HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 18, 2019

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

THIS WEEK

IN FOCUS

THE FUTURE OF THE ACA: IMPLICATIONS OF 5TH CIRCUIT DECISION IN TEXAS V. U.S.

This week, our *In Focus* section reviews *Texas v. United States.*, the most recent legal challenge to the Affordable Care Act (ACA). In July 2019, the United States Court of Appeals for the 5th Circuit heard oral arguments in the case and is reviewing the decision of United States District Court for the Northern District of Texas (District Court). The District Court ruled that the "individual mandate" provision of the ACA is unconstitutional as a result of the 2017 Tax Cuts and Jobs Act (TCJA) zeroing out of the tax penalty for not having health

insurance and, consequently, that the entire ACA should be struck down as a result. As the nation awaits the 5th Circuit panel's decision, this article discusses background, next steps in the court process, and the potential far-reaching implications of this case.

Background and Current Status

In the case of *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court of the United States (Supreme Court) upheld the constitutionality of the ACA's individual mandate by a vote of 5-4. The mandate was implemented by including a tax penalty in the Internal Revenue Code for failure to carry health insurance. The Supreme Court held that the individual mandate was within Congress' power set forth in Article I, Section 8 of the Constitution "to lay and collect taxes," with the majority of the justices also agreeing that the individual mandate was beyond the scope of Congress' authority under either the Commerce Clause or Necessary and Proper Clause.

Through a provision of the TCJA, Congress reduced the tax penalty to zero dollars for individuals opting not to purchase insurance as of January 1, 2019. This led Texas and other states to file a complaint in *Texas v. United States* challenging the continued constitutionality of the individual mandate and, consequently, the entire ACA. The plaintiffs argued that, with no tax penalty, the individual mandate is no longer an exercise of Congress' taxing authority and is therefore unconstitutional. They further argue that, because the individual mandate is not severable from the remainder of the ACA, the entirety of the ACA should be struck down as unconstitutional. The District Court agreed with the plaintiffs' arguments and held that the ACA in its entirety is unconstitutional, concluding that the individual mandate is a critical piece of an intricately designed scheme and, therefore, the entire ACA must fall without it. The District Court specifically discussed pre-existing condition protection, lifetime limits, and other consumer protections, deciding they all had to fall as nothing could be severed from the entire ACA.

What's Next

The 5th Circuit panel's review of the District Court decision will likely lead to a decision before the end of 2019, although the panel could take longer. The panel could agree with the District Court's decision to strike down the entire ACA, agree that the individual mandate is unconstitutional but sever it from the rest of the ACA, or rule that the individual mandate is still a valid exercise of Congress' taxing power as it remains a part of the Internal Revenue Code even though the tax penalty is now zero.

Whoever loses in the 5th Circuit is certain to petition the Supreme Court to take the case. The likelihood of the Supreme Court taking the case varies depending on the 5th Circuit holding. A decision reversing the District Court in its entirety and upholding the law as it stands is less likely to be taken up by the Supreme Court. A decision upholding the District Court in its entirety and striking down the entire ACA would almost assuredly compel the Supreme Court to take up the case. It is difficult to say what the Supreme Court would do with a middle-ground decision that finds the individual mandate unconstitutional when devoid of a tax penalty but severable from the rest of the ACA, as such a decision would have minimal practical impact. In the event that the Supreme Court were to hear the case, our best estimate is that it would likely be by early summer of 2020 given the case's far reaching implications for health care and the United States' economy.

Implications

What makes the District Court decision such a dramatic one is the finding that the individual mandate cannot be severed from the remainder of the vast provisions of the ACA. Upholding the decision, and thus striking down the ACA, would have far-reaching implications, including elimination of the following:

1. Medicaid expansion, which, under the ACA, can include adults up to 138 percent of the federal poverty level (FPL) at the state's option. As of August 1, 2019, 36 states plus the District of Columbia have adopted this expansion option, expanding Medicaid to cover approximately 12 million additional enrollees nationally.
2. Health Insurance Marketplaces (Marketplaces), through which individuals can enroll in health plan coverage and access financial assistance with coverage. The Marketplaces cover approximately 10 million individuals. This would not have as large of an impact on states that have created state-based Marketplaces by essentially codifying many federal ACA Marketplace provisions.
3. Income-based cost-sharing subsidies and premium tax credits for certain individuals who purchase coverage through the Marketplaces. In the 2018 coverage year, 8.9 million individuals received premium tax credits and 5.4 million received cost-sharing reductions (June 2018).
4. Requirement that all plans offering dependent coverage must allow unmarried individuals to remain on their parents' health insurance until the age of 26. This provision has resulted in coverage for 2.3 million young adults. Some states have enacted laws to retain this provision (and the items following in this list) in case the ACA is overturned.
5. Requirement that health plans cover 10 categories of essential health benefits (hospitalization, outpatient, maternity, prescription drugs, mental health, substance abuse treatment, habilitative services, rehabilitative services, pediatric dental, and pediatric vision services), and limit annual cost-sharing on these benefits. Prior to the implementation of these required benefits, 45 percent of plans did not cover substance use disorder treatment and 38 percent did not cover mental health services.
6. Prohibition on all health plans from establishing lifetime or annual limits on essential health benefits. Prior to the ACA, nearly 60 percent of employer-sponsored health plans had a lifetime limit.
7. Protections for pre-existing conditions, including banning discrimination based on health status, only allowing recession of coverage for fraud or misrepresentation, and not permitting variance of premiums based on gender or health status. An estimated 52 million Americans have a pre-existing condition that would have been deniable by insurers prior to the ACA.
8. Requirement that all plans cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention and certain preventive services for children recommended by the Health Resources and Services Administration, without any cost-sharing. As of 2018, an estimated 161 million U.S. residents are covered by Medicaid or commercial insurance plans that must provide free preventive services.

In addition to the eight provisions listed above, striking the ACA would eliminate many other provisions affecting Medicare, Medicaid, commercial health coverage eligibility, and health plan requirements.

Whatever the Outcome, Severability will be at the Heart of the Decision

In *NFIB v. Sebelius*, the Supreme Court declared the mandatory Medicaid expansion in the ACA unconstitutional but severed it from the rest of the law, upholding the rest of the ACA. The United States Court of Appeals for the 11th Circuit (11th Circuit) initially declared the individual mandate unconstitutional before the decision was overturned by the Supreme Court; however, the 11th Circuit also found that the individual mandate could be severed from the rest of the statute. Additionally, the federal and state Marketplaces seem to have stabilized in the absence of an enforceable individual mandate, which would seem to indicate that the mandate is not indispensable to the rest of the ACA. Also noteworthy is the following from Senator Susan Collins' Senate floor speech during Justice Kavanaugh's confirmation process:

> *One concern that I frequently heard was that the judge would be likely to eliminate the Affordable Care Act's vital protections for people with preexisting conditions. I disagree with this. In a dissent in Seven-Sky v. Holder, Judge Kavanaugh rejected a challenge to the ACA on narrow procedural grounds, preserving the law in full. Many experts have said that his dissent informed Justice Roberts's opinion upholding the ACA at the Supreme Court. Furthermore, Judge Kavanaugh's approach toward the doctrine of severability is narrow. When a part of a statute is challenged on constitutional grounds, he has argued for severing the invalid clause as surgically as possible while allowing the overall law to remain intact. This was his approach in a case that involved a challenge to the structure of the consumer financial protection bureau. In his dissent, Judge Kavanaugh argued for "severing any problematic portions while leaving the remainder intact." Given the current challenges to the ACA proponents, including myself, of protections for people with preexisting conditions should want a justice who would take just this kind of approach.*

Finally, the five justices who rejected the first challenge to the ACA in *NFIB v. Sebelius* and who agreed to sever the mandatory Medicaid expansion are all still on the Supreme Court.

In the end, the 5th Circuit decision may lead to the Supreme Court determining the legality of the ACA for a third time. The nation, and essentially one fifth of the economy of the United States, will await the 5th Circuit, and potential Supreme Court, decision.

For more information, please contact HMA's Amber Swartzell, Senior Consultant; Matt Powers, Managing Director MMS; or Nora Leibowitz, Principal. Jim Parker, former HMA Principal, also contributed.

HMA Medicaid Roundup

Arkansas

Anthem Acquisition of Beacon Consolidates Arkansas PASSE Program. *The Arkansas Democrat Gazette* reported on September 15, 2019, that Anthem's proposed acquisition of Beacon Health Options would give the company an ownership stake in health plans controlling more than 75 percent of the Arkansas Medicaid managed care market based on enrollment. Following the acquisition, Anthem would take over Beacon's 16.67 percent stake in Empower Healthcare Solutions, a provider-led Arkansas Shared Savings Entity (PASSE) with about 19,000 Medicaid members. Anthem already owns 49 percent of Summit Community Care, a PASSE with about 45,000 Medicaid members with significant mental illness or developmental disabilities. The state Insurance Department Deputy Commissioner is expected to approve the deal within the next week. Read More

Arkansas NEMT Provider Is Fined $300,000 for Falling Short on Providing Medicaid Rides. *U.S. News/The Associated Press* reported on September 14, 2019, that the Arkansas Department of Human Services, Division of Medical Services has fined its non-emergency medical transportation (NEMT) contractor more than $300,000 for falling short on providing Medicaid patients with rides. Southeastrans was fined $500 for each of the 645 trips it failed to provide in recent months. Southeastrans took over the state's NEMT contract this year from another NEMT company, which had also fallen short on providing rides. Read More

Connecticut

Connecticut Releases RFP for Person-Centered Medical Home Plus Program. On September 6, 2019, the Connecticut Department of Social Services (DSS) released a request for proposals (RFP) from qualified Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, and Advanced Network Lead Entities for the state's Person-Centered Medical Home Plus Program (PCMH+) in Wave 3 (W3). PCMH+ is a care delivery reform initiative for primary care practices. All prospective PCMH+ W3 applicants are required to submit a proposal whether they have participated in Wave 1 or Wave 2. PCMH+ W3 is scheduled to run from January 1, 2020 through December 31, 2021.

District of Columbia

District of Columbia to Rebid Medicaid Managed Care Contracts. On September 11, 2019, the District of Columbia Department of Health Care Finance (DHCF) announced that it will rebid Medicaid managed care contracts as part of a broader effort to fully transition to managed care over the next five years. The new awards are expected in Spring 2020. The new contracts will transition 22,000 additional high cost members into managed care, effective October 1, 2020. Currently, more than 276,000 Medicaid managed care enrollees are served by AmeriHealth Caritas, Anthem/Amerigroup, and Trusted Health Plan, which were awarded contracts in April 2019. The three plans will continue to serve members through fiscal 2020. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Lawmakers Press Medicaid Agency to Curtail Services for the Disabled. *The Miami Herald* reported on September 12, 2019, that health officials from Florida's Agency for Persons with Disabilities (APD) are evaluating cuts to the state's "iBudget" program, a Medicaid waiver program that provides specialized care for more than 30,000 people with disabilities. State lawmakers, frustrated with regular overspending, are pressing APD to curtail costs on the agency's $1.4 billion budget. APD is in the process of formulating a final plan to address the waiver program, which, after gubernatorial review, is due to the Legislature at the end of the month. Read More

Georgia

Walmart Opens First Health Center in Georgia. *Forbes* reported on September 17, 2019, that Walmart opened its first Walmart Health center in Dallas, GA, offering primary care, counseling, home care, eye and hearing exams, and dental services. Walmart already operates 19 "Care Clinics" in Georgia, South Carolina and Texas; however, the health centers offer a broader array of services. A second facility is scheduled to open next year in Calhoun, GA, with others expected in other markets. The health centers occupy 10,000 square feet of space, compared to 1,500 for the Care Clinics. Read More

Idaho

Legislative Committee Wants Counties to Pay Portion of Medicaid Expansion Cost. *Boise State Public Radio/NPR* reported on September 15, 2019, that a legislative committee in Idaho is expected to recommend that counties pay a quarter of the state's voter-approved Medicaid expansion cost in fiscal 2021. Republicans who support the measure believe counties can pay their share through savings in other indigent healthcare costs. Democrats argue the plan will result in higher property taxes. Read More

Michigan

Michigan to Exempt Some Medicaid Members from Reporting Work Requirements. *The Detroit Free Press/Associated Press* reported on September 11, 2019, that Michigan's Republican-led Senate has approved legislation to exempt some Medicaid members from reporting Medicaid work requirements. The bill, which Governor Gretchen Whitmer is expected to sign, would allow Medicaid enrollees ages 19 to 61 to verify compliance with other data. Work requirements take effect in the state January 2020. Read More

Missouri

Missouri Democrats Seek Answers for Medicaid Disenrollment. *The Missourian* reported on September 12, 2019, that Democratic lawmakers are demanding answers as to why nearly 130,000 beneficiaries, about 100,000 of them children, were dropped from Missouri's Medicaid program. Republican Governor Mike Parson and Republican leadership have pointed to economic growth as the chief reason for declining membership in the program, but state Representative Crystal Quade (D-Springfield) has indicated that lower unemployment rates do not account for why 80 percent of disenrolled members are children. Read More

Nebraska

Families Tell Lawmakers to Change Eligibility Standards that Limit Access to Care for Disabled Children. *Live Well Nebraska* reported on September 14, 2019, that Nebraska families are urging a panel of state lawmakers to revise eligibility standards that limit access to care for disabled children. The standards, which took effect earlier this year, make eligibility contingent on whether a child is disabled enough to require institutional care. The services are available to disabled children and adults under a waiver covering health services and long-terms supports, including respite care, special formulas and home modifications. The waiver is designed to keep disabled children and adults out of institutions. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Announces Date for Medicaid Public Comment. The New York State Department of Health announced that it will hold a downstate public comment day for New York's 1115 waiver programs on October 25, 2019, from 11 am to 2 pm, at Baruch College, 55 Lexington Ave, Room 14-220, in New York City. Written public comment may be submitted to 1115waivers@health.ny.gov through November 4, 2019. Comments may address any aspect of NY's Medicaid waiver, including but not limited to the Delivery System Reform Incentive Payment (DSRIP) program. Comments are limited to five minutes per presenter. The meeting will be webcast live here.

New Rate Structure for Consumer Directed Personal Care Challenged in Court. *Crain's Health Pulse* reported on September 17, 2019, that as part of the fiscal 2020 state budget, New York enacted a change in the way fiscal intermediaries (FIs) are reimbursed, moving from a rate structure based on the number of hours of care provided to a member to a fixed per member per month rate structure. Consumer advocates argue that the new rates are inadequate to support the agencies that provide fiscal intermediary services, and should the change be implemented those agencies will be forced out of business, effectively ending the Consumer Directed Personal Care program. Home care and independent living advocates have filed a suit seeking to block implementation of the change, arguing that the Department of Health is knowingly creating a Medicaid reimbursement structure for the FI's administrative costs that would bankrupt them, which violates numerous federal mandates. An Albany County Supreme Court judge heard arguments on the case on September 17. Counsel for the Consumer Directed Personal Assistance Association of New York State argued before the judge that the new rates for FIs are below their required costs of doing business, and that changes to the payment methodology are unconstitutional, as they were not completed under the State Administrative Procedure Act. Counsel for the Department of Health said that there is no evidence to support that the department violated the state constitution because it did not promulgate a rule; it merely interpreted a rule. The judge indicated that she intends to make a decision on the payment changes quickly. Separately, Home Health Care News reported that as a result of the change in payment methodology FIs in New York are laying off workers and threatening to close. Read More

New York Releases DSRIP Medicaid Waiver Amendment Request. The New York Department of Health has released a draft of its Section 1115 Medicaid Redesign Team (MRT) waiver amendment request for public comment. The amendment seeks to extend the state's Delivery System Reform Incentive Payment (DSRIP) program for an additional 4 years. The amendment requests an additional $8 billion in federal funds, of which $5 billion would be targeted to on-going DSRIP efforts. An additional $1.5 billion would be allocated to social determinants of health, $1 billion to on-going workforce development efforts, and $500 million to the Interim Access Assurance Fund, a mechanism to provide financial support to safety net hospitals.

New York began its DSRIP program in 2015 with the overarching goal of reducing avoidable hospital use by 25 percent, as well as encouraging system integration, an increase in community-based capacity, and a shift away from fee-for-service reimbursement toward value-based payment. The state asserts that it has made significant progress on those goals, but that it needs additional time and resources to fully transform the health care delivery system.

The current DSRIP program established provider-centered entities called Performing Provider Systems (PPSs) to develop geographic networks of providers and community-based organizations (CBOs) to work collaboratively on a series of specific projects. The waiver amendment envisions a next generation of these provider entities, to be known as Value-Driving Entities (VDEs). VDEs would bring together providers, community-based organizations working on social determinants of health, and Medicaid managed acre plans to continue implementing select DSRIP projects, "DSRIP Promising Practices," that have demonstrated effectiveness in meeting DSRIP

goals. Including managed care organizations is a significant change in the state's approach, as they were largely left out of the original DSRIP program design.

In addition to the "DSRIP Promising Practices," the state has identified three additional high-need priority areas for the next phase of DSRIP: 1) reducing maternal mortality; 2) children's population health, building on the state's Health Homes Serving Children; and 3) long-term care reform. In recognition of the state's aging population, the waiver amendment describes a focus on long-term and post-acute care that would focus on bundling and value-based payment in that sector, as well as on workforce investments.

The waiver amendment also seeks to build on New York's focus on social determinants of health. As part of the shift to population health the state has encouraged PPSs to partner with CBOs to work on social determinants of health, and currently requires managed care plans to contract with CBOs for social determinants of health interventions. The state proposes to establish "Social Determinants of Health Networks" to deliver socially focused interventions linked to value-based payment. A VDE, serving as the lead entity, would create a network of CBOs that would develop interventions that address housing, nutrition, transportation, interpersonal safety and toxic stress. The state would also finance the creation of regional CBO networks to create a single point of contracting for value-based payment of social determinants of health arrangements.

Written comments on the draft will be accepted through November 4, 2019.

A draft of the amendment proposal is available for review here.

North Carolina

North Carolina House Hands Governor Major Setback on Medicaid Expansion. *North Carolina Health News* reported on September 12, 2019, that the North Carolina House handed Governor Roy Cooper a major setback on Medicaid expansion by overriding his veto of the state budget. If the Senate also overrides, it could dash the Governor's attempts to leverage the budget as a bargaining chip to enact Medicaid expansion. Read More

Ohio

Ohio Psychiatric Crisis Services Get $21 Million More In State Funding. *Cleveland.com/The Plain Dealer* reported on September 10, 2019, that Ohio is set to expand psychiatric crisis services across the state by way of an expanded budget. The additional $20.75 million is targeted for expanding psychiatric crisis services networks and for providing clinical services and psychosocial supports such as transitional housing after hospitalization or home-based mental health services for families. Part of the new funds will be distributed directly to counties, while another portion will be tied to participation in a statewide crisis academy happening in October. Read More

Ohio is One of 8 States to See Uninsured Rate Rise. *Cleveland.com* reported on September 10, 2019, that Ohio was one of just eight states to see their uninsured rate rise, and one of just four Medicaid expansion states to see their uninsured population rise. The number of people without medical insurance rose to 744,000 in 2018, up 58,000 from the previous year. There is some concern that the increase means a higher number of children are going uncovered, as many children who were eligible weren't enrolled due to "red tape or trimmed outreach efforts," exacerbated by the federal cut to funding for Medicaid Navigator programs. Read More

Ohio Lawmakers Await Report on PBM Pass-Through Drug Pricing Model. *The Columbus Dispatch* reported on September 16, 2019, that members of the Ohio Joint Medicaid Oversight Committee are eager to learn about the impact of the state's shift this year from spread pricing to a pass-through pricing model for pharmacy benefit managers. Medicaid Director Maureen Corcoran will appear before the committee this week and hopes to present the results of a report on the topic. The delay has frustrated lawmakers. Read More

Pennsylania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Lawmakers Make Another Attempt to Pass Work Requirements. *WITF* reported on September 12, 2019, that two Pennsylvania lawmakers, Senator Scott Martin (R-Lancaster) and Senator David Argall (R-Schuylkill/Berks), have introduced a Medicaid work requirement bill. Activities that would fulfill this requirement include self-employment, volunteering, internships, job training, attending college, actively seeking employment and more. Senate Bill 847 includes exemptions for anyone who is disabled, pregnant, younger than 18, older than 65, undergoing treatment for mental health or substance abuse issues, or anyone taking care of someone younger than 6, permanently disabled or in hospice care. Governor Tom Wolf has previously vetoed similar pieces of legislation in 2017 and 2018. The bill is pending before the Senate Health and Human Services Committee. Read More

Pennsylvania Receives Funding for Money Follows the Person. Pennsylvania received $20 million for the Money Follows the Person (MFP) grant in federal funding. Funds will expand community-based services for seniors, veterans and people with disabilities, including:

- Partnering with the Pennsylvania Department of Aging on expanding the Shared Housing and Resource Exchange (SHARE) housing pilot.
- Supporting community-based housing opportunities for veterans experiencing homelessness or living in restrictive settings.
- Strengthening and simplifying service delivery for people with intellectual disabilities and autism.
- Building capacity to support clients with co-occurring health needs.
- Supporting Employment Opportunities for Individuals with Disabilities. Read More

Tennessee

Tennessee Releases Medicaid Block Grant Proposal. *The Associated Press* reported on September 17, 2019, that Tennessee officials have released details of a Medicaid block grant proposal, which would provide the state with $7.9 billion in federal funds in a lump sum payment. The final version is expected to be submitted to federal regulators in November. Overall, the Tennessee Medicaid program costs more than $12 billion in state and federal funds. The block grant would cover core medical services for 1.2 million children, adults, and disabled, blind, and elderly individuals. Administrative costs, prescription drugs, uncompensated hospital care, and dual eligibles would not be covered by the block grant. The state would get to keep 50 percent of any unspent block grant funds. Read More

Texas

Texas Health Plan Falls Short on STAR+Plus Service Coordination Requirements. On August 22, 2019, the Texas Health and Human Services Commission (HHSC) released an audit conducted by the state Office of Inspector General (OIG), which found that Cigna had failed to meet certain service coordination requirements for STAR+PLUS members. According to OIG, not all Cigna members received the required number of face-to-face visits for home and community-based services, timely follow-up after receiving approved services, and member assessments within 30 days of entering a nursing facility.

Virginia

Virginia Investigates Medicaid Contract Award to Consultant. *The New York Times* reported on September 11, 2019, that Virginia has opened an investigation into a $1.5 million contract between the state Department of Medical Assistance Services (DMAS) and consulting firm AYS Finance Management Services. AYS is headed by Teia Miller, who helped oversee federal oversight of the state when she worked for the Centers for Medicare & Medicaid Services (CMS). Read More

West Virginia

West Virginia Issues Request for Quotation (RFQ) for Non-Emergency Medical Transportation Services. On September 6, 2019, West Virginia issued a request for quotations (RFQ) for Non-Emergency Medical Transportation Services (NEMT). The state Bureau for Medical Services will accept bids from vendors that have at least five years' experience providing NEMT services.

National

States Face Barriers in Efforts to Control Medicaid Drugs Costs, Study Says. *Modern Healthcare* reported on September 17, 2019, that states are facing legal, regulatory, and operational barriers in their attempts to control Medicaid drug costs through a variety of alternative payment models, according to a study from the Duke-Margolis Center for Health Policy. Still, states are moving ahead, using approaches like price transparency, pooled purchasing, and utilization review in an effort to drive down cost by increasing drug purchasing power. Outcomes-based payment models, such as those used in Colorado, Michigan, and Oklahoma, match reimbursements to health outcomes. Under the population-based model, Louisiana and Washington agree to buy a drug at a given price until it reaches a predetermined cap, after which the state pays a lower price for the drug. Read More

Federal Judge Overturns CMS Rule That Cut Medicare Payments to Outpatient Hospital Clinics. *Modern Healthcare* reported on September 17, 2019, that U.S. District Judge Rosemary Collyer has overturned a Centers for Medicare & Medicaid Services (CMS) rule that had reduced Medicare reimbursement rates for off-campus hospital clinic visits. The rule was initiated by the Trump administration in January under the existing site-neutral pay policy in an effort to pay the same rate to hospitals as to independent physicians. Read More

HHS Awards Grants for Health Centers in 23 States. On September 11, 2019, the U.S. Department of Health and Human Services (HHS) announced the award of more than $50 million to establish health centers and expand access in 23 states, Puerto Rico, and the Mariana Islands. The funding, delivered through the Health Resources and Services Administration (HRSA), will increase health care access for more than 400,000 new patients. Read More

Rise in Uninsured Rate May Reflect Fear Over Trump Immigration Policy. *The Associated Press* reported on September 15, 2019, that the increase in the uninsured rate in 2018 may reflect growing fear over the Trump Administration's initiatives to deny permanent residency status to immigrants who use government benefits like Medicaid. Census Bureau data shows that some of the biggest declines in health coverage were among Hispanics and non-citizens. Read More

2 Percent of Medicaid Expansion Enrollees in 9 States Don't Meet Income Eligibility Requirements, Study Shows. *The Center Square* reported on September 13, 2019, that more than 500,000 Medicaid expansion beneficiaries in nine states have incomes that exceed eligibility requirements, according to a study by the National Bureau of Economic Research. The figure represents about 2 percent of the 22.8 million expansion beneficiaries in those nine states. The authors add that nationwide the total number of ineligible individuals receiving expansion coverage could be three time higher if all expansion states were included in the analysis. The nine states studied were Arkansas, Kentucky, Michigan, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, and West Virginia. Read More

Providers, Advocates Oppose Repeal of Medicaid Access Rule. *Modern Healthcare* reported on September 16, 2019, that a proposed federal repeal of the Medicaid access rule is drawing opposition from providers and patient advocacy groups, who argue that the change would reduce provider pay and patient access to care. The Centers for Medicare & Medicaid Services (CMS) hopes to ease the administrative burdens for states by repealing the rule, which requires states to monitor fee-for-service Medicaid payments and their impact on access to care. Read More

Industry News

Purdue Pharma Files For Chapter 11 Bankruptcy. *The New York Times* reported on September 16, 2019, that OxyContin producer Purdue Pharma LP has filed for Chapter 11 bankruptcy protection as part of a proposed deal to settle thousands of lawsuits related to the company's alleged role in the opioid crisis. The Sackler family, which owns Purdue, has offered $3 billion in cash and an additional $1.5 billion from the sale of Mundipharma, another Sackler company. States opposed to the settlement seek more than $10 billion. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Washington DC	RFP Release	276,000
August 30, 2019 - PENDING	Texas STAR+PLUS	Awards	530,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
December 1, 2019	Texas STAR and CHIP	Awards	3,400,000
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
Spring 2020	Washington DC	Awards	276,000
January 1, 2020	Louisiana - Protests May Delay Implementation Date	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	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	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
January 6, 2020	Hawaii	Awards	340,000
February 1, 2020	North Carolina - Phase 1 (delayed) & 2	Implementation	1,500,000
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
December 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
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

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Arizona Medicaid Managed Care Enrollment is Up 1.6%, Sep-19 Data
- California Dual Demo Enrollment is Down 3.6%, Jul-19 Data
- California Medicaid Managed Care Enrollment is Down 1.3%, Jul-19 Data
- Colorado RAE Enrollment is Down 3.1%, Aug-19 Data
- DC SNP Membership at 16,212, Mar-19 Data
- Florida Medicaid Managed Care Enrollment is Down 1.9%, Aug-19 Data
- Hawaii Medicaid Managed Care Enrollment is Down 3.1%, Aug-19 Data
- Illinois Dual Demo Enrollment is Up 6.5%, Aug-19 Data
- Illinois Medicaid Managed Care Enrollment is Down 1.3%, Aug-19 Data
- Kentucky Medicaid Managed Care Enrollment is Down 0.9%, Sep-19 Data
- Michigan Dual Demo Enrollment is Flat, Jul-19 Data
- Michigan Medicaid Managed Care Enrollment is Down 1.4%, Jul-19 Data
- New Jersey Medicaid Managed Care Enrollment is Down 1.2%, Aug-19 Data
- Ohio Dual Demo Enrollment is Flat, Sep-19 Data
- Oregon Medicaid Managed Care Enrollment is Down 1.0%, Aug-19 Data
- Tennessee Medicaid Managed Care Enrollment is Up 5.3%, Aug-19 Data
- West Virginia Medicaid Managed Care Enrollment is Down 2.7%, Sep-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Connecticut Person-Centered Medical Home (PCMH) Plus Program Wave 3 RFP, Sep-19
- Kentucky Legal Services – Pharmacy Benefits Manager Matter RFP, Sep-19
- Nevada Medicaid Pharmacy Benefit Manager RFI, Sep-19
- Ohio Medicaid Nursing Facility Rate Development RFP, Sep-19
- Rhode Island Project Management and Analytic Tool Development Support for the Integrated Data System Module of the Medicaid Information Technology Enterprise RFP, Sep-19
- WV Medicaid Non-Emergency Medical Transportation RFQ, Sep-19

Medicaid Program Reports, Data and Updates:

- GAO Report on Efforts to Identify, Predict, or Manage High-Expenditure Medicaid Beneficiaries, Aug-19
- AK Medicaid Demographics, Aug-19
- Alaska Semi-Annual Medicaid Management Information System Update, 2016-19
- Arizona AHCCCS Population Demographics, Sep-19
- Arkansas Monthly Enrollment and Expenditures Report, Aug-19
- Florida Medicaid Program Rate Certifications and Appendices, SFY 2019-20
- Indiana Medicaid Managed Care Quality Strategy Plan, 2017-19
- New York Medicaid Redesign Team (MRT) DSRIP 1115 Waiver Amendment Request, Sep-19

- Ohio Medicaid Annual Reports, 2014-19
- Oklahoma Quality of Care in the SoonerCare Program Report, Jun-19
- Tennessee Medicaid Managed Care Enrollment by Age, Gender, County, 2015-18, Aug-19
- Tennessee TennCare II 1115 Waiver Amendment Drafts, Sep-19
- Texas Annual Performance Report for the Prescription Drug Rebate Program, Aug-19
- Texas OIG Audit of STAR+PLUS Service Coordination at Cigna, Aug-19
- Texas Quarterly Report from the HHS Ombudsman Managed Care Assistance Team, Quarter 1 FY 2019
- Utah 1115 Primary Care Network Demonstration Waiver Documents, 2016-19
- Wisconsin Medicaid HMO Quality Guides, 2018-19

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

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

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With 23 offices and over 200 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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