

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... August 7, 2019



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THIS WEEK

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THE HMA WEEKLY ROUNDUP WILL NOT PUBLISH ON AUGUST 14, 2019 AND WILL RESUME AUGUST 21, 2019.

IN FOCUS

CMS MEDICARE FEE-FOR-SERVICE FY 2020 PROPOSED RULES PART 2: PHYSICIAN FEE SCHEDULE AND HOME HEALTH

This week, our *In Focus* section reviews the new Centers for Medicare & Medicaid Services (CMS) Medicare Fee-For-Service FY 2020 proposed rules: the Physician Fee Schedule (PFS), released on July 2019, and Home Health prospective payment system, released on July 11, 2019. For the hospital outpatient department (HOPD) and ambulatory surgical center (ASC)

prospective payment systems (PPS) and the End-Stage Renal Disease (ESRD) PPS proposed rules, please see last week's *In Focus* [here](#).

2020 Physician Fee Schedule (PFS) Proposed Rule Highlights

PFS payment and coding provisions

CMS proposed a slight increase of less than 0.5 percent to overall PFS payment rates by raising the PFS conversion factor to \$36.09 in CY 2020, up from \$36.04 in CY 2019. CMS's proposals also include new PFS codes which provides reimbursement for new services for beneficiaries and as well as provisions to reduce the clinicians' burden. Specifically, CMS proposed to:

- Reduce the number of levels of evaluation and management (E&M) codes for new patients from five to four, while retaining the five-tier system for established patients. As a part of this, CMS also proposed to revise the standard of time required to treat patients at each code level and the medical decision making process for these E&M codes to enable clinicians to choose the E&M level based on either time or medical decision making, as opposed to only time.
- Increase payment for the Transitional Care Management (TCM) service code, which accounts for care management services provided to beneficiaries following inpatient discharge.
- Create additional codes as a part of the Chronic Care Management (CCM) service to enable clinicians to bill separately for patients requiring more time or resources.
- Create a new care management code for Principal Care Management (PCM) services. This code would pay clinicians for providing care management for patients with high risk conditions.
- Add three new telehealth codes to the list of permitted telehealth services, each of which provide for a bundled episode of care for treatment in opioid use disorders.

Opioid use disorder (OUD) treatment services

To meet the statutory requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, CMS proposed the establishment of a new Medicare Part B benefit for opioid use disorder treatment services. OUD services include: opioid agonist and antagonist treatment medications approved by the Food and Drug Administration (buprenorphine, methadone, and naltrexone), the administration of these medications, substance use counseling, individual and group therapy with a physician or psychologist, toxicology testing. This also includes medication-assisted treatment (MAT) furnished by opioid treatment programs (OTP), which Medicare has not previously covered. These new services are proposed for implementation January 1, 2020. To bill Medicare for these services, OTPs must be enrolled in Medicare, and must have current accreditation with SAMHSA to provide a wide range of OUD services.

CMS proposes to pay OTPs a bundled rate for OUD services but seeks input on the various aspects of how the bundle should be designed. CMS proposed the OUD bundle will be a 7-day episode bundle, and OTPs would be permitted to bill for partial episode payment if the patient does not complete the full episode. CMS proposes to develop different OUD bundles depending upon the level of drug therapy used for treatment. Telehealth will be permitted and add-on payments for extra therapy sessions will be provided. Payment for these

services would not rely on PFS relative value units because these services will fall outside of the PFS. CMS is considering several methodologies for pricing the OUD payment bundles.

Bundled payment policies

CMS continues to focus on the development of bundled payment models. In the 2020 PFS proposed rule, CMS proposed to create a bundled payment for the of care for opioid use disorder (OUD). The proposed OUD bundled payment would provide a monthly episode payment to the clinician for overall care management, care coordination, individual and group psychotherapy, and substance use counseling. CMS proposed separate codes for 1) the initial month of service, 2) subsequent months of treatment, and 3) add-on counseling services. As a part of the bundled payment, services could be provided via telehealth.

CMS is also soliciting comment on two other bundled payment issues. First, CMS solicited comments on bundled payment for other substance use disorders and for the use of medication assisted treatment in the emergency department setting. Second, CMS solicited comments on new bundled payment model concepts that could be implemented within the PFS.

Clinician reporting and documentation requirements

CMS proposed several changes designed to reduce clinicians' administrative documentation requirements. Notably, CMS proposed modifying the physician supervision requirement for physician assistants (PA) to create greater flexibility for clinicians by permitting PAs to document in the medical record that they had been working with physicians to furnish services rather than requiring physician documentation. In addition, CMS proposed that clinicians of all types will no longer be required to re-document notes in the medical record in order to be in compliance with documentation requirements. Instead, clinicians will be permitted to review and verify information in the patient medical record.

Merit-based Incentive Payment System (MIPS) Value Pathways and Medicare Shared Savings Program (MSSP)

CMS proposed to reduce physician quality data reporting requirements under MIPS beginning in 2021. Under the current MIPS system, clinicians are required to report on many measures across the multiple performance categories, such as Quality, Cost, Promoting Interoperability and Improvement Activities. Under the new MIPS Value Pathways program, clinicians would report on a smaller set of measures that are specialty-specific, outcome-based, and more closely aligned to Alternative Payment Models (APMs). The new program is meant to connect activities and measures from the four existing MIPS performance categories that are relevant to the population clinicians are treating.

CMS solicits comment on how to better align the quality performance scoring methodology of the Medicare Shared Savings Program (MSSP) more closely with the MIPS quality performance scoring methodology. In addition, CMS proposed making slight modifications to the MSSP quality measure set.

Therapy Services

Beginning in January 2020, claim modifiers identifying the use of physical therapy assistants or occupational therapy assistants for therapy services will

be required. In addition, CMS proposed to implement a 10 percent minimum standard to claims involving therapy assistants. On claims where 10 or more percent of the service is attributable to the therapy assistant, payment will be made according to the therapy assistants' rate, not the non-assistant therapist.

Ambulance payment policy

CMS proposed revisions to the Physician Certification Statement requirements ambulance suppliers and providers are subject to in order to justify ambulance transport. CMS acknowledged that it will accept other forms of PCS documentation when formal signatures cannot be obtained. In addition, CMS proposed to expand the list of non-physician clinicians who may certify transport of a patient when a signed PCS cannot be obtained. The list was expanded to include licensed practical nurses, social workers, and case managers.

CMS proposed the various data collection format and elements to collect cost reports from ambulance providers and suppliers from 2020 through 2024. For 2020, the agency proposes to collect a stratified random sample of 25 percent of the ambulance industry. CMS proposed to stratify the sample based on characteristics such as location (urban, rural, and super-rural) ownership status (for-profit, non-profit, government), and Medicare transport volume. This sampling effort will be in place for four years. After 2024, CMS will require cost reports from one-third of the industry annually. Beginning in 2022, sampled ambulance providers and suppliers failing to submit cost data will have their payments for individual transports reduced 10 percent.

2020 Medicare Home Health Proposed Rule Highlights

Home Health payment provisions

CMS proposed to update home health payment rates by 1.5 percent in FY 2020. This increase is smaller than the increase made to 2019; a 2.2 percent increase was implemented in CY 2019. On net, this will result in an increase in payments to home health providers of \$250 million (1.3 percent net increase). The rate update for CY 2020 includes adjustments for anticipated changes related to implementation of the Patient-Driven Groupings Model (PDGM), which will revise the home health payment model from 60-day episodes based on the number of therapy visits to 30-day periods of care based on patient characteristics. CMS also proposed a behavioral-based payment reduction of 8 percent to offset anticipated increases in overall spending that result from changes in coding and diagnosis practices after the model is implemented. CMS also proposes the use of updated wage index data for the home health wage index, and updates to the fixed-dollar loss ratio to determine outlier payments.

CMS seeks comments on the wage index used to adjust home health payments and suggestions for possible updates and improvements to the geographic adjustment of home health payments.

Proposed Payment Rate Changes for Home Infusion Therapy Temporary Transitional Payments and New Home Infusion Therapy Benefit for CY 2021

Under the proposed rule, CMS would make routine updates to the home infusion therapy payment rates for CY 2020 and would implement a permanent home infusion therapy benefit beginning in CY 2021. CMS is proposing to group infusion drugs into three payment categories, with each

category having an associated single unit of payment in accordance with the Physician Fee Schedule and weighted based on geographic practice cost indices. CMS would set higher payment amounts for a beneficiary's first home infusion therapy visit, with lower amounts for each subsequent visit.

Regulatory Burden Reduction and Program Integrity Changes

In an effort to reduce administrative burden and potential program integrity risks, CMS proposes to phase out Requests for Anticipated Payment (RAP), which enable home health agencies to receive payments at the beginning of episodes of care based on the total estimated cost of services. CMS would reduce the RAP split-percentage payment for existing home health agencies in CY 2020 and eliminate split-percentage payments for all home health agencies in CY 2021.

Paraprofessional Roles – Improving Access to Care

CMS proposes to modify current regulations to allow therapist assistants, in addition to therapists, to perform maintenance therapy under the Medicare home health benefit in accordance with individual state practice requirements, allowing therapist assistants to practice at the top of their licensure and providing home health agencies with flexibility to meet their patients' maintenance therapy needs.

Home Health Value-Based Purchasing (HHVBP) Model

To support the ability to compare home health agency quality, CMS is proposing to publicly report HHVBP Model performance data including the Total Performance Score (TPS) and the TPS Percentile Ranking for each home health agency in the nine Model states that qualified for a payment adjustment for 2020. CMS expects that these data would be made public after December 1, 2021, after CMS issues the final CY 2020 Annual Report to each home health agency.

Home Health Quality Reporting Program (HH QRP)

Under the HH QRP, CMS publicly reports on quality measure and standardized patient assessment data submitted by home health agencies. CMS is proposing to remove one HH QRP measure, adopt two new measures to improve the transfer of health information and interoperability, modify an existing measure, adopt new standardized patient assessment data beginning with the CY 2022 HH QRP, codify the HH QRP policies in a new section, and remove a question from all the HH Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

Specifically, CMS is proposing to eliminate the Pain Interfering with Activity Measure to "mitigate any potential unintended, over-prescription of opioid medications inadvertently driven by these measures." CMS is also proposing to adopt several standardized patient assessment data elements designed to assess cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, and social determinants of health.

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 ANNOUNCES ATTENDEE BREAKDOWN FOR ANNUAL MEDICAID CONFERENCE; NEARLY 60% OF REGISTRANTS ARE FROM HEALTH PLANS, PROVIDERS, OR STATE AND FEDERAL GOVERNMENT

Nearly 400 health care executives are registered to date for HMA's annual conference, titled *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.

Close to 60% of attendees are from Medicaid managed care plans, provider organizations, or state and federal government. More than 25% of attendees are C-suite executives. "Currently a quarter of our attendees come from health plans, another 25% represent providers, and nearly 10% are government officials," said HMA Principal Carl Mercurio.

This is the fourth annual Medicaid conference presented by HMA. Register now before space runs out: <https://conference.healthmanagement.com/> or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

The conference will feature a high-level list of 45 industry speakers who 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.

Speakers this year include:

State Medicaid Speakers (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
- Alyssa Brown, Deputy Director, Innovation, Research and Development, Office of Health Care Financing, Maryland Department of Health
- 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 (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 (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

Additional Leading Industry Speakers (In alphabetical order)

- Jonathan Blum, Managing Principal, HMA; former CMS Deputy Administrator for Medicare
- John Coster, Director, Division of Pharmacy Center for Medicaid and CHIP Services, CMS
- Terry Cothran, Director, Pharmacy Management Consultants, University of Oklahoma College of Pharmacy
- Jack Dailey, Director of Policy and Training, Coordinator of Consumer Center for Health Education and Advocacy, Legal Aid Society of San Diego, Inc.
- Josh Fredell, Senior Director, Specialty Product Development, CVSHealth
- Ray Hanley, President and CEO, AFMC
- Jimmy Lewis, CEO HomeTown Health, LLC
- Darren Moore, Senior Director, Value and Market Access, Melinta Therapeutics
- Corey Waller, Principal, HMA
- Tracy Wareing Evans, Executive Director, American Public Human Services Association
- Alan Weil, Editor-in-Chief, Health Affairs



HMA MEDICAID ROUNDUP

Delaware

Delaware Wins Approval to Use Federal Funds for Substance Abuse Treatment in Institutions for Mental Disease. *Delaware Public Media* reported on August 5, 2019, that federal regulators have approved Delaware's Section 1115 waiver request for the use of federal funds to provide substance abuse disorder treatment to individuals in state mental health facilities with at least 16 beds. Twenty-four other states have received similar approval from the Centers for Medicare & Medicaid Services (CMS). [Read More](#)

Florida

Florida to Raise Medicaid Managed Care Rates 0.2 Percent, Decrease LTC Rates 2.3 Percent. *Health News Florida* reported on August 7, 2019, that Florida will increase Medicaid managed care rates to plans serving women and children by an average of 0.2 percent and decrease rates for long-term care plans by an average of 2.3 percent. The rate changes would be among the smallest since the statewide Medicaid managed care program was fully launched in 2013. [Read More](#)

Georgia

Corrections Department Awards Behavioral, Dental Contract to Incumbent Centene/Centurion. Centene Corp. announced on August 2, 2019, that its Centurion subsidiary has again won the contract to provide behavioral and dental health services to justice-involved individuals in Georgia. The new contract, awarded by the Georgia Department of Corrections and effective July 1, 2019, includes nine annual renewal options. Centurion operates in the state as MHM Correctional Services, LLC. [Read More](#)

Illinois

Illinois Enacts Legislation to Address Medicaid Applications Backlog, Require Health Plans to Pay Providers Promptly. *The Northwest Herald* reported on August 5, 2019, that Illinois enacted comprehensive legislation aimed at eliminating the state's Medicaid applications backlog and requiring health plans to pay claims within 30 days. Governor J.B. Pritzker signed the bill this month. About 95,000 Medicaid applications hadn't been processed within 45 days of submission. [Read More](#)

Iowa

Iowa Faces Wrongful Termination Lawsuit from Former Human Services Director. *The Washington Post* reported on July 31, 2019, that Jerry Foxhoven, who is the former director of the Iowa Department of Human Services, is expected to file a wrongful termination lawsuit against the state, according to his lawyer. Foxhoven is expected to claim he was ousted after objecting to a pay arrangement concerning the governor's deputy chief of staff. [Read More](#)

Kansas

Kansas Warns Aetna of Non-Compliance in Medicaid Contract. *The Associated Press* reported on August 6, 2019, that Aetna is at risk of losing its \$1 billion a year Medicaid managed care contract with the state of Kansas for non-compliance. The state sent Aetna a letter dated July 24, outlining a list of issues that needed to be addressed, including claims problems and delays in credentialing medical providers. Aetna joined KanCare, the state's Medicaid program, this year. [Read More](#)

Kansas Learns Dozens of Medicaid Fraud Complaints Went Unread. *The Kansas City Star* reported on August 05, 2019, that dozens of fraud, waste, and abuse complaints concerning the Kansas KanCare Medicaid program went to a health department email that no one was monitoring, according to a report from the state Attorney General. A total of 209 emails were left unread, the report said, with 42 containing substantiated allegations of Medicaid fraud or illegal acts that weren't addressed. [Read More](#)

Kentucky

Kentucky Launches Medicaid Program to Help Cover Cost of Employer-Sponsored Insurance Premiums. *BereaOnline.com* reported on August 5, 2019, that the Kentucky Cabinet for Health and Family Services has announced a program that helps subsidize the cost of employer-based health insurance for Medicaid beneficiaries. The Kentucky Integrated Health Insurance Premium Payment program (KI-HIPP) will pay the employee's share of the premium for Medicaid eligible individuals enrolled in employer-sponsored health plans. Medicaid members eligible for KI-HIPP can enroll starting August 5. [Read More](#)

Louisiana

Louisiana Suspends Automatic Termination of Medicaid Coverage for Failure to Respond to Renewal Notices. *The Advocate* announced on August 6, 2019, that the Louisiana Department of Health has suspended the automatic termination of Medicaid coverage for individuals who fail to respond to annual renewal notices within 30 days. The automatic termination is a feature of a new Medicaid eligibility system, which was set to drop 75,000 individuals, including children and families. [Read More](#)

Louisiana Releases Scoring Sheets for Medicaid Managed Care Contract Awards. On August 6, 2019, the Louisiana Department of Health released scoring sheets for its recently announced Medicaid managed care contract awards. It also released responses and evaluation tools. Contracts, which are set to begin on January 1, 2020, were awarded to AmeriHealth Caritas, Healthy Blue/Anthem, UnitedHealthcare, and Humana. [Read More](#)

Louisiana Announces Medicaid MCO Awards. On August 5, 2019, the Louisiana Department of Health announced that it has awarded Medicaid managed care contracts serving 1.7 million members to incumbents AmeriHealth Caritas, Healthy Blue/Anthem, and UnitedHealthcare, and new entrant Humana. New contracts, which generated approximately \$7.6 billion in payments to Medicaid plans in fiscal 2018, will begin January 1, 2020. Current plans Aetna and Louisiana Healthcare Connections/Centene were not awarded contracts. [Read More](#)

Governor Highlights Study on Positive Impact of Medicaid Expansion. *The Advocate* reported on July 31, 2019, that Louisiana Governor John Bel Edwards celebrated the third anniversary of Medicaid expansion by highlighting a new report co-released by the Louisiana Department of Health and Tulane University, which showed that Medicaid expansion in the state has significantly increased access to care. The study found that Medicaid expansion decreased the incidence of beneficiaries foregoing doctor visits by 4.2 percent and taking a prescribed medication by 6.9 percent. Expansion enrollment stands at about 454,000. [Read More](#)

Missouri

Health Care Task Force to Consider Medicaid Expansion Waiver. *KCUR 89.3* reported on August 5, 2019, that a task force created by Missouri Governor Mike Parson to address health care costs in the state will consider recommending a Medicaid expansion waiver as well as potential changes to the state insurance Exchange. The task force is expected to make recommendations by January 31, 2020. [Read More](#)

Montana

Hospitals Are State's Leading Sector for Jobs, Income. *The Great Falls Tribune* reported on July 31, 2019, that hospitals in Montana are the leading sector for jobs and income in the state, according to a study co-released by the Bureau of Business and Economic Research and the Montana Hospital Association. Hospitals in Montana account for about 7 percent of the state's private sector employment and 10 percent of private sector wages. The study also found that Medicaid funds to hospitals alone account for 12,000 jobs statewide. Hospitals take in nearly \$576 million in net Medicaid funds annually. [Read More](#)

Montana Now Says 26,000 Could Be Impacted by Medicaid Work Requirements. *Montana Public Radio* reported on July 30, 2019, that the Montana Department of Public Health and Human Services now projects that nearly 26,000 Medicaid expansion beneficiaries could be impacted by work requirements, up from an earlier projection of 8,000. The requirements, which still require federal approval, are set to take effect on January 1, 2020. [Read More](#)

New Hampshire

New Hampshire to Appeal Federal Judge's Decision to Block Medicaid Work Requirements. The Concord Monitor reported on July 31, 2019, that New Hampshire will appeal a federal judge's decision to block work requirements for Medicaid expansion beneficiaries in the state. Under the policy, Medicaid expansion beneficiaries making up to 138 percent of the federal poverty level would be required to log at least 100 hours of work or community engagement per month. Governor Chris Sununu is confident that the work requirement will be upheld. [Read More](#)

New Jersey

[HMA Roundup - Karen Brodsky \(Email Karen\)](#)

New Jersey Proposes to Conduct Consumer Engagement for 2020 Exchange Enrollment. *NJ Spotlight* reported on August 6, 2019, that the New Jersey Department of Banking and Insurance has proposed to invest \$2 million on consumer engagement to provide residents with outreach and enrollment assistance to sign up for individual health Exchange for 2020 coverage. The state still plans to launch its own online portal and begin oversight to replace federal oversight for the 2021 coverage year. The proposal would boost outreach efforts from those in the prior year, likely increase enrollment, and ease the transition to full management of the state's health exchange in 2021. [Read More](#)

New York

[HMA Roundup - Denise Soffel \(Email Denise\)](#)

New York New Rate Structure for Consumer Directed Personal Care Challenged in Court. *Spectrum News* reported on August 1, 2019, that as part of the fiscal 2020 budget, New York enacted a change in the way fiscal intermediaries 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 (FI) 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 the FIs, which violates numerous federal mandates. [Read More](#)

New York Creates Maternal Mortality Review Board, Advisory Council. On August 1, 2019, New York Governor Andrew M. Cuomo announced that he has signed legislation to create a Maternal Mortality Review Board charged with reviewing the cause of each maternal death in New York and making recommendations to the Department of Health on strategies for preventing future deaths and improving overall health outcomes. While the state has made improvements in reducing maternal mortality rates since 2010, when it was ranked 46th in the nation for the lowest mortality rate, the state still ranks 30th in the nation. The Board will review every maternal death in New York, and make policy and best practice recommendations to the Department of Health. The legislation also establishes a community-led Maternal Mortality Advisory Council comprised of community organizations, public health professionals, clinicians and those individuals most affected by disparate maternal health outcomes. The Maternal Mortality Review Board builds on the recommendations of the Taskforce on Maternal Mortality and Disparate Racial Outcomes, which was established in 2018 and released a report with recommendations in March 2019. This year's budget includes \$8 million over two years to support Taskforce recommendations. [Read More](#)

New York Is Actively Pursuing DSRIP Waiver Renewal; Proposal Due November. *The Wall Street Journal* reported on August 5, 2019, that the New York Department of Health is actively pursuing a Delivery System Reform Incentive Payment (DSRIP) waiver renewal as the program is set to expire in March 2020. A July report released by the United Hospital Fund concluded that with additional time and substantial investment, the DSRIP program could yield a lasting impact on the state's Medicaid system. The New York Department of Health released a June report identifying a 21 percent reduction in potentially preventable hospital admissions and an 18 percent reduction in avoidable hospital re-admissions. A final DSRIP waiver renewal proposal to CMS is due in November. [Read More](#)

North Carolina

North Carolina MCO AmeriHealth Caritas Contracts with Community Care Physician Network for Primary Care Services. On August 5, 2019, managed care organization AmeriHealth Caritas North Carolina announced that it has signed a contract with Community Care Physician Network (CCPN), a network of more than 2,500 primary care clinicians in over 880 practices across the state, to serve Medicaid members seeking primary care services. The first phase of the state's transition to Medicaid managed care is set to start on November 1, 2019, in 27 counties; the remaining counties will begin on February 1, 2020. AmeriHealth Caritas North Carolina will be one of five MCOs to operate within the state's Medicaid managed care program. [Read More](#)

Oklahoma

Governor Appoints Businessman Kevin Corbett as Medicaid Director. *U.S. News/Associated Press* reported on August 5, 2019, that Oklahoma Governor Kevin Stitt has named businessman and certified public accountant Kevin Corbett director of the Oklahoma Health Care Authority, effective August 15. The appointment requires state Senate confirmation. [Read More](#)

Pennsylvania

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

Governor Issues Executive Order to Overhaul State Services and Systems Serving Vulnerable Populations. Pennsylvania Governor Tom Wolf issued an Executive Order on July 31, 2019, announcing an overhaul of the state services and systems to protect the most vulnerable populations. The Executive Order establishes an Office of Advocacy and Reform, with an executive director that includes a new Child Advocate position and integrates the Long-term Care Ombudsman. The order also establishes a Council on Reform made up of appointed advocates charged with protecting vulnerable populations from three perspectives: prevention and diversion, protection and intervention, and justice and support. This process builds on and incorporates important reforms passed and proposed by the General Assembly. [Read More](#)

Utah

Utah Seeks Per Capita Waiver for Medicaid Expansion Population. Utah Governor Gary Herbert announced on July 31, 2019, that the state Department of Health will submit a waiver request for a per capita cap plan for Medicaid expansion members. The waiver also includes an enrollment cap, community engagement requirements, mandatory enrollment in employer-sponsored insurance, and housing supports. The state must finalize an expansion waiver by July 2020 or it will have to implement full Medicaid expansion as required by recently enacted Medicaid expansion legislation. A prior waiver request for a partial expansion was rejected by the Centers for Medicare & Medicaid Services. [Read More](#)

Virginia

Virginia Enrolls 300,000 Medicaid Expansion Members. *The Washington Post/Associated Press* reported on August 1, 2019, that Virginia has enrolled more than 300,000 adults in Medicaid expansion, according to Governor Ralph Northam. More than 75 percent of the newly insured adults have visited a doctor or refilled a prescription since gaining coverage. [Read More](#)

National

CMS Seeks to Abolish Medicaid Access Rule, Ease Requirements on Health Plans as Well. *The PEW Charitable Trusts/Associated Press* reported on August 7, 2019, that the Trump administration and state health departments are seeking to abolish the three-year-old Medicaid Access Rule, which requires states to monitor how Medicaid reimbursement rates affect the number of physicians in fee-for-service Medicaid programs. The administration is also seeking to relax requirements on Medicaid managed care plans. The Centers for Medicare & Medicaid Services (CMS) will make a decision on whether to eliminate the rule after the public comment period ends next month. [Read More](#)

CMS Issues New Guidance on Medicaid Opioid Utilization Review. *Modern Healthcare* reported on August 5, 2019, that the Centers for Medicare & Medicaid Services (CMS) has issued new guidance requiring Medicaid managed care plans and state fee-for-service Medicaid programs to revise their opioid drug utilization review programs. The new rules require caps on opioid prescriptions and the tracking of Medicaid beneficiaries for potential abuse. States must submit plans to CMS by December 31. [Read More](#)

MACPAC Projects Medicaid Funding Shortfalls In US Territories By 2020. In July 2019, the Medicaid and CHIP Payment and Access Commission (MACPAC) released an issue brief projecting that all five U.S. territories will experience Medicaid funding shortfalls when federal supplemental funds expire in 2019, unless Congress provides additional funding and sufficient resources. According to the brief, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands will be left with funding Medicaid entirely with unmatched local funds, cutting services, or tightening eligibility. [Read More](#)

Federal Judge Orders U.S. to Reimburse \$479 Million in ACA Fees to Six States. *The Topeka Capital-Journal* reported on July 31, 2019, that a U.S. District Court judge in Texas ordered the federal government to reimburse \$479 million in provider fees associated with the Affordable Care Act (ACA) to Indiana, Kansas, Nebraska, Texas, and Wisconsin. The federal government is appealing the decision. [Read More](#)

CMS Finalizes Rule to Increase Rural Hospital Payments. *CQ Health* reported on August 2, 2019, that the Centers for Medicare & Medicaid Services (CMS) finalized a rule that will increase payments to rural hospitals in 2020. The rule also increases payments for innovative treatments under Medicare and increases long-term care facility payments. [Read More](#)



INDUSTRY NEWS

Senator Urges Federal Review of Centene's Coverage Denial Policies. *ProPublica/The Dallas Morning News* reported on August 6, 2019, Senator Bob Casey (D-PA) urged federal regulators in a letter to review the coverage denial policies of Centene. Casey sent the letter to the Centers for Medicare & Medicaid Services (CMS) after meeting with Centene chief executive Michael Neidorff. [Read More](#)

Drug Distributors McKesson, Cardinal, AmerisourceBergen Offer to Settle Opioid Litigation. *Bloomberg* reported on August 6, 2019, that drug distributors AmerisourceBergen, Cardinal Health, and McKesson have offered to pay \$10 billion to settle claims related to the opioid epidemic. Both opioid manufacturers and distributors have been hit with nearly 2,000 lawsuits claiming they helped fuel the epidemic. Settlements have already been reached by McKesson in West Virginia for \$37 million and by Johnson & Johnson, Purdue Pharma, and Teva Pharmaceuticals in Oklahoma for more than \$350 million. [Read More](#)

Addus HomeCare Considers Larger Acquisitions in Medicaid, Medicare. *Home Health Care News* reported on August 6, 2019, that Addus HomeCare is considering larger acquisitions to expand the company's Medicaid personal care services business and to prepare for Medicare Advantage opportunities. Earlier this week, Addus announced it had acquired home health providers in New Mexico and New York. [Read More](#)

Addus HomeCare Acquires Providers in NM, NY. Home care provider Addus HomeCare Corporation announced on August 5, 2019, that it has completed acquisitions in New Mexico and New York for approximately \$24 million. Addus acquired New Mexico-based Alliance Home Health Care, LLC and its affiliate House Calls of New Mexico, LLC, with combined annual revenues of about \$19 million. Addus also acquired the assets of New York City-based personal care provider Foremost Home Care, Inc., with annual revenues of about \$6 million. [Read More](#)

RHA Health Services Sold to Blue Wolf Capital By Formation Capital, Safanad Limited. On August 5, 2019, private equity and investment firms Formation Capital and Safanad Limited announced the sale to Blue Wolf Capital of RHA Health Services, a provider of behavioral health services to individuals with intellectual and developmental disabilities. RHA serves 25,000 individuals each year across 440 locations in four southeastern states. Details of the sale have not been disclosed. [Read More](#)

Kadiant Announces Partnership with Behavioral Education for Children with Autism. On August 5, 2019, California-based Kadiant Partners announced a partnership with Behavioral Education for Children with Autism (BECA), which provides Applied Behavior Analysis (ABA) services to individuals with autism spectrum disorder. Terms of the partnership were not disclosed. BECA is the fifth provider to partner with Kadiant, which itself is a partnership among Lani Fritts, TPG Capital, and Vida Ventures. [Read More](#)

Guidehouse Acquires Navigant For \$1.1 Billion. On August 2, 2019, Guidehouse, a management consulting portfolio company of Veritas Capital, announced its acquisition of publicly traded Navigant Consulting, Inc. for nearly \$1.1 billion or \$28 per share in cash. Pending regulatory approvals and closing conditions, the finalization of the acquisition is expected to occur at the end of the year. [Read More](#)

LHC Group Completes Home Care Transactions in 3 States. On August 1, 2019, LHC Group, Inc. announced it had completed home health provider transactions in three states. In Missouri, LHC completed the purchase from SSM Health of two home health agencies and one hospice agency through a joint venture with Capital Region Medical Center. In Alabama, LHC Group finalized a partnership with Atmore Community Hospital to share ownership of a home health provider. And in Ohio, LHC Group acquired the assets of two home and community-based locations from Comfort Home Care.

Healthfirst Selects Landmark Health to Provide In-Home Medical Care to Medicare Advantage Members. Landmark Health and New York's largest not-for-profit health insurer Healthfirst, Inc., announced on August 1, 2019, that they are partnering to offer in-home medical care and coordination to 7,500 Healthfirst Medicare Advantage members with complex, chronic conditions. The program will focus on addressing difficulties that individuals face in getting to their doctors on a regular basis. Landmark will provide medical professionals who are available around the clock to bring care to members in their homes through routine and urgent house calls. Pharmacists, dietitians, nurse care managers, social workers and behavioral health specialists are all part of the Landmark care team, available to members both in home and over the phone. The Landmark program is voluntary and offered at no cost to eligible Healthfirst Medicare Advantage members. Financial terms between Healthfirst and Landmark are not being disclosed, but [Crain's HealthPulse](#) reports that the companies will share risk. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
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
Fall 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
Fall 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
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	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January - 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

Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations

HMA NEWS

New this week on HMA Information Services (HMAIS):

Medicaid Data

- California Dual Demo Enrollment is Down 3.7%, Jun-19 Data
- California Medicaid Managed Care Enrollment is Down 1.0%, Jun-19 Data
- Colorado RAE Enrollment is Down 2.5%, Jun-19 Data
- Maryland Medicaid Managed Care Enrollment Is Up 0.2%, Jun-19 Data
- Minnesota SNP Membership at 43,751, Mar-19 Data
- Nebraska Medicaid Managed Care Enrollment Is Down 0.7%, May-19 Data
- New York Medicaid Managed Care Enrollment is Flat, Jun-19 Data
- MLRs at Ohio Medicare Advantage MCOs Average 83.6%, 2018 Data
- Oklahoma Medicaid Enrollment is Flat, Jun-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Up 0.6%, Jun-19 Data
- MLRs at Texas Medicare Advantage MCOs Average 86.9%, 2018 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.7%, Jun-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alaska DHSS TEFRA Medicaid Eligibility & Program Management Services RFI, Aug-19
- District of Columbia Medicaid Third Party Liability (TPL) Verification RFP, Aug-19
- Louisiana Medicaid Managed Care Organizations (MCO) RFP, Proposals, Scoring, and Related Documents, 2019
- Louisiana Medicaid MCO Contract Amendments, 2019
- Ohio Transition Coordination for HOME Choice Program RFGA, Proposals, and Scoring, 2019
- Oregon, Washington Pharmacy Benefit Administration Services Joint RFP, Aug-19
- Pennsylvania HealthChoices Physical Health Contract, 2019
- Pennsylvania Medicaid Managed Care Independent Audit Services RFI, Jul-19

Medicaid Program Reports, Data and Updates:

- MACPAC Issue Brief on When Will the U.S. Territories Exhaust Federal Medicaid Funding, Jul-19
- California Transitioning Medi-Cal Pharmacy Services from Managed Care to FFS Presentation, Jul-19
- Colorado Medical Assistance & Advisory Council Meeting Materials, May-19
- Florida Medical Care Advisory Meeting Materials, Mar-19
- Kansas Office of the Medicaid Inspector KanCare Audit, Jul-19
- Maryland HealthChoices 1115 Medicaid Waiver Documents, 2016-19
- Medicaid Managed Care Enrollment for 300 Plans in 38 States, Plus Ownership and For-Profit vs. Not-for-Profit Status, Updated Jul-19
- North Carolina Final Guidance on BH, IDD Tailored Plan Eligibility and Enrollment, Aug-19

- New York Office of the State Comptroller Audit of OMH Performance on Incidence Reporting, Jul-19
- Oklahoma Medical Advisory Meeting Materials, Jul-19
- Texas Evaluation of Rural Hospital Medicaid Funding Initiatives Report, Aug-19
- Texas HHSC Electronic Visit Verification Tool Kit Presentations, 2019
- Texas Quarterly Reports of Waiting Lists for Mental Health Services and of Mental Health Services for the Former NorthSTAR Service Area, Jul-19
- West Virginia Medicaid Managed Care Capitation Rates, SFY 2020

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