri Medicaid Rate Update Dental Services, Jul-19
- North Carolina Medical Care Advisory Committee Meeting Materials, Jul-19
- Ohio Medicaid Buy-In for Workers with Disabilities Program Report, Mar-19
- Ohio Medicaid Enrollment by Eligibility Category, Jun-19
- Oklahoma Medicaid Enrollment by Age, Race, and County, Jun-19 Data
- Oregon CCO Metrics Final Reports, 2017-18
- Oregon Medicaid Dental Health Service Delivery by Plan and by Select Demographics, Jun-19

- Oregon Medicaid Mental Health Service Delivery by Plan and by Select Demographics, Jun-19
- Oregon Medicaid Physical Health Service Delivery by Plan and by Select Demographics, Jun-19
- Texas Medicaid CHIP Data Analytics Unit Quarterly Reports, Jul-19
- Utah Medical Care Advisory Committee Meeting Materials, Jul-19
- Virginia Medallion 4.0 and CCC Plus Medicaid Operations Analysis, 2017-19
- Virginia Medicaid Expansion Enrollment Dashboard, Jul-19
- Wyoming Department of Health Medicaid Expansion Enrollment and Cost Projections Report, 2018

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:

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