HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 19, 2018

RFP CALENDAR

HMA News

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The HMA Weekly Roundup will be off the Wednesday, December 26th and January 2nd. We will resume our regular weekly publication on January 8th. The HMA Weekly Roundup team wishes all our readers happy and safe holidays!

IN FOCUS

MEDICAID EXPANSION CONSIDERATIONS FOR NON-EXPANSION STATES

This week, our In Focus section is led by Matt Powers, a Principal in our Chicago office, who worked with HMA colleagues to summarize the factors that non-expansion states weigh when considering whether or not to expand Medicaid under the Affordable Care Act. Including the states where Medicaid expansion ballot initiatives passed, 37 states have chosen Medicaid expansion or are moving toward Medicaid expansion. More than 12 million newly eligible individuals are insured by state Medicaid programs through the expansion. Comments on recent ACA Court Ruling:

Prior to our discussion of Medicaid expansion considerations, we first consider the implications of last week's ruling on the constitutionality of the Affordable Care Act. A federal district judge in Texas ruled Friday that the ACA is unconstitutional but gave no injunctive relief, therefore leaving the law legally and practically in place while the case moves to appeal. The root of the court's decision is that, when the Supreme Court first upheld the ACA in 2012, the decision stated that the individual mandate would have been unconstitutional under the commerce clause. The Supreme Court upheld the individual mandate however, and the bulk of the ACA, because it was coupled with a tax penalty and therefore permissible under the taxing power given to Congress by the Constitution. Once the 2017 Tax Cut and Jobs Act reduced the penalty to zero, twenty attorneys general sued to have the law invalidated on the basis that the individual mandate could no longer be considered part of a tax structure and therefore was unconstitutional under the commerce clause; an interpretation that U.S. District Judge Reed O'Connor agreed with in his ruling Friday. More importantly, O'Connor ruled that the individual mandate was inseverable from the rest of the ACA provisions and therefore the entire ACA was unconstitutional. The case will soon go to the 5th Circuit Court of Appeal and possibly the Supreme Court. These appeals could take up to two years to reach the Supreme Court.

The court's decision is almost entirely based on arguments made in the earlier case and findings of Congress that the individual mandate was essential and that all the provisions of the ACA were to "work together." In the next rounds of appeals, even if the ruling on the individual mandate is upheld, there will be close scrutiny of the ruling that this provision was inseverable from the rest of the ACA.

While the case works its way through the courts, we don't anticipate any impact on current Medicaid expansion states, or states with immediate plans to implement Medicaid expansion. However, it is possible that the verdict is considered during Medicaid expansion discussions in non-expansion states, along with a number of other factors that we discuss in more detail below.

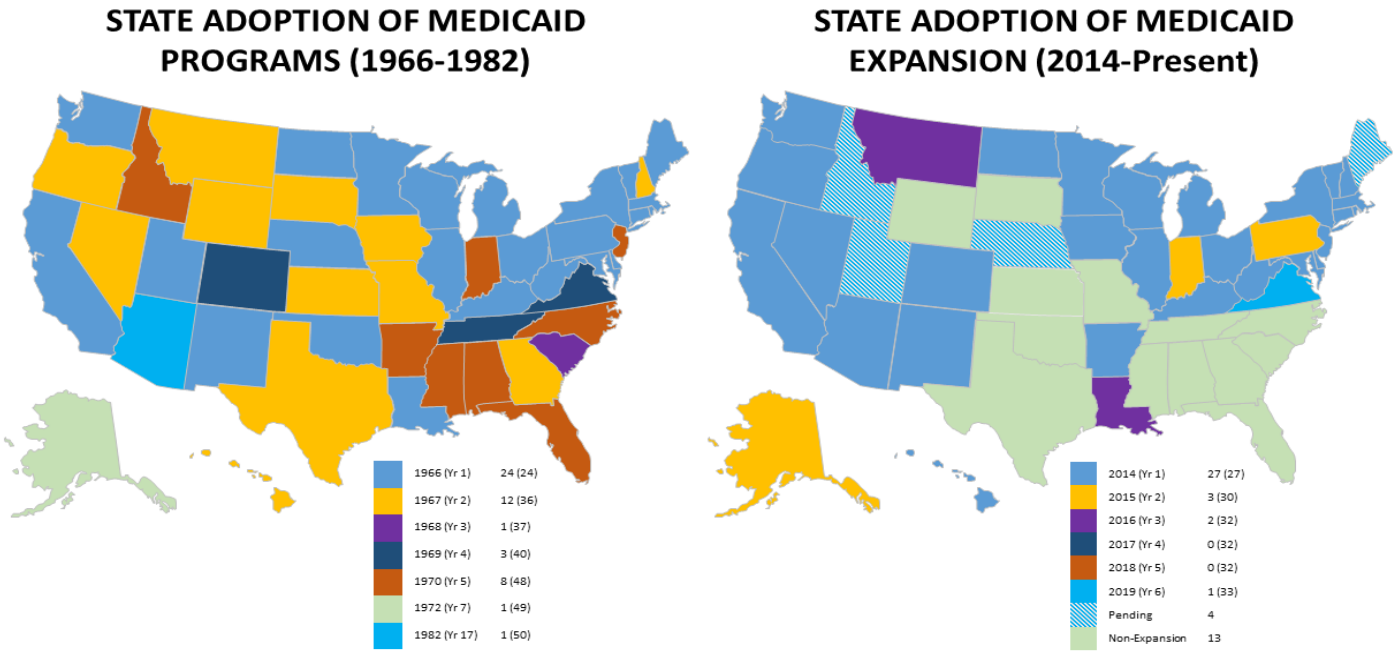
Looking Back - Adoption of the Original Program and the Adoption of Medicaid Expansion

While the court ruling represents in many ways the back-and-forth intensity of the current political times, the dynamics at the time of the original adoption of the Medicaid program were every bit as compelling. As Figure 1 notes, it took 16 years for 50 states to adopt Medicaid programs. While 49 states adopted the program by 1970 (five years after the bill creating the Medicaid program was signed) the last holdout, Arizona, did not adopt Medicaid until 1982 – a full 12 years after the 49th adoption. There are certainly parallels between the order in which states adopted Medicaid and the order in which states adopted Medicaid expansion, as Figure 1 demonstrates.

Some key assumptions were made in the categorization of states in Figure 1:

- Wisconsin is considered an expansion state due to childless adults being covered under the BadgerCare program that pre-existed the ACA;
- Idaho, Utah, Maine and Nebraska are categorized as pending given the successful Medicaid expansion ballot initiatives in those states;
- Kansas remains in the non-expansion category due to the opposition of the state legislature, although the election of a new Governor who supports expansion may boost the chances of expansion in 2019 or in subsequent years.

Figure 1 – Adoption of Medicaid in 1966 Compared to 2014 Medicaid Expansion Provisions enabled by ACA



Source for 1966-1982 Map: Nichols, L. (2015, May). Health Reform Beyond the ACA – Which Way from Here. Presented at HMA Meeting, Loudon, VA.

What States are Next to Watch?

After the 2018 November election and ballot initiative results, 37 states have adopted or are poised to adopt Medicaid expansion. Voters in Utah, Nebraska, and Idaho elected to expand Medicaid on their 2018 midterm ballots. Each of these states has discussed work requirements for Medicaid enrollees, and Utah has drafted a waiver.

Figure 2 identifies the remaining non-expansion states and provides context as to the size of the potential expansion population relative to existing Medicaid enrollment. A subset of non-expansion states to watch are states that allow ballot initiatives - Florida, Oklahoma, Missouri, Mississippi, and Wyoming. Additionally, hospital and hospital associations continue the push for expansion, either at the statewide level or even a regional approach, as hospitals exhaust substantial (and frequently unmatched) resources as required by the EMTALA law to provide medical screenings and treatments for emergency medical conditions.

Figure 2 – 13 Non-Expansion States Medicaid and Coverage Gap Populations

State	Current Medicaid Population[1] (September 2018)	Population Currently in Coverage Gap (<100% FPL)[2] (2016)	Percent of Current Medicaid Population	Percent of Total Population in Coverage Gap
Alabama	910,008	75,000	8.2%	3.5%
Florida	4,224,719	384,000	9.1%	18.0%
Georgia	1,764,356	240,000	13.6%	11.2%
Kansas	384,737	48,000	12.5%	2.2%
Mississippi	634,950	99,000	15.6%	4.6%
Missouri	921,839	87,000	9.4%	4.1%
North Carolina	2,033,474	208,000	10.2%	9.7%
Oklahoma	783,354	84,000	10.7%	3.9%
South Carolina	1,012,160	92,000	9.1%	4.3%
South Dakota	116,882	15,000	12.8%	0.7%
Tennessee	1,377,849	163,000	11.8%	7.6%
Texas	4,329,625	638,000	14.7%	29.8%
Wyoming	57,554	6,000	10.4%	0.3%
TOTAL	**18,551,507**	**2,138,000**	**11.5%**	

Much of the discussion and concerns identified by non-expansion states focus on states' share of the cost, which will be 10 percent in 2020 and beyond. This is a sizeable outlay for the states and many state legislators fear that the federal government may turn out to be a less reliable partner due to the rising federal debt and the potential for future Congressional efforts to curb entitlement spending. Some states consider non-disabled adults without dependent children as a sector of the population that warrants a different set of

[1] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[2] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

considerations and rules. Beyond the federal matching and partnership issues, difficulties expressed in the debate include trying to keep up with state innovations and understanding what CMS has approved. Many of the 37 states that have expanded Medicaid have their own twist on the expansion, with significant policy variations. Even with the recent court ruling, it is very likely that Medicaid expansion will remain part of the fabric of state policy and that states will continue to debate about expansion. What follows is an attempt to provide insights into the dynamics for non-expansion states with lessons learned incorporated from the 37 states that have adopted expansions.

Key Issues that Factor into State Decisions Regarding Medicaid Expansion

1. Waiver Flexibilities Granted Under Current Administration May Not Be Available After 2020. Of the remaining 13 non-expansion states, 11 will have Republican Governors in 2019 and all 13 states will have Republican majorities in both legislative chambers. The Trump administration has been willing to approve, via 1115 waivers, limitations not allowed in the Medicaid programs under the previous administration. Knowing the current administration is in place may bode well for consideration of expansions in the remaining 13 states as the political alignment may help diminish the political discourse at the state level. Additionally, states may find it advantageous from both financial and policy perspectives to learn from the "early adopters'" mistakes and choose from a menu of CMS-approved adoptions, such as expanded cost sharing and differential benefit designs (as was approved in Indiana), or work requirements. Partial waiver proposals that would expand Medicaid in a limited geographical region, but not statewide, are worth watching as well. Most of the recent expansions include some type of work requirements, also referred to as community engagement, for the expansion population. These work requirements vary on the spectrum of restriction, but have included provisions such as:

a. Requirements to work a set number of hours per week/month, or be engaged in other activities (i.e., education or volunteering)
b. Lockout and/or disenrollment from Medicaid if requirements aren't met
c. Reporting of exemptions and/or hours worked in a state monitoring system
d. Exemptions for community engagement - generally medical frailty, pregnant women, disabled individuals, full-time students, family caregivers

It is also noteworthy that since the beginning of the 2016 election cycle (and before), while "repeal and replace" bills have been a point of contention in Congress, most of the introduced "repeal and replace" bills kept the Medicaid expansion in place. Rescinding coverage for 12 million newly covered Medicaid beneficiaries is politically unpalatable and the threat to Medicaid funding factored in the failure of "repeal and replace" bills in the past. These factors, along with the fact that the House will have a Democratic majority beginning in 2019, make consideration of an expansion repeal unrealistic in both the short and long term; supporting the point that there's a unique window of opportunity before 2020.

2. Financial Implications of Historic Proportions - non-Expansion States Dislike Sending Billions to Expansion States. Every year, state residents pay over $3 trillion in federal income taxes. The federal government keeps money for federally-led activities and effectively sends back funding to states and state governments through Medicaid, infrastructure, public health grants and other legislated program vehicles. This process of taxpayers sending money to the federal government and states receiving federal funds back to finance state/federal programs is a process that can be called "financial migration." In 2018, it is projected that 55 percent of all federal assistance to state and local governments is derived from the Medicaid program federal match.[3][4] Interestingly, the 13 non-expansion states matching rate is 63.9 percent while the match rates of the 37 expansion states is just 58.6 percent. As such, states that have historically been the beneficiary of the higher matching rates are potentially now bringing down their effective matching percentage by not expanding.

While there are certainly more factors than the expansion in play, for approximation purposes only, Figure 3 compares pre-expansion to post-expansion (2013 and 2017 NASBO State Expenditure Reports[5]) and indicates that expansion states' federal funds have increased by $97 billion (28 percent) while non-expansion have increased in that period by $4 billion (3 percent).

Figure 3 – Non-Expansion State vs. Expansion State Federal Fund Growth

	Federal Fund Growth ($) 2013 to 2017	Federal Fund Growth (%) 2013 to 2017	Federal Fund Growth Per Capita
Non-Expansion *(13 states)*	$4,477,000,000	3.05%	$43
Expansion *(37 states)*	$97,164,000,000	27.61%	$440

For an additional perspective, assuming the 2.1 million individuals in non-expansion states were to be covered at an approximately $475 per member per month (HMAIS calculations from public documents) capitated rate at the 90 percent federal matching rate, nearly $11 billion net federal dollars would flow to these 13 states annually at full participation/take up. While the $475 rate may be slightly high for the remaining 13 states as those states tend to be slightly lower cost states, the expansion choice clearly has material financial implications for states. Figure 4 illustrates how the nearly $11 billion annual monies would be available to support state enrollees and providers at full-take up rate, 90 percent federal match and a $475 PMPM

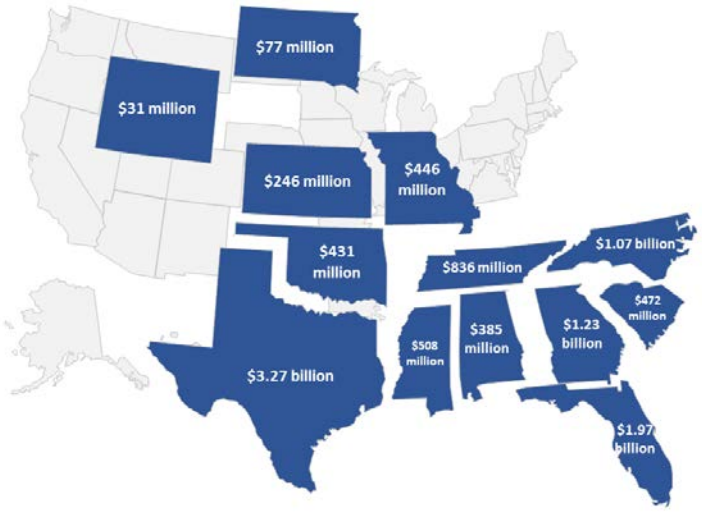
[3] Federal Medical Assistance Percentage for Medicaid and Multiplier. FY 2019. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] Federal assistance to state and local governments by program is available in Table 12.3 at https://www.whitehouse.gov/omb/historical-tables/

[5] NASBO State Expenditure Reports 2013 and 2017. Retrieved from https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives

3. Evidence suggests that States Realize General Revenue Fund Savings with Expansion. Setting aside the new resources that providers and patients see from expansion, many states have seen an immediate budgetary benefit. Although Medicaid expansion still will have a 10 percent state share in 2020, the short-term impact is often savings. This is because most non-expansion states are operating state-funded-only health programs, mainly in the areas of mental health and substance abuse as well as corrections. Individuals served in these programs overwhelmingly tend to be Medicaid eligible under expansion. As a result, there are opportunities to fund certain benefits with Medicaid funds that are matched at the higher expansion match rate. For states facing significant budget pressures, the Medicaid expansion funding source may be an attractive opportunity for short-term savings. In addition, when states use provider taxes to fund the state share of Medicaid expansion, these short-term general fund savings are even greater. Virginia, which is funding the state share of expansion with a hospital tax, has projected savings to their general fund of $421.6 million in the first two years of expansion.[6] Other states expecting general revenue savings from Medicaid expansion are Arkansas ($444 million total from 2018-2021)[7], Michigan ($1 billion from 2018-2021)[8] and Montana (over $50 million).[9]

Figure 4 – Potential Annual Funding Available to Remaining States



[6] DMAS Overview of Governor's Introduced Budget http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf

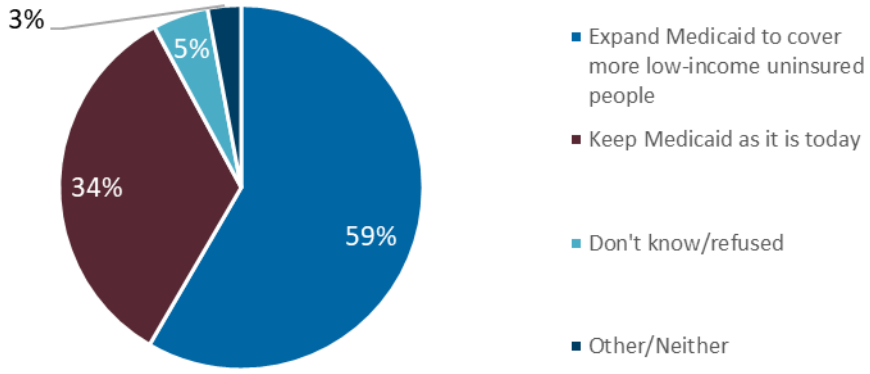
[7] The Stephen Group, "Arkansas Health Reform Legislative Task Force: Final Report," December 15, 2016, http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%2012-15-16.pdf.

[8] John Ayanian *et al.*, "Economic Effects of Medicaid Expansion in Michigan," *New England Journal of Medicine*, February 2, 2017, https://www.nejm.org/doi/full/10.1056/NEJMp1613981.

[9] Bryce Ward and Brandon Bridge, "The Economic Impact of Medicaid Expansion in Montana," University of Montana Bureau of Business and Economic Research, April 2018, https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

4. Medicaid Expansion Polls Well in Non-Expansion States. As Figure 4 indicates, 59 percent of those polled in non-expansion states would support expanding Medicaid to cover more low-income uninsured people. Overall, the proportion in favor of the Medicaid expansion in Florida is similar to the share seen in other non-expansion states, with nearly six in ten residents saying their state should expand Medicaid, while nearly four in ten say their state should "keep Medicaid as it is today." The majority of GOP voters in these states said they'd support a measure that "would expand Medicaid to people with incomes below $17,000 a year if they are single and $22,000 a year for a family of two," including more than 60 percent of Republican voters in Idaho. Polling suggested that when ballot language was simplified, support for Medicaid expansion was even greater in these states than final vote tallies suggested. Although on many issues, polling results favorable to an initiative can be reduced when language is added about raising taxes to pay for the initiative, it should be noted that the ballot initiative to expand Medicaid in Utah passed despite the fact it included language authorizing a sales tax increase to pay for the expansion.

Figure 5 – Significant Support of Medicaid Expansion Among Those Living in Non-Expansion States



Source: Kaiser Family Foundation, Health Tracking Poll – November 2018: Priorities for New Congress and the Future of the ACA and Medicaid Expansion

5. Business Wants a Healthy Workforce. Both private employers and state and local governments managing their work forces benefit if a viable and largely bipartisan path can be found to bring coverage to the uninsured. In many cases, workers are one illness or one accident away from being unable to work due to a lack of insurance coverage. One substantial hospital stay is frequently followed by the need for rehab and home care to recover and can lead to a "medical bankruptcy." For those in the coverage gap who are not working, many have chronic conditions, including physical and behavioral health conditions; others are struggling to stay in school and incurring significant debt to do so; still others are caring for an aging parent or a child with disabilities, frequently leading to burnout that caused them to lose their job. There are reasons why many conservative-leaning business groups have frequently been supportive of expansion. Many employers realize that health coverage reduces absenteeism and turnover and improves productivity.

Figure 6 – Healthcare as Hub for State Pressure Points

6. Expansion Offers Systematic Resources for State High-Pressure Points. Expansion gives states a more dependable, systematic resource that improves states' abilities to manage what is currently a complex set of variables. The point applies to both every day catastrophes for real people with physical and behavioral needs as well as natural disasters. Examples include:

a. *Opioid Epidemic.* As the leading cause of death for Americans under 50 years old[10], addressing the opioid epidemic has become an "all hands-on deck" movement. Medicaid expansion can play an important role in addressing the epidemic by providing access to treatment for affected individuals who otherwise would have been uninsured. In fact, expansion states have been able to use expansion funds for treatment (e.g. BH counseling; addiction treatment; Medication Assisted Treatment) so that they can use other federal resources for prevention while non-expansion states must use more federal resources for treatment since the expansion resources are not available.[11]

b. *Mental Health Gaps.* Gaps in the mental health systems are frequently cited as an area that both parties agree need more resources and reforms. As policy-makers discuss the need for improvements, expansion potentially provides an organized hub for mental health treatment and services for at-risk populations.

c. *Incarceration Pressures.* Medicaid expansion can provide ongoing healthcare support to individuals transitioning out of the criminal justice system. Both sides of the partisan aisle are looking for ways to work together for criminal justice reform and are searching for ingredients to reduce incarceration rates. Given the mental health and other system gaps, expansion presents a major resource to help with criminal justice reform.

[10] https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html

[11] ACA Repeal Would Jeopardize Treatment for Millions with SUD, Including Opioid Addiction. https://www.cbpp.org/research/health/aca-repeal-would-jeopardize-treatment-for-millions-with-substance-use-disorders

d. *Natural Disasters.* Expansion provides a consistent source of funding to hospitals and clinics that respond to community needs during natural disasters.

7. Non-Expansion Cost Shifts to Employees and Employers. About one-third of all health care spending is Private Health Insurance (CMS NHE Tables).[12] Hospitals and clinics incur tens of billions of dollars in uncompensated care costs annually. HMA reviewed CMS S-10 reports for all 50 states and determined that Uncompensated Care reported to CMS by hospitals in expansion states decreased by 33 percent from 2013 through 2016 while increasing by 19 percent in non-expansion states. The increased uncompensated care is often passed on to privately insured patients, resulting in higher insurance premiums for employees and employers.

Figure 7 - Uncompensated Hospital Care by Non-Expansion State

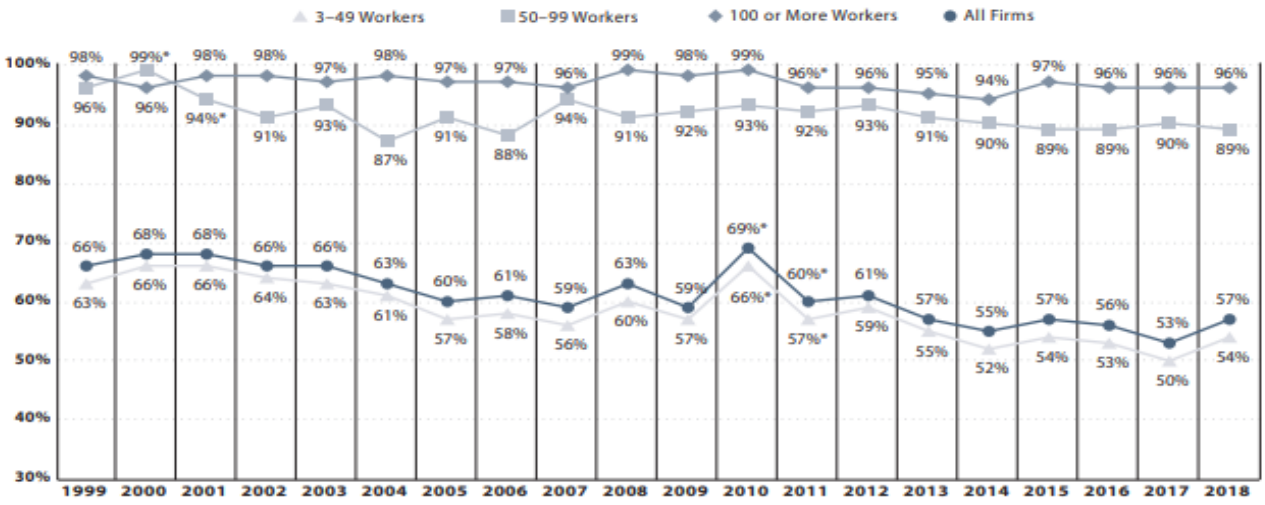
State	Uncompensated Hospital Care by Non-Expansion State (2016)
Alabama	$570,180,000
Florida	$3,417,100,000
Georgia	$1,833,240,000
Kansas	$289,900,000
Mississippi	$572,710,000
Missouri	$1,037,230,000
North Carolina	$1,652,740,000
Oklahoma	$597,780,000
South Carolina	$1,014,230,000
South Dakota	$102,860,000
Tennessee	$828,510,000
Texas	$5,926,050,000
Wyoming	$108,380,000
TOTAL	**$17,950,910,000**

Source: *HMA Analysis from CMS S-10 Reports, Dennis Roberts, Principal, Happy Retirement!*

8. The Concern that Medicaid Expansion Would "Crowd-Out" Employer Sponsored Insurance has not Materialized. Prior to the implementation of Medicaid expansion in 2014, there was concern that the expansion would create too large of an incentive for employers to dis-continue health care coverage for low-wage employees that would otherwise be eligible for Medicaid. As Figure 8 from the annual Kaiser Family Foundation Employer Benefits Survey points out below, this concern has not materialized. The percentage of all firms offering health benefits has remained unchanged in 2018 compared to 2013 at 57 percent.

[12] National Health Expenditure measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net costs of health insurance, and investment related to health care. Retrieved from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

Figure 8 - Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2017

HMA MEDICAID ROUNDUP

Arkansas

Arkansas Drops Another 4,655 Medicaid Beneficiaries for Failing to Meet Work Requirements. *The Hill* reported on December 17, 2018, that in the last month, Arkansas dropped another 4,655 Medicaid beneficiaries for failing to meet the state's work requirements. Nearly 17,000 have lost coverage as a result of the imposition of work requirements in August. Adults without dependent children are required report they are working, looking for a job, or going to school for 80 hours per month for three straight months. Read More

Arkansas to Allow Medicaid Recipients to Report Work By Phone. *Modern Healthcare* reported on December 12, 2018, that Arkansas will allow individuals to report compliance with Medicaid work requirements by phone instead of online, effective December 19. Since Arkansas implemented Medicaid work requirements, nearly 13,000 beneficiaries in the state have lost coverage for failing to report. Lack of internet access may have been a factor in failure to report for some individuals, researchers say. Read More

California

Molina Healthcare to Cut Ties with Golden Shore Medical Group Clinics. *The Los Angeles Times* reported on December 14, 2018, that Molina Healthcare has decided to cut ties with Golden Shore Medical Group clinics affecting about 79,000 Medicaid beneficiaries in California. Golden Shore is a network of 16 clinics purchased from Molina by Mario Molina, former chairman and chief executive of Molina Healthcare. Golden Shore suffered substantial financial losses this last year due to low Medicaid reimbursement rates imposed on the clinics. Molina Healthcare has decided to cancel its contract with the company as of February 1, 2019, after negotiations reached an impasse. Read More

California Spent $959 Million in State, Federal Funds on Ineligible Medicaid Recipients, Audit Estimates. *California Healthline* reported on December 13, 2018, that California spent $959 million in state and federal Medicaid funds on 803,000 ineligible individuals from 2014 to 2015, according to an audit from the U.S. Office of the Inspector General. The audit also found that the state spent $4.5 billion on 3.1 million beneficiaries whose eligibility could not be documented. The audit examined individuals eligible for Medicaid before the Affordable Care Act, excluding the expansion population. Read More

Georgia

Senate Committee Proposes Certificate of Need Reforms. *The Gwinnett Daily Post* reported on December 18, 2018, that a Georgia Senate study committee is proposing changes to the state's certificate of need (CON) laws, easing restrictions on Cancer Treatment Centers of America in Newnan, GA, and clearing a path for a planned sports medicine center in Alpharetta. The proposal will also exempt from CON review medical equipment purchases, most imaging services, mental health and substance abuse facilities, and the addition of cardiac services by hospitals in some cases. The Georgia House proposes a similar plan. Read More

Indiana

Indiana Releases PBM Administrative Services RFP. On December 17, 2018, Indiana released a request for proposals (RFP) for the state's Medicaid pharmacy benefit management administrative services contract. Proposals are due February 25, 2019, with awards expected to be announced June 2019. The vendor will work under the state Office of Medicaid Policy and Planning (OMPP) to administer pharmacy benefits for the Indiana Health Coverage Program. Read More

Michigan

Health Plans Urge Transition of Medicaid Behavioral Health to Managed Care. *Crain's Detroit Business* reported on December 17, 2018, that the Michigan Association of Health Plans (MAHP) is urging the state to speed up the consideration of transitioning Medicaid behavioral health to managed care, citing heavy losses among public mental health authorities. An MAHP analysis found that nine of Michigan's 10 regional mental health authorities, or Prepaid Inpatient Health Plans (PIHP), are running a combined deficit of $92.8 million. The state currently has three-year Medicaid managed behavioral pilot programs scheduled to begin in November 2019 in Genesee, Saginaw, Muskegon, Lake, Mason and Oceana counties. Read More

Minnesota

Attorney General Seeks Law Regulating Not-for-Profit Health Plan Conversion. *The Star Tribune* reported on December 18, 2018, that Minnesota Attorney General Lori Swanson called for legislation to regulate the sale and conversion of not-for-profit health plans in the state to for-profit status. In 2017, Minnesota lawmakers lifted a 40-year ban on for-profit plans operating in the state; however, a two-year moratorium was place on the sale or conversion of not-for-profits. That moratorium expires in July 2019. Read More

New Jersey

Legislation Passed to Increase Welfare Assistance for First Time in 31 Years. *NJ.com* reported on December 18, 2018, that a New Jersey bill was signed into law on December 17, 2018, (S2845/A4351), to raise the value of monthly cash assistance payments by 10 percent in the current fiscal year, effective immediately. The increase includes families enrolled in the Temporary Assistance to Needy Families (TANF) program and childless adults enrolled in the General Assistance program. Another law will need to be passed to extend the increase beyond State fiscal year 2019. Senator Vitale plans to propose legislation that would continue the increase beyond this fiscal year. Read More

NJSave Provides New One-Stop, Online Benefits Application for Older Residents. The New Jersey Division of Aging Services launched NJSave, a new online application to help residents age 65+ with low incomes and people with disabilities to apply for prescription assistance, help with Medicare premiums, utility bills and hearing aid costs. The following programs are in place to help qualified applicants:

1. Pharmaceutical Assistance to the Aged and Disabled (PAAD)
2. Senior Gold Prescription Discount Program
3. Lifeline Utility Assistance
4. Medicare Savings Programs
5. Medicare part D's Low Income Subsidy (LIS)
6. Hearing Aid Assistance to the Aged and Disabled

The NJSave application is also used to screen applicants for other savings and assistance programs including, for example, the Universal Service Fund (USF) for credit on natural gas or electricity costs, Low Income Home Energy Assistance grants to help with heating and cooling costs, and Supplemental Nutrition Assistance Program (SNAP). NJSave information can be found here.

New Jersey FIDE-SNP Plans Expand Coverage in 2019. Four of the five Medicaid managed care plans in New Jersey operate fully integrated dual eligible special needs plans (FIDE-SNP) for individuals who have both Medicare and Medicaid coverage. The following (see data package below) FIDE-SNP service area expansions are planned effective January 1, 2019.

PLAN NAME	2018 COUNTIES	2019 EXPANSION COUNTIES
Amerivantage Dual Coordination FIDE SNP	Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Union	None
Horizon NJ TotalCare FIDE SNP	Atlantic, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Monmouth, Morris, Passaic, Salem, Somerset, Sussex, Union, Warren	Bergen, Burlington, Camden, Cape May, Middlesex and Ocean
UnitedHealthcare Dual Complete ONE FIDE SNP	Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union	None
WellCare Liberty FIDE SNP	Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Somerset, Union	Atlantic, Camden, Mercer

Medicaid Enrollment Down Through First 11 Months of 2018. New Jersey's Medicaid program saw a slight decrease in overall enrollment between January and November 2018, from a high of 1,779,789 in May to a low of 1,724,232 in November, down by 55,557. Reductions occurred in all enrollment eligibility categories except for dual eligibles in the Aged, Blind and Disabled group, which saw an increase of over 3,000. At the same time the state's long term care population increased by over 4,000 from last year.

New York

HMA Roundup – Denise Soffel (Email Denise)

New Leadership at New York City Health + Hospitals. On December 12, 2018, New York City Mayor Bill de Blasio announced the appointment of five new members to the NYC Health + Hospitals Board of Directors, effective January 2019. The Board of Directors is charged with governance and oversight of NYC Health + Hospitals, the largest public health care system in the nation. NYC Health + Hospitals serves more than a million New Yorkers annually in more than 70 patient care locations across the city's five boroughs. Health + Hospitals is a quasi-independent public benefit corporation. In addition to the five Mayoral appointees, the board includes one appointment from each of the five borough's City Council delegations, as well as 5 appointees who serve in an ex officio capacity as a function of their role in NYC government (i.e., the Commissioner of the Human Resources Administration, the Commissioner of the Department of Health and Mental Hygiene, the Executive Deputy Commissioner, Department of Health & Mental Hygiene responsible for behavioral health services). Jose Pagan, a professor at NYU's College of Global Public Health, has been named as Chair of the board. Read More

Governor Andrew Cuomo Announces "First 100 Days" Agenda. On December 17, 2018, in a speech hosted by the Roosevelt Institute, New York Governor Cuomo outlined an agenda for the first 100 days of 2019. Labeled the Justice Agenda, it articulated the Governor's priorities for the legislative session beginning in January. The agenda, framed as a push-back against federal policies, includes "a suite of ambitious proposals to ensure the promise of full, true justice for all, including economic justice, social justice, racial justice." The agenda includes a commitment to protect New York from the erosion of the Affordable Care Act by codifying the health exchange into law and passing a law to ensure pre-existing conditions continue to be covered by insurance companies regardless of what happens at the federal level. Read More

New York DOH Announces Funding for Community-Based Organizations. The New York State Department of Health has announced the execution of a contract with the Healthy Community Alliance, Inc. (HCA) for the Rest of State region for the Community-Based Organization (CBO) Planning Grant. The announcement comes two years after an initial award had been announced, funding the S2AY Rural Health Network. That contract was never executed for reasons that have not been explained. The contract is the third of three regional grants that the state has made to support strategic planning activities for CBOs to facilitate their engagement in DSRIP, population health and value-based payment activities. The $2.5 million grant will be used to build a consortium across upstate New York of CBOs that address social and economic factors affecting individuals' health but do not yet have payment agreements with Medicaid for their services. The winning application for the New York City region was the Arthur Ashe Institute for Urban Health, which began its work in March of 2017. The award for the third region, made up of Long Island and the mid-Hudson region, went to the Health and Welfare Council of Long Island, which began its work in January 2018. The one-year contract with Healthy Community Alliance began December 1, 2018.

New York Reports Open Enrollment Success. New York's open enrollment period ended on December 15, 2018, for coverage beginning in January. Enrollment numbers are up over last year's open enrollment period for both Qualified Health Plans and for the Essential Plan, New York's Basic Health Program established under the Affordable Care Act. Approximately 247,000 people have enrolled in Qualified Health Plans, and 776,000 people enrolled in the Essential Plan, up by 68,000 over last year's enrollment. In addition, 413,000 children enrolled in Child Health Plus, and over 3 million people enrolled in Medicaid. New York State of Health, the New York health exchange, has not yet broken out how much of that enrollment is new enrollment and how much is individuals renewing their coverage. Read More

Office of Mental Health Reopens RFP to Children's Mental Health Clinics, RTFs. The New York State Office of Mental Health (OMH) has reopened a grant opportunity available to children's mental health clinics and Residential Treatment Facilities. The office has determined that a technical fix is required to address confusion regarding the eligibility criteria for applicants responding to the "Capital Grants for Preservation, Expansion and/or Restructuring of Children's Clinics and RTFs" Request for Proposals (RFP), and has issued a clarification to ensure all potential applicants have a full understanding of the eligibility requirements. OMH re-opened the RFP on Tuesday, December 18; revised submissions are due February 8, 2019. Read More

Ohio

Medicaid Director Barbara Sears to Step Down. *The Blade* reported on December 17, 2018, that Ohio Medicaid director Barbara Sears will be stepping down effective December 31, 2018. Sears, a former state representative, will join Strategic Health Care as a consultant. Assistant director James Tassie will serve as interim Medicaid director for the remaining days of Governor John Kasich's administration. Read More

Ohio Issues Medicaid Managed Care Performance Report Cards. *The Dayton Daily News* reported on December 13, 2018, that Ohio issued its latest annual performance report cards on the state's five Medicaid managed care plans. Centene/Buckeye Health Plan, Ohio's second largest Medicaid plan, had the highest overall score. CareSource, the state's largest Medicaid plan, ranked third. The state ranks plans annually in five performance areas: getting care, doctor's communication and service, keeping kids healthy, living with illness, and women's health. Read More

Lawmakers Approve Quarterly Medicaid Eligibility Verification. *Cleveland.com* reported on December 12, 2018, that the Ohio Senate passed legislation requiring the state to verify the eligibility of Medicaid and Supplemental Nutrition Assistance Program (SNAP) recipients every quarter as opposed to annually. The bill, which already passed the House, also expands verification criteria to include citizenship status, medical bills, and disabilities. Read More

Oregon

Oregon Names Lori Coyner Medicaid Director. The Oregon Health Authority (OHA) announced on December 12, 2018, the appointment of Lori Coyner as Medicaid director, effective January 28, 2019. It is the second time Coyner has served in the position. Most recently, she was a managing principal for Health Management Associates. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Auditor General Issues Recommendations for Increased PBM Oversight. *The Times* reported on December 11, 2018, Pennsylvania Auditor General Eugene DePasquale said he wanted action to reduce Medicaid prescription costs. Medicaid contracts with Pharmacy Benefit Managers (PBMs) to administer prescription drug plans that cover about 2.9 million Pennsylvania residents. DePasquale issued 10 recommendations, including a call for legislation to:

- Allow Pennsylvania to directly manage its prescription drug benefits instead of contracting with healthcare managers to do so
- Increase transparency into PBM pricing practices
- Allow state oversight of PBM contracts
- Require a flat-fee pricing model so that the state pays PBMs only for services rendered. Read More

Pennsylvania Governor Appoints Home Health Workers Advisory Group. *The Pittsburgh Post-Gazette* reported on December 13, 2018, that Pennsylvania Governor Tom Wolf appointed five members to a statewide advisory group to discuss "ways to improve the quality of care delivered" to individuals receiving home services. The advisory group on participant-directed home care will meet with the Department of Human Services (DHS) quarterly and its membership will include the DHS Secretary and the DHS Office of Long Term Living Deputy Secretary. The advisory group, which survived a legal challenge earlier this year, is not a union and will not be able to bargain a contract but will work with DHS to develop worker policies. Read More

South Carolina

Senate Democrats Seek Referendum on Medicaid Expansion. *The Herald* reported on December 14, 2018, that South Carolina Senate Democrats introduced a bill calling for a statewide referendum on Medicaid expansion. Expansion, which would take effect in 2020 under the measure, would impact a projected 312,000 eligible adults with incomes up to 138 percent of the federal poverty level. Read More

Texas

Lawmakers Remain Opposed to Medicaid Expansion Even as Uninsured Rate Hits 19 Percent. *Forbes* reported on December 12, 2018, that Republican lawmakers in Texas remain opposed to Medicaid expansion, even though 19 percent of working adults under age 65 in the state are uninsured. About 4.7 million adults under age 65 in Texas lacks health insurance, according an Urban Institute report. The report estimates that Texas could cover 1.2 million uninsured individuals by expanding Medicaid or coming up with an alternative plan to provide health insurance to low-income adults earning up to $35,000 for a family of four. Read More

National

Senator Rubio Introduces DSH Funding Overhaul. *Modern Healthcare* reported on December 18, 2018, that Senator Marco Rubio (R-FL) introduced legislation to overhaul the disproportionate share hospital (DSH) funding formula. Under the proposal, a state's DSH allotment would be based on total adults living below poverty, with states allowed to reserve some unspent DSH funds for future use. Hospitals that treat high numbers of poor patients would receive more funds. In addition, hospitals would be able to include uncompensated costs associated with certain outpatient physician and clinical services. The long-delayed DSH payments cuts are scheduled to begin October 1, 2019, as mandated by the Affordable Care Act. Florida receives one of the lowest DSH shares. State receiving high DSH shares, including Alabama, Missouri, New York, New Jersey and South Carolina, face the biggest potential cuts. Read More

December MACPAC Meeting Focuses on State Innovations in Drug Pricing, Network Adequacy, DSH Funding. The December 13, 2018, Medicaid and CHIP Payment and Access Commission (MACPAC) public meeting agenda focused on state innovations in drug pricing, network adequacy in managed care, disproportionate share hospital allotment reduction recommendations, proposed revisions to Medicaid and CHIP managed care rules and proposed rules affecting integrated care for dually eligible beneficiaries. Highlights from discussion:

State Innovations on drug pricing- Dr. Rebekah Gee, Secretary of the Louisiana Department of Health presented on the significant cost of the Hepatitis C public health crisis and the approach the state took to select a subscription model policy, paying a monthly or yearly fee to a drug manufacturer for unlimited access to its hepatitis C medication. Dr. Paul Jeffrey, Director of Pharmacy for MassHealth presented on Massachusetts' 1115 waiver pharmacy provisions proposing a closed formulary and selective pharmacy network which were not included in the state's June 2018 approved 1115 waiver renewal from the Centers for Medicare and Medicaid Services (CMS). The Commission was interested in gathering more information about capturing savings, Medicaid best price, risks to pharmacy rebate programs, and effects of carving out drugs. The discussion included how Medicaid compares to commercial payers, the capacity to create partnerships with pharmacy manufacturers, state flexibility crafting cost arrangements, concern about accelerated approval of drug efficacy, system transparency, and state resources

to measure drug value. The Commission's two pending recommendations are to establish a grace period for states to have more time to consider criteria for drug coverage and remove a reimbursement cap so that manufacturers will slow price growth.

Network adequacy in managed care- Moira Forbes, MACPAC Policy Director, presented on the review of publicly available state network oversight documents and an analysis focusing on time and distance standards. The Commission is primarily interested in gathering information on other metrics in addition to time and distance, certain providers and provider types, modalities like telemedicine, and in the future looking at network adequacy gaps and how states react to those gaps.

Disproportionate share hospital allotment reductions and upper payment limits for hospitals- The Commission heard proposed recommendations from Robert Nelb, MACPAC Principal Analyst, on disproportionate share hospital allotment (DSH) reductions and upper payment limits (UPL) for hospitals. Regarding DSH payment reductions, the Commission requested more information on third party payments and raised concern about the ability of states to transition base rates to supplemental payments, adjusting for differences in cost, and distributing funds. Regarding UPL, the Commission was concerned that the recommendations did not rise to the level of response necessary for the issue and a need for multiple levels of accountability to ensure states calculate UPL properly.

Proposed revisions to Medicaid and CHIP managed care rules and Proposed rule affecting integrated care for dually eligible beneficiaries- Moira Forbes presented a review of proposed revisions to Medicaid and CHIP managed care rules with possible areas for comment including directed payments (portion of capitated payments to providers to further state goals), pass-through payments, network adequacy, and in-lieu of payments for Institutes for Mental Disease (IMDs). Kristin Blom, MACPAC Principal Analyst, and Kristal Vardaman, MACPAC Principal Analyst, presented a review of Contract Year (CY) 2020 Medicare Advantage and Part D Flexibility Proposed Rule provisions regarding integration requirements for Dual Eligible Special Needs Plans (D-SNPs) and unified grievance and appeals procedures for D-SNPs to be met by 2021.

Click here for link to December 13, 2018 MACPAC public meeting presentations**.**

MACPAC Says States Are Using UPL as Medicaid 'Piggy Bank'. *Modern Healthcare* reported on December 14, 2018, that the Medicaid and CHIP Payment and Access Commission (MACPAC) issued draft recommendations to address overspending by states on upper payment limit funds (UPL). The recommendations include a new system for the U.S. Department of Health and Human Services to check the accuracy of hospital payment data. MACPAC, which found that 17 states overspent on UPL by $2.2 billion in 2016, said some states are using the program like a "piggy bank." UPL funds are supplemental payments made largely to hospitals to compensate for Medicaid fee-for-services rates that fall below what Medicare would have paid for the same service. Read More

MACPAC Advises Slow Phase-In of DSH Payment Cuts. *Modern Healthcare* reported on December 14, 2018, that the Medicaid and CHIP Payment and Access Commission (MACPAC) is expected to suggest that Congress slowly phase in Medicaid disproportionate share hospital (DSH) payment cuts for uncompensated care after years of delay. Currently, DSH payments are set to decrease by $4 billion in fiscal 2019 and by $8 billion in fiscal 2020. However, MACPAC is expected to advise that the cuts start at $2 billion and increase incrementally to $8 billion by fiscal 2023. Read More

Federal Judge Rules ACA is Unconstitutional Without Penalty for Lacking Health Insurance. *Kaiser Health News* reported on December 14, 2018, that a federal Judge in Texas has struck down the Affordable Care Act (ACA), ruling that the law was rendered invalid after Congress eliminated the penalty for not having health insurance. The ruling by U.S. District Judge Reed O'Connor is a victory for the 18 Republican state attorneys general and two Republican governors who filed the lawsuit. In 2012, the U.S. Supreme Court had upheld the ACA by ruling that the penalty for not having insurance was a tax. Since Congress eliminated the penalty as part of the 2017 tax law, O'Connor found that the constitutional underpinnings of the law were no longer valid. Read More

Congress Approves Debt Refinancing Option for Rural Hospitals. *Modern Healthcare* reported on December 13, 2018, that Congress passed legislation allowing rural hospitals to refinance debt through lower interest loans from the U.S Department of Agriculture. Rural hospitals view the measure as part of a broader push to establish freestanding emergency departments. Read More

ACA Enrollment is Down 11.7 Percent As Deadline Nears. *Modern Healthcare* reported on December 12, 2018, that 4.1 million individuals had enrolled in Affordable Care Act (ACA) Exchange plans through six weeks of open enrollment, down 11.7% from the same period last year. While auto-enrollment and last-minute shoppers are expected to boost the total before open enrollment ends on December 15, total sign-ups are still expected to fall short of last year. Read More

Industry News

Civitas Solutions to Be Acquired by Centerbridge for $1.4 Billion. Publicly-traded Civitas Solutions announced on December 18, 2018, a definitive agreement to be acquired by investment firm Centerbridge Partners in a deal valued at $1.4 billion. The share price of $17.75 in cash represents a 27% premium over the company's 30-day average. The transaction, which is expected to close by the end of Civitas' second fiscal quarter, was approved by the company's board and awaits shareholder approval. Read More

Deloitte Wins MES Contracts in MT, OH, VA, WY. *Government Technology* reported on December 14, 2018, that Deloitte was awarded contracts to implement Medicaid Enterprise Systems (MES) in Montana, Ohio, Virginia, and Wyoming. Read More

Acadia Healthcare Appoints Debbie Osteen as CEO. Acadia Healthcare announced on December 17, 2018, the appointment of Debbie Osteen as chief executive. Osteen, who was formerly president of the Behavioral Health Division of Universal Health Services, replaces Joey Jacobs. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
December 2018	Massachusetts One Care (Duals Demo)	RFP Release	150,000
2019	Hawaii	RFP Release	360,000
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
2019	Louisiana	RFP Release	1,500,000
January 1, 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract Awards	1,500,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Colorado RAE Enrollment is 1.2 Million, Nov-18 Data
- DC Medicaid Managed Care Enrollment is Down 3.6%, Aug-18 Data
- Indiana Medicaid Managed Care Enrollment is Down 4.1%, Nov-18 Data
- Minnesota Medicaid Managed Care Enrollment is Down 1.4%, Dec-18 Data
- Ohio Medicaid Managed Care Enrollment is Down 3.7%, Nov-18 Data
- Pennsylvania Medicaid Managed Care Enrollment is Down 1%, Oct-18 Data
- Utah Medicaid Managed Care Enrollment is Down 5.3%, 2018 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.9%, Nov-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- California Diabetes Prevention Program (DPP) RFI, Dec-18
- Georgia Third Party Liability Services (TPL) RFI Dec-18
- Indiana Pharmacy Benefit Management Services RFP, Dec-18
- Minnesota Targeted Opioid Treatment, Prevention, and Recovery Services RFP, Dec-18
- New Hampshire External Quality Review Organization (EQRO) RFP, Dec-18
- Nevada External Quality Review Technical Reports, SFY 2014-18
- Oklahoma Care Management RFP, Dec-18

Medicaid Program Reports, Data and Updates:

- Alaska Statewide Opioid Action Plan 2018-22
- California HHS OIG Medicaid Payment Audit Report, Dec-18
- California Managed Care Advisory Group Meeting Materials, Dec-18
- CMS National Health Expenditure Projections, 2017-26
- Florida Medicaid Health Plan Report Card, 2017 Data
- Idaho Medical Care Advisory Committee Meeting Materials, Jul-18
- Michigan Healthy Michigan Plan – MIHA Summary Report, Sep-18
- Michigan Medicaid Health Plan CAHPS Reports, 2015-18
- Michigan Medicaid Health Plan HEDIS Reports, 2016-18
- Michigan Medical Care Advisory Council Meeting Materials, Aug-18
- Missouri Medicaid Fee for Service Access Monitoring Review Plan, Oct-18
- North Carolina Behavioral Health I/DD Tailored Plans Webinar Materials, Nov-18
- North Carolina Medical Care Advisory Committee Meeting Materials, Dec-18
- New Mexico Centennial Care Public Event Presentations, Dec-18
- New York Medicaid Managed Care Financials, 2017
- Ohio Managed Care Plans Report Cards, 2017-18
- Pennsylvania Department of Human Services Monthly Data Report, Oct-18
- Utah Medical Care Advisory Committee Meeting Materials, Nov-18

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