

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... June 5, 2019



[RFP CALENDAR](#)

[HMA News](#)

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IN FOCUS

TEXAS 2020-21 BIENNIUM BUDGET OVERVIEW

This week, our *In Focus* section reviews the Texas 2020-21 biennium budget. The Texas Legislature adjourned its biennial legislative session on May 27, 2019, after adopting a \$250.6 billion budget (all funds). The total budget is 6.3 percent higher than the 2018-19 budget with an increase of \$14.8 billion.

Total Health and Human Services (HHS) funding increased from \$83.6 billion in 2018-19 to \$84.4 billion, an increase of \$784.5 million (0.9 percent). Medicaid

funding includes \$66.5 billion (all funds), an increase of \$0.8 billion over 2018-19 funding. The budget increase is due primarily to a more favorable Federal Medical Assistance Percentage (FMAP) resulting in a higher proportion of HHS costs being funded with Federal Funds. State General Revenue Funds actually decreased by \$1.9 billion from the prior budget.

The funding increase supports caseload growth, maintains fiscal year 2019 average costs for most services, and provides funding for cost growth based on average costs established by the federal government. The budget also includes funds for an additional 1,628 community-based waiver slots; provides attendant wage and rate enhancement program increases; rate increases for consumer-directed services and certain waivers; and payment-rate increases for certain services provided by rural hospitals, intermediate care facilities for individuals with intellectual disabilities, and certain therapy services.

Despite the budget increase, the legislature did not fully fund anticipated cost increases due to medical inflation, higher utilization of services, or increased acuity of Medicaid recipients. The budget also assumes savings of \$0.9 billion (all funds) and directs the Health and Human Services Commission (HHSC) to achieve savings of at least \$350 million in General Revenue Funds through implementation of cost containment initiatives.

Medicaid Funding for 2020-21 Biennium

Funding Category ¹	SFY 2020-21 Funding - All Funds	SFY 2018-19 Funding - All Funds	Increase/Decrease from SFY 2018-19
Medicaid Client Services	\$61.6 billion	\$57.4 billion	+ \$4.1 billion
Other Programs supported by Medicaid Funding	\$1.8 billion	\$1.7 billion	+ \$.1 billion
Medicaid Program Administration	\$3.1 billion	\$3.3 billion	-.2 billion
Total	\$66.5 billion	\$64.2 billion	+\$0.8 billion

CHIP funding totals \$2.0 billion for the biennium, a slight decrease of \$8 million from 2018-19.

Separately, the Legislature also approved supplemental funding to meet budget shortfalls for the current fiscal year for Medicaid and several other state programs. House Bill 500 provides \$4.15 billion (all funds) to meet underfunded Medicaid expenses through August 31, 2019. A similar Medicaid shortfall for FY 2021 is anticipated when the legislature reconvenes in 2021.

Other HHS budget highlights include:

- Total \$3.3 billion for non-Medicaid/CHIP behavioral health services, including funding for community mental health services, mental

¹ Texas Legislative Budget Board, *Summary of Conference Committee Report for House Bill 1 – 2020-21 Biennium*, May 2019

health services for veterans, and substance abuse prevention, intervention, and treatment services.

- Total of \$341.6 for Women's Health Programs, an increase of \$67.9 million from 2018-2019
- The Medicaid budget assumes an average monthly cost per full-benefit Medicaid client (including drug and long-term care services) of \$496 in 2020 and \$511 in 2021. The average Aged and Medicare-related cost per recipient per month is estimated at \$1,176 in 2020 and \$1,220 in 2021.
- Medicaid prescription drug costs are estimated at \$83 per recipient per month in 2020 and \$86 in 2021.

Medicaid-related Budget Riders

The Appropriations legislation for the Health and Human Services Commission also includes 176 "riders" that address additional requirements related to program operations, funding, and budget guidance. Following is a summary of some of the more significant Medicaid riders.

Rider 12: Requires a study of Medicaid medical transportation program utilization and costs and how HHSC intends to address unmet transportation needs.

Rider 15: Requires HHSC to submit quarterly reports to the legislature on utilization, appeals, provider participation, and other data on pediatric acute care therapy services.

Rider 19: Requires HHSC to develop and implement cost containment initiatives to achieve savings of at least \$350 million in GR funds for the 20-21 biennium, for a total of \$0.9 billion, all funds. The agency is directed to focus on increasing fraud, waste, and abuse prevention and detection; seeking to maximize federal flexibility; and other programmatic and administrative efficiencies without adjusting the amount, scope or duration of services or otherwise negatively impacting access to care.

Rider 27: Requires HHSC to study the cost impact of STAR Kids members with high utilization and cost drives in each MCO to determine if the current rate-setting methodology should be adjusted. HHSC is to make appropriate adjustments only if the changes would not result in increased expenditures.

Rider 33: Requires HHSC to review claims and expenditures for Medicaid recipients in STAR+PLUS with a serious mental illness to evaluate any inappropriate variation in services by MCO. HHSC also is directed to identify performance measures to better hold MCOs accountable for outcomes and spending and develop recommendations to improve quality of care. The report is due no later than August 31, 2020.

Rider 34: Requires HHSC to evaluate prescribing practices for opioids under Medicaid and provide recommendations on steps to take to better align prescribing practices with guidelines adopted by the Centers for Disease Control and Prevention.

Rider 38: Requires HHSC to issue a report on outcomes achieved by providers participating in the Medicaid Delivery System Reform and Incentive Payment Program (DSRIP). The report must include review years 7 and 8 of the waiver and provide information on project outcomes, cost effectiveness, and amount

of funds earned by participating providers. The report is due to the legislature, governor and legislature budget board no later than December 1, 2020.

Rider 43: Requires HHSC to create an incentive program that auto-assigns Medicaid enrollees to an MCO based on quality of care, performance, and efficiency and effectiveness of services. HHSC is required to implement the program by September 1, 2020 and issue a report by January 15, 2021 that includes information on program cost, quality of care, and Medicaid member satisfaction.

Rider 45: Clarifies that the adopted budget includes \$87.1million to increase the base wage of personal attendants to \$8.11 per hour in FY 2020-21; and \$13.5 million to fully fund the rate enhancement programs for community care and IDD providers.

Rider 47: Clarifies that the adopted budget includes funds for a 10 percent rate increase in Medicaid provider rates for physical, occupational, and speech therapies provided in home to children, and increase reimbursement rates for therapy assistants to 80 percent of the rate paid to a licensed therapist.

Rider 58: Places 10 percent of funds allocated to Local Mental health Authorities (LMHA) and Local Behavioral Health Authorities (LBHA) at risk and subject to recoupment for failure to achieve HHSC outcome targets. Recouped funds may be used for technical assistance or redistributed as an incentive payment.

Rider 67: Requires HHSC to develop a proposal to improve the efficiency of administering substance abuse treatment services and expand the capacity of substance use treatment services. The report is due by December 1, 2020.

Rider 115: Clarifies the legislature's intent that HHSC use funds appropriated to the Office of Inspector General to detect, investigate, and prosecute abuse by dentists and orthodontists, and conduct more extensive reviews of medical necessity for orthodontia services.

Rider 157: Requires HHSC to develop strategies to recruit, retain, and ensure adequate access to the services of community attendants. The rider outlines detailed requirements for the study, including developing enhanced network adequacy standards Medicaid MCOS for ensuring sufficient member- access to attendants. The report with recommendations is due November 1, 2020.

Rider 170: Requires HHSC to clarify the process for the inclusion of prescription drugs in the Medicaid and CHIP programs.

Links to information used in developing this summary are available at the Texas Legislative Budget Board website, <https://www.lbb.state.tx.us/budget.aspx>.

Texas State Legislation Summary

In addition to the state biennial budget, the Legislature enacted numerous legislative proposals that impact public and private insurance plans. Not all enacted legislation has been signed by the governor. The governor has 10 days after receipt of a bill to sign or veto the legislation or allow it to become law without signature. For bills sent to the governor within 10 days of adjournment (May 27, 2019), the governor has 20 days to sign or veto a bill or allow it to become law without signature.

Following is a brief summary of some of the more significant legislation impacting health care and health insurance programs. Links to all legislation are available at the Texas Legislature Online at <https://capitol.texas.gov/>.

Senate Legislation

- SB 436: Opioid Treatment Services - Improves access to services for opioid use disorders among pregnant and post-partum women
- SB 670: Telemedicine - Requires Medicaid to cover telemedicine and telehealth services and clarifies ambiguous provisions that may have previously prevented access to services
- SB 749: Maternal/Neonatal Care - Establishes level-of-care designations for hospitals that provide maternal and neonatal care
- SB 750: Maternal Postpartum Care - Improves access to postpartum care through the Healthy Texas Women Program
- SB 1096: Medicaid Formulary Requirements - Enacts numerous MCO provisions related to prior authorizations and access to medications on the Medicaid formulary
- SB 1207: Operations Related to Medicaid and HHSC Oversight - Imposes new requirements related to operational functions of HHSC and their oversight of MCOs. Some of the more significant provisions include:
 - New requirements related to prior authorization requests, adverse determinations and denials of coverage, with a goal of reducing the overall number of prior authorizations
 - Provisions related to external medical reviews conducted by HHSC and/or MCOs
 - Additional requirements for STAR Kids contracts between an MCO and HHSC
 - Implementation of a Medicaid help-line for escalated complaints and inquiries
 - A review and improvement of the care needs assessment tool for the STAR Kids program
 - Requirements to streamline aspects of the STAR Kids program
 - HHSC must develop an easy process to allow a recipient with complex medical needs to continue receiving care from a specialty provider
- SB 1264: Surprise Medical Bills - Amends the Texas insurance code to prohibit health care providers from billing patients for certain out-of-network services when patients have no choice, including when patients receive care from an out-of-network doctor at an in-network ER (including freestanding ERs) during an emergency, or when they receive care from an out-of-network doctor at an in-network facility. Establishes binding mediation procedures for providers and insurers to resolve payment disputes and requires plans to pay reasonable or agreed-to amounts for out-of-network care as determined through mediation.
- SB 1519: Long Term Care Council - Establishes a Long-Term Care Facilities Council to study and make recommendations regarding the dispute resolution process for long-term care facilities and a Medicaid quality-based payment system for those facilities.
- SB 1564: Reimbursement for Buprenorphine - expands access to buprenorphine for Medicaid enrollees for treatment of an opioid use disorder by expanding types of practitioners who can prescribe the medication

- SB 1742: Health Plan Directory Accuracy - Requires health plan directories to clearly identify which physician specialties are in-network at network facilities

House of Representatives Legislation

- HB 25: Medicaid Medical Transportation - Creates a pilot program to streamline nonemergent medical transportation services in Medicaid and allow children to accompany their pregnant mothers on doctor's visits, including postpartum care
- HB 72: Medicaid Enrollment for Foster Care Children - Requires HHSC to develop strategy to ensure more foster children continue their Medicaid coverage by ensuring coordination for children transitioning between the STAR Health program for children in foster care and other Medicaid managed care programs
- HB 170: Coverage of Diagnostic Mammograms - Amends the Texas Insurance Code to require health plans to cover diagnostic mammograms at 100 percent, as is already required for screening mammograms
- HB 253: Treatment of Postpartum Depression - Requires HHSC to develop a strategic plan to address and treat post-partum depression for Medicaid enrollees
- HB 1063: Home Telemonitoring - Requires Medicaid to cover home telemonitoring for specific pediatric patients
- HB 342: Six Month Review of Medicaid Eligibility - Authorizes HHSC to confirm certain children's eligibility for Medicaid six months following eligibility/re-eligibility certification
- HB 1065: Graduate Medical Education - Creates a grant program to develop residency training tracks for physicians practicing in rural, underserved settings
- HB 1584: Restrictions on Step-Therapy for Breast Cancer - Amends the Texas Insurance Code to prohibit health plans from requiring step-therapy protocols for stage 4 metastatic breast cancer
- HB 1941: Limitation on Out-of-Network Charges - Restricts free-standing emergency centers from charging rates that are 200 percent or more of the average charge for the same or substantially similar treatment at a hospital emergency room
- HB 2050: Use of Psychotropic drugs in Long Term Care Facilities - Requires written consent for the administration of psychoactive drugs to long-term care facility residents
- HB 2174: Opioid prescriptions - Limits the duration of opioid prescriptions, requires electronic prescribing beginning January 2021, requires opioid-related Continuing Medical Education, and prohibits prior authorization requirements for medication-assisted treatment for opioid use disorder.
- HB 2041: Freestanding Emergency Room Notices - Requires free-standing ER facilities to post notices they might be out-of-network, along with disclosure of possible fees
- HB 2327: Medical Service Authorization Transparency - Establishes greater prior authorization transparency in Medicaid and requires that utilization reviews be conducted by a licensed Texas physician
- HB 2536: Drug Pricing - Requires drug pricing transparency by imposing requirements on drug manufacturers, health plans and pharmacy benefit managers (PBMs). Drug manufacturers must submit a report to HHSC

when there is a price increase for a specific drug of at least 40 percent in its wholesale acquisition cost in the preceding three calendar years, or at least 15 percent in the previous calendar year. The reports, which will be posted online by HHSC, must include a detailed statement explaining the cause of the price increase. PBMs and health plans must submit to the Texas Department of Insurance annual reports including information on aggregated drug rebates, fees and price protection payments collected from drug manufacturers for PBMs, the names of the 25 most frequently prescribed drugs, percent increase in annual net spending for drugs, and percent increase in health plan premiums attributable to drugs.

- HB 2813: Behavioral Health Coordinating Council – Permanently codifies creation and operations of the Statewide Behavioral Health Coordinating Council
- HB 3285: Opioid Use/Substance Use Disorder – Makes numerous changes to Medicaid to improve access to services and prescriptions for treating opioid use or substance use disorder
- HB 3345: Telemedicine Services Flexibility – Allows physicians to choose the best platform for providing telemedicine services rather than having health plans dictate the platform
- HB 3703: Cannabis Use – Expands the list of conditions for which a physician can recommend low-THC cannabis for medical use to include epilepsy, a seizure disorder, multiple sclerosis, spasticity, amyotrophic lateral sclerosis, autism, terminal cancer, or an incurable neurodegenerative disease.
- HB 4533: Pilot Managed Care Program for Individuals with IDD – Requires HHSC to implement a Medicaid pilot program in which long term services and supports will be provided through a managed care plan for individuals with intellectual or developmental disabilities. Includes detailed requirements related to the pilot. The pilot must include not more than two MCOs and would begin September 1, 2023, and end September 1, 2025.

Please contact Dianne Longley at dlongley@healthmanagement.com for more information.

EARLY BIRD REGISTRATION DISCOUNT EXPIRES JUNE 24 FOR HMA CONFERENCE ON THE NEXT WAVE OF MEDICAID GROWTH AND OPPORTUNITY, SEPTEMBER 9-10 IN CHICAGO; NEARLY 200 ALREADY REGISTERED TO ATTEND

Be sure to register soon for HMA's 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. The Early Bird registration rate of \$1595 per person expires on June 24. After that, the rate is \$1795.

Nearly 200 people are already registered to attend, and a total of more than 400 are expected. Visit our website for complete details: <https://conference.healthmanagement.com/> or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

A high-level list of 40 industry speakers, including health plan executives, state Medicaid directors, and providers will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations. There will also be a Pre-Conference Workshop on Sunday, September 8.

State Medicaid Speakers to Date (In alphabetical order)

- Natalie Angel, Healthy Indiana Plan Director, Indiana Office of Medicaid Policy and Planning
- Mari Cantwell, Chief Deputy Director, Health Care Programs, California Department of Health Care Services
- Mandy Cohen, MD, Secretary, North Carolina Department of Health and Human Services
- Doug Elwell, Medicaid Director, Illinois Department of Healthcare and Family Services
- Carole Johnson, Commissioner, New Jersey Department of Human Services
- Rebecca Jones-Gaston, Executive Director, Social Services Administration, Maryland Dept. of Human Services
- Karen Kimsey, Chief Deputy, Virginia Department of Medical Assistance Services
- Tricia Roddy, Director, Planning Administration, Health Care Financing, Maryland Medicaid
- Dennis Smith, Senior Advisor, Medicaid and Health Care Reform, Arkansas Department of Human Services
- Jami Snyder, Director, Arizona Health Care Cost Containment System
- Betsey Tilson, MD, Chief Medical Officer, North Carolina Department of Health and Human Services
- Carol Steckel, Commissioner, Kentucky Division of Medicaid Services

Medicaid Managed Care Speakers to Date (In alphabetical order)

- Jean Caster, HIP Program Director, Anthem Indiana Medicaid

- Heidi Garwood, President Medicaid, Health Care Service Corp.
- Janet Grant, Regional Vice President, Great Plains Region, Aetna Medicaid
- Brad Lucas, MD, Senior Medical Director, Buckeye Health Plan
- Joanne McFall, Market President, Keystone First Health Plan
- Sarita Mohanty, MD, VP, Care Coordination, Kaiser Permanente
- Kevin Moore, VP, Policy, Health & Human Services, UnitedHealthcare Community & State
- Dennis Mouras, CEO, UnitedHealthcare Community Plan of Michigan
- Elise Pomerance, MD, Senior Medical Director, Practice Transformation, Inland Empire Health Plan
- Allison Rizer, VP, Strategy & Health Policy, Medicare/Medicaid Integration, UnitedHealthcare Community & State
- Lois Simon, EVP, Policy and Programs, Seniorlink
- Patrick Sturdivant, President, Virginia Medicaid Health Plan, Anthem, Inc.
- Paul Tufano, Chairman, CEO, AmeriHealth Caritas

Provider Speakers to Date (In alphabetical order)

- Fred Cerise, MD, President, CEO, Parkland Health & Hospital System
- Alan Cohn, CEO, President, AbsoluteCARE Inc.
- Deepu George, Division Chief - Behavioral Medicine, Department of Family & Preventive Medicine, UTHealth
- Mitchell Katz, MD, President and CEO, NYC Health + Hospitals
- Rebecca Kavoussi, President, West, Landmark Health
- Sharon Raggio, President, CEO, Mind Springs Health
- Walter Rosenberg, Director, Social Work and Community Health, Rush University Medical Center
- René Santiago, Deputy County Executive, County of Santa Clara, CA
- Deborah Weidner, MD, VP, Safety and Quality, Behavioral Health Network, Hartford HealthCare

Other Speakers to Date (In alphabetical order)

- Jonathan Blum, Managing Principal, HMA; former CMS Deputy Administrator for Medicare
- Terry Cothran, Director, Pharmacy Management Consultants, University of Oklahoma College of Pharmacy
- Josh Fredell, Senior Director, Specialty Product Development, CVSHealth
- Ray Hanley, President and CEO, AFMC
- Darren Moore, Senior Director, Value and Market Access, Melinta Therapeutics
- Corey Waller, Principal, HMA (Lansing, MI)
- Tracy Wareing Evans, Executive Director, American Public Human Services Association

2018 Conference Attendee Statistics

Total Attendance: 460

Attendee Breakdown by Sector

- Health Plans: 25%
- Providers: 24%
- Vendors: 24%
- Consultants: 14%
- Government Officials: 8%
- Investors: 5%



HMA MEDICAID ROUNDUP

Arizona

Arizona To Allow Rideshare Companies To Provide NEMT Services. The Arizona Health Care Cost Containment System (AHCCCS) announced on May 1, 2019, a policy change that allows rideshare companies to participate in the state's Medicaid non-emergency medical transportation (NEMT) program, effective May 1. Under the new policy, rideshare companies can serve Medicaid members who do not require personal assistance during medically necessary transportation. [Read More](#)

California

Governor Proposes Individual Mandate to Fund Exchange Subsidies Up to 600 Percent of Poverty. *California Healthline* reported on June 3, 2019, that California Governor Gavin Newsom proposed a penalty on uninsured individuals - modeled after the individual mandate - to fund tax credits for middle-class families who do not qualify for federal Exchange subsidies. The credits would apply to 850,000 individuals between 200 percent and 600 percent of the federal poverty level. Legislators will debate the plan during budget negotiations, which must finish by June 15. [Read More](#)

Connecticut

State Health Insurance Subsidy Bill Is Dead. *The Hartford Courant* reported on May 29, 2019, that a bill to offer state insurance subsidies to individuals who aren't eligible for federal Exchange subsidies and to small businesses has died. The measure, called the Connecticut Option, had faced strong opposition from at least one major Connecticut-based insurer. [Read More](#)

Delaware

Delaware to Seek Waiver for Exchange Plan Reinsurance Program. The Delaware Department of Health and Social Services (DHHS) announced on May 30, 2019, that the state Department of Insurance will seek a federal 1332 waiver to establish a reinsurance program aimed at lowering premiums in the individual health insurance market, including insurers on the Exchange. The public comment period is May 30 to June 28; the state will hold two public hearings. If approved, the reinsurance program would be effective for the 2020 year plan.

Florida

Florida Medicaid Expansion Ballot Measure Goes to State Supreme Court for Review. *The Tampa Bay Times* reported on June 3, 2019, that Florida Decides Healthcare, a political committee, has gathered 81,690 signatures in support of a proposed Medicaid expansion ballot measure, enough to send the measure to the state Supreme Court for review. If the Supreme Court signs off, the political committee would need a total of 766,200 signatures to get the measure on the ballot. [Read More](#)

Illinois

Legislature Passes Bill Requiring Medicaid Plans to Pay Claims in 30 Days. *Crain's Chicago Business* reported on May 31, 2019, that the Illinois Legislature unanimously passed a health care reform package, which requires Medicaid managed care plans to pay claims within 30 days or face a penalty. The bill, which now heads to Governor J.B. Pritzker, would also require the state Department of Healthcare & Family Services to publish Medicaid plan medical loss ratios, improve the beneficiary eligibility renewal process, and mandate the establishment of a provider complaint portal allowing physicians to submit unresolved insurance claims. [Read More](#)

Kentucky

Democrats Focus on Medicaid Expansion in Gubernatorial Race. *The Hill* reported on June 4, 2019, that Kentucky Democrats are focusing on Medicaid expansion to unseat Republican incumbent Governor Matt Bevin. Bevin has imposed work requirements and monthly premiums on expansion members in the state. He also opposes the Affordable Care Act (ACA). Andy Beshear, Kentucky's attorney general and Democratic candidate, supports both expansion and the ACA. [Read More](#)

Louisiana

Louisiana Announces Medicaid Managed Care RFP Bidders. On May 1, 2019, the Louisiana Department of Health released a list of six health plans that submitted bids for the state's Medicaid managed care program:

1. Aetna Better Health of Louisiana
2. AmeriHealth Caritas Louisiana
3. Anthem/Community Care Health Plan of Louisiana, dba Healthy Blue
4. Humana
5. Centene/Louisiana Healthcare Connections
6. UnitedHealthCare Community Plan [Read More](#)

Nebraska

Nebraska Announces Fiscal 2020 MLTC Rate Increase For Nursing Homes. Nebraska announced on June 5, 2019, that average per diem base rate for Medicaid nursing homes will increase 6.1 percent in fiscal 2020 to \$190.51, according to the state Department of Health and Human Services, Division of Medicaid and Long-Term Care. There are 165 nursing facilities that will see an increase, and 29 that will see a decrease. [Read more](#)

New York

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

New York Posts 2020 Individual Exchange Rate Increase Requests. The New York Department of Financial Services (DFS) has posted individual market rate increase requests for health plans that participate in the state's health Exchange, New York State of Health. Requests for premium increases average 8.4 percent, ranging from a low of 4.2 percent requested by Excellus to a high of 27.1 percent, requested by UnitedHealthcare. Fidelis Care, now owned by Centene, filed for a 6.8 percent increase in rates. Last year rate requests on the individual market averaged 24 percent; final approved rates increased 8.6 percent. [Read More](#)

North Carolina

Budget Proposal Would Increase Number of IDD Medicaid Waiver Slots. *The Winston-Salem Journal* reported on May 29, 2019, that a North Carolina Senate budget proposal for fiscal 2019-21 increases by up to 1,000 the number of Medicaid waiver slots offering personal care and in-home assistance services to individuals with intellectual and developmental disabilities. The proposal would also scale back certificate of need laws, making it easier to open ambulatory surgical, diagnostic, and specialty centers. [Read More](#)

Ohio

Ohio Releases Draft Medicaid Managed Care Procurement Timeline. On May 29, 2019, Ohio released a draft timeline for the state's Medicaid managed care procurement. Requests for Information (RFIs) are scheduled for release in June 2019 and August 2019, with a Request for Application (RFA) following sometime between January and March 2020. Implementation is expected to be January 1, 2021.

The timeline was released during a behavioral health stakeholder update and discussion presented by the Ohio Department of Medicaid and the Department of Mental Health and Addiction Services. Presenters focused mainly on the state's goal of addressing the opioid crisis, Ohio Mental Health and Addiction Services priorities, and the state health improvement plan. Presenters also provided an update on the behavioral health redesign and Ohio's pursuit of a 1115 Medicaid waiver for Substance Use Disorders. [Read More](#)

Pharmacy Benefit Managers Profit From Specialty Drugs. *The Columbus Dispatch* reported on April 24, 2019, that Ohio pharmacy benefit managers (PBMs) are allegedly using the fastest-growing and most expensive segment of prescription drugs to enrich themselves. The process for specialty drugs, such as those used to treat hepatitis, cystic fibrosis, and HIV, are increasing to levels that allow PBMs to make hundreds of thousands of dollars per prescription. A spokeswoman for Ohio Medicaid said that specialty drugs are already on their radar, and that steps are being taken to examine that area. [Read More](#)

PBM Withdraws Contract Sent to Pharmacies in Ohio. *The Columbus Dispatch* reported on June 2, 2019, that Express Scripts, the pharmacy benefit management company hired by CareSource in Ohio, withdrew a contract distributed to pharmacies in the state amid concerns over reimbursements and transparency. CareSource, which is the state's largest Medicaid managed care plan, had dropped its previous PBM, CVS Caremark, over similar concerns. CareSource's existing contract with CVS Caremark expires December 31, 2019. Ohio is one of several states attempting to address transparency in PBM contracts. [Read More](#)

Pennsylvania

Pennsylvania Awards Grants for Projects Leveraging Community Health Workers for Better Health Outcomes. Pennsylvania announced on June 4, 2019, a \$3 million grant award for five projects selected to improve health outcomes in North Philadelphia's Health Enterprise Zone (HEZ). Each program will use community health workers to increase health promotion and education to address health disparities in children, older adults, and those who are frequent users of medical services. [Read More](#)

Texas

Texas Releases STAR Health Draft RFP. On June 4, 2019, the Texas Health and Human Services Commission released a draft request for proposals (RFP) for the state's STAR Health managed care program for foster children. New statewide contracts are expected to run from September 1, 2021, through August 31, 2024. Responses to the draft RFP, which is meant to collect suggestions and comments, are due July 5, 2019. Last year, the state released a request for information for program improvements to STAR Health, which covers medical and behavioral services. [Read More](#)

Utah

Utah Seeks CMS Approval for Enhanced Federal Expansion Match, Per Capita Cap. *Modern Healthcare* reported on May 31, 2019, that Utah submitted a 1115 waiver proposal asking federal regulators to approve a 90 percent match for the state's proposed partial Medicaid expansion to individuals earning 100 percent of the federal poverty level. The proposal, submitted to the Centers for Medicare & Medicaid Services (CMS), also includes a federal funding cap; however, the state is asking that the rate of increase in federal payments be capped at the rate of medical inflation, rather than the consumer price inflation rate. [Read More](#)

Virginia

Republicans Who Voted to Expand Medicaid Escape Primary Challenges. *The Washington Post* reported on June 4, 2019, that only three of the nearly 24 Virginia Republicans who voted in favor of Medicaid expansion last year will face primary challengers. Virginia Delegate Terry Kilgore (R-Scott) notes that the popularity of expansion could account for the small number of primary challengers. [Read More](#)

Wisconsin

Committee Approves Health Care Budget Without Medicaid Expansion. *The Milwaukee Journal Sentinel* reported on June 4, 2019, that the Wisconsin Republican-controlled Joint Finance Committee approved a spending increase for state health care programs, but rejected a plan to expand Medicaid. Wisconsin Governor Tony Evers campaigned on the promise of expanding Medicaid. The increase in spending will help boost funding for nursing homes and personal care workers. [Read More](#)

Governor Announces Plan To Boost Exchange Enrollment, Expand Medicaid. *The Milwaukee Journal Sentinel* reported on June 3, 2019, that Wisconsin Governor Tony Evers announced a program aimed at boosting Exchange enrollment, even as he continues to push for Medicaid expansion. The program would provide information to consumers about the Exchanges through a joint effort of the Department of Health Services and the Office of the Commissioner of Insurance. As for expansion, the Republican-controlled legislature continues to oppose the initiative. [Read More](#)

National

House Health Subcommittee Debates DSH Formula Overhaul. *Modern Healthcare* reported on June 4, 2019, that during a House subcommittee hearing, lawmakers debated whether Congress should repeal the Medicaid disproportionate-share cuts scheduled to take effect October 1 or overhaul the hospital funding formula. Representative Michael Burgess (R-Texas), along with other GOP lawmakers, are pushing to overhaul the funding formula to better reflect the needs of the states. The cuts, if implemented, would result in payment reductions of \$4 billion for DSH hospitals. [Read More](#)

CMS Administrator Still Favors Lump Sum Funding for Medicaid. *CQ News* reported on May 31, 2019, that Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS) continues to call for federal lump sum funding for Medicaid. In exchange for receiving a lump sum, states would be granted additional flexibility in operating their Medicaid programs. She also mentioned Medicaid funding caps for partial Medicaid expansions. Utah has such a funding proposal awaiting CMS approval. [Read More](#)

ACA Led to Increases in Early Diagnosis, Treatment of Cancer, Research Shows. *The Wall Street Journal* reported on June 2, 2019, that the Affordable Care Act (ACA) led to improvements in early diagnosis and treatment of cancer, according to various studies. Improvements were noted for white Americans overall; women with ovarian cancer; African-Americans with lung and breast cancer; and patients with blood cancer multiple myeloma.

Researchers attributed the improvements to expanded insurance coverage, including Medicaid. [Read More](#)

Supreme Court Rules Against Medicare DSH Cuts. *Modern Healthcare* reported on June 3, 2019, that the U.S. Supreme Court ruled 7-1 against cuts to Medicare disproportionate-share hospital (DSH) payments made by the Department of Health and Human Services (HHS). The revised Medicare DSH payment calculation in question began to combine Medicare Advantage enrollees with traditional Medicare enrollees, and HHS estimated the magnitude of the change to be \$3 billion to \$4 billion in cuts between fiscal 2005 and 2013. The justices' decision cited the need for a notice and comment period prior to implementing such a significant change in payment policy. [Read More](#)

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Data Merging and Integration in Medicaid. On June 12, 2019, from 3:00 PM - 4:30 PM ET, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program (IAP) will host a national webinar for state Medicaid agencies interested in learning about data merging and linkage of Medicaid data with other non-Medicare data sources. During this webinar, presenters will provide an overview of approaches, strategies, and methods for merging Medicaid data with other data sets. A speaker from West Virginia will describe their experience with integrating mortality data to Medicaid eligibility data, including strategies used to achieve high match rates. The webinar's second speaker, representing Washington State, will share real-life analytic use case examples and lessons learned in the state's data integration efforts.

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

Partners Backs Away from Proposed Care New England Acquisition. *The Boston Business Journal* reported on June 4, 2019, that Massachusetts-based Partners HealthCare has backed away from a planned acquisition of Rhode Island-based Care New England Health System. The move came after Rhode Island Governor asked Care New England to first pursue a deal with Lifespan and the Brown University medical school. Partners didn't rule out the idea of restarting acquisition discussions in the future. [Read More](#)

Ensign Group Acquires Texas Nursing Facility. The Ensign Group, Inc. announced on June 5, 2019, that it had acquired the real estate and operations of Golden Palms Rehabilitation and Retirement, a Texas-based skilled nursing facility effective June 1, 2019. This acquisition brings Ensign's portfolio to 198 skilled nursing facilities. [Read More](#)

Humana Will Not Pursue Merger with Centene. Humana announced on June 3, 2019, that it will not pursue a merger with Centene, according to a filing with the SEC. Humana released the 8-K filing in order to clear up speculation that the two companies might strike a deal if Centene's planned merger with WellCare fell through. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
June 2019	Ohio	RFI #1 Release	2,360,000
June 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
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 5, 2019	Kentucky	Proposals Due	1,200,000
July 8, 2019	Louisiana	Awards	1,500,000
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 2019	Ohio	RFI #2 Release	2,360,000
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
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
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 On HMAIS: Medicare Advantage Enrollment Tool. HMA Information Services announced on May 30, 2019, the launch of a Medicare Advantage enrollment tool allowing users to search for Medicare Advantage enrollment data by state and among top plans for the period indicated and for the corresponding prior-year period. Data includes market share as well as minimum and maximum Star Ratings, premiums, and deductibles by plan. The tool is located [here](#) and is available to all current subscribers to HMAIS. Currently, the tool presents data as of February 2019 and will be updated monthly.

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

Medicaid Data

- Medicare Advantage Enrollment Tool
- Special Needs Plans (SNP) Enrollment by State and Plan, Mar-19 Data
- Iowa Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Kansas Medicaid Managed Care Enrollment is Down 6.7%, Jun-19 Data
- Massachusetts Medicaid Managed Care Enrollment is 1,013,776, Apr-19 Data
- Massachusetts Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Bed Days per 1000 Members Average 986 for Minnesota Medicaid MCOs, 2018 Data
- MLRs Average 90.8% at Minnesota Medicaid MCOs, 2018 Data
- Minnesota Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- New Mexico Medicaid Managed Care Enrollment is Flat, May-19 Data
- New York CHIP Managed Care Enrollment is Up 3.5%, May-19 Data
- Washington Medicaid Managed Care Enrollment is Up 1.9%, Apr-19 Data
- Washington Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Bed Days Per 1000 Members Average 445 at Washington Medicaid MCOs, 2018 Data
- MLRs at Washington Medicaid MCOs Average 86.8%, 2018 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alabama Coordinated Health Network RFP and Awards, 2019
- Alabama Medicaid Management Information System (MMIS) Program Management Office (PMO) Services RFP, May-19
- Alabama Medicaid Third Party Liability Services RFP, May-19
- Arkansas Expanded Medicaid Evaluation IFB, Proposals and Related Documents, May-19
- Florida Canadian Prescription Drug Importation Program RFI, May-19
- Ohio Pre-Admission Screening and Resident Review (PASRR) for Indications of Serious Mental Illness (SMI) Level II Assessments and Select Determinations RFP, Proposals, and Scoring, 2018
- Pennsylvania MMIS 2020 Platform Project – Outpatient Drug Services RFP, May-19

- Texas STAR Health Managed Care Services DRAFT RFP, Jun-19

Medicaid Program Reports, Data and Updates:

- Alabama Coordinated Health Network (ACHN) Presentations for Delivering Healthcare Professionals (DHCP), Providers, 2019
- Alabama Medicaid FFS Fee Schedules
- Arizona Behavioral Health Annual Report SFY 2018
- Arizona AHCCCS Population Demographics, Jun-19
- Minnesota DHS EQR Annual Technical Reports, 2016-17
- New Mexico External Quality Review Reports, 2016-19
- New Mexico Medicaid Managed Care Plan CAHPS Reports, 2017-18
- New Mexico Medicaid Statistical Reports, 2014-18
- Ohio Behavioral Health Stakeholder Update and Discussion Presentation, May-19
- Texas 2020-21 Biennium Budget Summary of Conference Committee Report, May-19
- Utah Per Capita Cap 1115 Waiver Request, May-19
- Virginia Medallion 4.0 Rate Reports, 2019
- Washington Adding Behavioral Health Services to the Medicaid State Plan Report, Mar-19
- Washington Medicaid Financing and Home Visiting Services Legislative Report, Jan-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.

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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