HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 17, 2018

RFP CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Annie Melia
Email

Alona Nenko
Email

Anh Pham
Email

THIS WEEK

IN FOCUS

KENTUCKY 1115 WAIVER WITH WORK REQUIREMENTS

This week, our *In Focus* section reviews Kentucky's 1115 waiver, Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH), approved by the Centers for Medicare & Medicaid Services (CMS) on January 12, 2018. The waiver was approved for five years, effective January 12, 2018, through

September 30, 2023. The decision from CMS represents the first approval of a Medicaid waiver that includes a work requirement as a condition of eligibility.

Kentucky developed the waiver in collaboration with HMA Medicaid Market Solutions (HMA MMS).

Medicaid Expansion Overview

Kentucky expanded Medicaid in 2014 to all newly eligible adults with income below 138% of the federal poverty level. By April 2016, 428,000 individuals enrolled under Medicaid expansion, double the state projections. Despite high levels of enrollment, the state reported that health metrics were low. Under 10 percent of beneficiaries received an annual wellness or physical exam during the first year following implementation. Kentucky also had the second highest rate of cigarette smokers in the nation and twelfth highest rate of obesity in the nation. As a result, the new waiver was designed to save money and incentivize beneficiaries to improve their health. The state currently has 1.26 million members in managed care as of December 2017.

Kentucky HEALTH

The Kentucky Health program will offer individuals two coverage options:

1. The employer premium assistance program, which offers premium assistance to help individuals in purchasing employer-sponsored health insurance coverage.
2. The consumer driven health plan, which offers members a high deductible health plan with commercial market benefits, while expanding mental health and substance use disorder benefits through an IMD waiver.

Eligible individuals are adults with income up to 138 percent of the federal poverty level, as well as all nondisabled adults currently covered under traditional Medicaid. Exempt groups are individuals eligible for 1915(c) waivers, individuals on Medicaid due to a disability, including those with an SSI determination, individuals over 65 years of age, and individuals residing in an institution, such as a nursing facility.

The program will operate statewide, with some components phased in by county, including the work requirement.

Implementation of Kentucky HEALTH will require the state to amend existing managed care contracts, modify systems and other operational procedures, and conduct readiness review with the various state vendors.

Work Requirements

Kentucky will implement a "community engagement" requirement as a condition of eligibility for adult beneficiaries ages 19 to 64 in the Kentucky HEALTH program. The following groups will be exempt from the work requirements:

- former foster care youth
- pregnant women
- primary caregivers of a dependent (limited to one caregiver per household)
- beneficiaries considered medically frail
- beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements, as validated by a medical professional.
- full time students

Non-exempt beneficiaries must complete 80 hours per month of community engagement activities, such as employment, education, job skills training, and community service. First time Kentucky HEALTH members will be given a three-month notice period of the requirements. Current members who will transition to Kentucky HEALTH will not be provided the three-month notice period, however, will receive detailed communications and formal notice prior to the roll-out in their region.

The original waiver requested graduated hours for community engagement that increased by five hours for every quarter the member was enrolled in Kentucky HEALTH. However, due to member communications and IT complications, Kentucky amended the waiver to align with the Supplemental Nutrition Assistance Program (SNAP) requirements.

Other Provisions

Healthcare Accounts

The Kentucky HEALTH program will include two member health care spending accounts that incentivize beneficiaries to obtain preventive care, participate in disease management programs, and engage in their communities. The My Rewards Account will be used to buy optional benefits, including dental, vision, fitness services, and over-the-counter medicine. Members will be able to earn My Rewards dollars six months before Kentucky HEALTH benefits, beginning January 2018. The Deductible Account will be used to fully fund the deductible for the consumer driven health plan. The state will contribute $1,000.

Premiums

Under the waiver, beneficiaries eligible for Kentucky HEALTH (with exceptions for pregnant women, former foster care youth, and those determined medically frail) will need to make monthly premiums. Former foster care youth and those determined medically frail may opt to pay premiums to access the My Rewards Account, but they are not required to. The state can determine the premium amount, up to four percent of the household income, with a minimum of $1. Total premiums and copayments cannot exceed five percent of household income.

Beneficiaries with an income above 100 percent of the federal poverty level who stop paying premiums will be disenrolled and subject to a non-eligibility period for six months. However, they will have 60 days to make the premium payment before disenrollment. Beneficiaries will also be permitted to regain eligibility prior to the expiration of the 6-month non-eligibility period by paying the missed premium payments and taking a health or financial literacy re-entry course.

Substance Use Disorder Benefits

The waiver will expand current mental health and substance use disorder (SUD) benefits for beneficiaries ages 21 through 64 residing in an Institution for Mental Diseases (IMD) for SUD short-term residential stays. These include SUD residential treatment, crisis stabilization, and withdrawal management services provided in IMDs. The state estimates that there are nearly 90,000 newly enrolled individuals that may have a SUD requiring treatment. The state will also begin covering methadone treatment, however, non-emergency medical transportation will not be provided to and from methadone treatment for the required daily dosing, for all Medicaid populations, except pregnant women, children under 21 years of age, and former foster youth.

SUD treatment will count as a qualifying activity to meet the work requirement.

Governor's Executive Order

On January 12, 2018, Kentucky Governor Matt Bevin signed an executive order that if a court successfully challenges the work requirements, premiums, or other changes of the waiver, he will direct the Health and Family Services Cabinet to terminate Medicaid expansion, after several national health advocacy groups said they will sue the state.

Link to KY HEALTH Waiver

https://kentuckyhealth.ky.gov/Pages/index.aspx

For more information on HMA MMS, please contact Amanda Schipp.

HMA Medicaid Roundup

Arizona

State Lawmaker Proposes Medicaid Buy-In. *AZ Central* reported on January 11, 2018, that Arizona state representative Kelli Butler (D-Phoenix) wants to allow uninsured individuals to buy into the state's Medicaid program. Butler is expected to introduce legislation to authorize a buy-in or direct state officials to study the proposal. The buy-in option would require consumers to pay the full cost of their insurance coverage. Read More

California

California Approves Aetna's Entry Into Medi-Cal Market. Aetna announced on January 11, 2018, that it has been approved by the California Department of Health Care Services to participate in the state's Medi-Cal Medicaid managed care program in Sacramento and San Diego counties, effective immediately. The company will do business as Aetna Better Health of California. Read More

Florida

Florida Proposal to Transition Children's Medical Services Program to Managed Care Draws Concern. The *Palm Beach Post* reported on January 10, 2018, that Florida lawmakers are concerned about a proposal from Governor Rick Scott to transition the state's Children's Medical Services program to private managed care organization. Among the concerns are whether the transition will save money and the timeline, which calls for implementation in January 2019. The state Department of Health is expected to release an invitation to negotiate the contract by the end of January and select a vendor by June. Read More

Illinois

Illinois Medicaid Hit with Lawsuit Over Low Nursing Home Rates. *The New York Times* reported on January 12, 2018, that five nursing home operators have filed a federal lawsuit against the state of Illinois, arguing that low Medicaid payment rates and a claims backlog are jeopardizing patient care. The lawsuit was filed by Generations Health Care Network, Carlyle Healthcare Center, St. Vincent's Home, Clinton Manor Living Center, and Extended Care Clinical, which operate 100 skilled nursing facilities throughout the state. Read More

Iowa

Medica Decides Not to Bid for Iowa Medicaid Managed Care Contract. *The Gazette* reported on January 11, 2018, that Medica Health Plans has decided not to submit a bid to be the third Medicaid managed care plan in Iowa. Medica was one of only two plans that had originally submitted letters of intent to bid; the other is Centene/Iowa Total Care. Iowa announced its intent to contract with a third plan after AmeriHealth Caritas exited the state's Medicaid market, leaving Amerigroup and UnitedHealthcare as the only Medicaid plans in the state. Read More

Iowa Struggles with Medicaid Managed Care Appeals Process. *Des Moines Register* reported in January 2018, that Iowa Medicaid managed care members who attempt to appeal care denials face "a thicket of administrative and legal roadblocks" and "must clear hurdle after hurdle to secure care." The Register investigated 200 appeals cases and found that members are sometimes denied care even after they win their appeals hearing before an administration law judge. Read More

Kansas

Lawmakers Seek Delay of KanCare 2.0 Waiver. *The Topeka Capital-Journal* reported on January 10, 2018, that a bipartisan group of Kansas state legislators is urging the administration of Governor Sam Brownback to postpone submission of a federal waiver request for KanCare 2.0, a revamping of the state's Medicaid managed care program until after 2019. Lawmakers expressed concerns over behavioral and mental health issues, among others. Read More

Louisiana

Louisiana Considers Medicaid Work Requirements. *The Advocate* reported on January 11, 2018, that Louisiana is working on a proposal that would impose work requirements on able-bodied Medicaid recipients. Governor John Bel Edwards had previously expressed concerns over work requirements. Read More

Massachusetts

Massachusetts Lawmakers Call for Investigation of Kindred Healthcare. The *Boston Globe* reported on January 16, 2018, that eight Massachusetts lawmakers are calling for an investigation of Kindred Healthcare, which is closing four nursing homes and an assisted living facility in the Boston area. At issue is whether Kindred received state funds when it already knew it was closing the facilities and whether funds improperly went to executive salaries instead of worker wages and benefits. Read More

Mississippi

Citing Savings from Managed Care, Mississippi Medicaid Cuts Funding Request. *U.S. News & World Report* reported on reported on January 10, 2018, that the Mississippi Division of Medicaid (DOM) will request $21 million less than expected for the remainder of fiscal 2018. Previously, the DOM had requested an additional $47 million. Interim DOM director Drew Snyder cites savings through managed care. Read More

Montana

Montana Providers Feel Pinch of 3 Percent Medicaid Rate Cut. *Bozeman Daily Chronicle* reported on January 17, 2018, that Montana providers are beginning to feel the effects of a 3 percent Medicaid rate cut that went into effect January 1, 2018. The Medicaid cuts were driven by broader state budget pressures. Montana has more than 145,000 Medicaid members. Read More

New Hampshire

Democrats Are Concerned Over Work Requirements in Medicaid Expansion Renewal Bill. The *Concord Monitor* reported on January 16, 2018, that New Hampshire Democrats are skeptical of legislation that would reauthorize the state's Medicaid expansion program if the bill includes Medicaid work requirements. The state submitted a waiver request to federal regulators in October asking for permission to implement work requirements. Democrats did approve work requirements in 2016 as part of a reauthorization bill, but the Obama administration rejected the required waiver. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Murphy Takes Office. *The New York Times* reported on on January 16, 2018, that New Jersey Democratic Governor Philip D. Murphy took the oath of office to serve as the state's 56th governor. Sheila Oliver was sworn in as Lt. Governor. In his inauguration speech, Murphy pledged to balance the budget "fiscally and morally," resist any attempt to deny access to health care for children, seniors and the working poor, and articulated his support of Planned Parenthood, among many other things. Governor Murphy represents among the most liberal of candidates, which is a shift for New Jersey as he moves the state beyond the eight-year tenure of Republican Governor Chris Christie. Read More

Governor-Elect Murphy Nominates Einahal for Health Commissioner Post. *NJBiz* reported on January 10, 2018, that Dr. Shereef Einahal has been nominated to serve as New Jersey's commissioner of the Department of Health under the Murphy administration. Dr. Einahal is currently serving as assistant deputy under secretary for health with the US Department of Veteran Affairs, leading their Quality, Safety & Value work. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Executive Budget Proposal. The Governor introduced his Executive Budget for FY 2019 on January 16, 2018. The Executive Budget proposal for SFY 2019 totals $168.2 billion, of which $70.1 billion, or 41.7 percent, is spending on Medicaid. Medicaid spending under the Global Cap is increased by 3.2 percent, which is tied to the 10-year average of the medical care consumer price index. Spending under the Global Cap will increase by $593 million, to total $18.9 billion.

New York is navigating the most challenging fiscal environment since 2011. The FY 2019 budget closes a budget gap estimated at $4.4 billion. The gap is the largest since FY 2012 in both absolute dollars and as a percentage of tax receipts. Several factors contribute to the size of the current gaps, including persistent weakness in tax collections and uncertain Federal support for Medicaid, a significant portion of the overall budget. While the state generated surpluses in four of the last five fiscal years, they are now projecting deficits of $6 - $8 billion over the next three years. In addition, federal tax reform hurts the state in a number of ways, particularly in eliminating the deductibility of state and local taxes. Uncertainty about federal health care policy is a significant challenge for NY. Changes in health care financing through the Disproportionate Share Hospital program, as well as changes to the Affordable Care Act cost sharing reduction program, could lead to an additional loss of $2 billion. To mitigate these potential losses the Governor has proposed a series of new revenue streams including the following.

Healthcare Shortfall Fund: The FY 2019 Executive Budget creates a new fund of $1 billion to be held in reserve against federal health care spending cuts, ensuring the continued availability of funding for health. The Financial Plan includes $500 million annually over four years from conversions, acquisitions, or related transactions in which not-for-profit health insurers convert to corporations organized for profit. NY believes that such activity is likely in the current health insurance market.

Excise Tax on Vapor Products and Opioid Epidemic Surcharge: The budget calls for a 10 cent per fluid milliliter excise tax on vapor products at the distributor level and proposes a 2 cent per milligram surcharge on opioids that would be charged to manufacturers to raise $170 million. The opioid surcharge directs all proceeds to the Opioid Prevention, Treatment and Recovery Fund to support on-going efforts to respond to the epidemic.

Healthcare Insurance Windfall Profit Fee: The budget includes a plan to impose a 14 percent surcharge on the net profits of private health insurers in the state. Health insurers are expected to benefit from a 40 percent decrease in the corporate tax rate under the new federal tax law. The new surcharge is meant to recapture some of the estimated $14 billion in annual revenue that New York will lose under the new federal tax law. The money will go directly into the state's Health Care Reform Act (HCRA) pools.

Minimum Wage: The budget includes money to fund increases in the minimum wage for health care providers ($703 million) in FY 2019.

Managing Loss of Federal Aid: The budget updates legislation approved in last year's budget that sets forth a process by which the state would manage significant reductions in federal aid. The updated legislation requires the Budget Director to prepare a plan for consideration by the Legislature in the event that Federal actions reduce Federal financial participation in Medicaid funding to New York State by a combined $850 million or more in FY 2019 or FY 2020. Upon receipt of the plan, the Legislature has 90 days to prepare its own corrective action plan, which may be adopted by concurrent resolution passed by both houses, or the plan submitted by the Budget Director takes effect automatically.

Child Health Insurance Program: The Budget directs the director of the DOB in consultation with the Commissioner determine if any programmatic changes are needed to continue to cover all eligible children within State-only funding levels (if Federal funding is determined not to be forthcoming) and requires development of an implementation plan which may include emergency regulations to ensure continued coverage.

Pharmaceutical Pricing Efficiencies: In last year's budget New York passed legislation that set a spending limit on pharmaceuticals, and provided the state with enhanced authority to negotiate additional rebates with manufacturers to maintain spending within the spending limit. Manufacturers that don't reach rebate agreements are subject to Drug Utilization Review (DUR) Board referral for a value-based review and recommendations for targeted supplemental rebates. The budget proposal extends the pharmacy drug cap within the Medicaid program for an additional year.

Retail Practices: The budget authorizes the establishment of retail practices that would provide treatment and referral for common health care complaints in a retail setting such as a pharmacy, grocery store, or shopping mall. Retail practices would be required to offer extended hours, walk-in availability, and a sliding fee scale.

Health Home Incentives: The budget proposes an initiative that would provide incentive payments to Health Home members for participating in wellness programs, and for avoiding unnecessary hospitalizations and unnecessary use of the Emergency Department. The Budget also establishes penalties for managed care plans and health homes who fail to enroll a targeted number of high-risk enrollees into the Health Homes program.

Statewide Health Care Facility Transformation Program: The third phase of the program includes $450 million to health care providers that fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community. A minimum of $60,000,000 of this total amount is available for community-based health care providers, which are defined as diagnostic and treatment centers, mental health and alcohol and substance abuse treatment clinics, primary care providers and home care providers. The objective of the Statewide Health Care Facility Transformation Program is to support capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including merger, consolidation, acquisition or other activities intended for a number of functions: to create financially sustainable systems of care, to preserve or expand essential health care services, to modernize obsolete facilities, to foster participation in value-based payment, to increase the quality of care in residential facilities, and to improve health information technology infrastructure. Read more.

New York Expands Program to Help Individuals with Disabilities Find Employment. The New York State Employment First Commission, created by Governor Andrew M. Cuomo and chaired by the New York State Office of Mental Health, has announced new resources to help increase employment opportunities for individuals with disabilities. The new program, called the Employment First Benefits Advisory System, will provide advice on financial assistance and work incentives for individuals with disabilities who are working or seeking work. In September of 2014, Governor Cuomo established the Employment First Commission to increase the employment rate, and decrease the poverty rate for New Yorkers who are receiving services from the state. The resulting Benefits Advisory System, which provides users with a single point of access for all employment-related services, will be rolled out during the first quarter of 2018. The Commission is sponsoring a webinar on, January 16, and on January 30, to describe the process design and benefits in more detail. Read More

North Carolina

Aetna to Bid on North Carolina Medicaid Managed Care RFP. Aetna Inc. announced on January 10, 2018, that it will bid on the North Carolina Medicaid managed care procurement. A request for proposal is expected to be released as early as spring 2018 by the North Carolina Department of Health and Human Services. Aetna also announced an agreement to utilize care management and medical home services from Community Care of North Carolina, Inc. (CCNC). The value-based, delivery model calls for CCNC to support complex patients with care management, care coordination, medication use support, and coordination of community services to address social determinants of health. Read More

North Carolina Waiver Request is Buoyed by CMS Guidance Approving of Work Requirements. The *Winston-Salem Journal* reported on January 12, 2018, that North Carolina is preparing to impose work requirements in its Medicaid program, following the release of guidance by federal regulators that approve of such arrangements. North Carolina submitted a federal Medicaid waiver request to the Centers for Medicare & Medicaid Services in November that would require Medicaid recipients to be employed, in job training, or doing volunteer work. Read More

Pennsylvania

Pennsylvania Governor Declares Opioid Epidemic a Statewide Public Health Disaster. On January 10, 2018, Pennsylvania Governor Tom Wolf declared a statewide public health disaster in response to the opioid epidemic in Pennsylvania. The declaration triggers a 90-day state constitutionally-limited period where additional state resources can be coordinated and regulations waived en masse to allow PA to enhance state response and increase access to treatment. The declaration includes 13 initiatives which are the culmination of a collaboration between all state agencies with a focus on the Department of Health (DOH) and Department of Drug and Alcohol Programs (DDAP), the Pennsylvania Emergency Management Agency (PEMA), the Pennsylvania Commission on Crime and Delinquency (PCCD) and the Pennsylvania State Police (PSP). Initiatives include:

- An Opioid Command Center located at the Pennsylvania Emergency Management Agency
- Expanding access to the Prescription Drug Monitoring Program (PDMP) to other commonwealth entities for clinical decision-making purposes
- Enabling emergency medical services (EMS) providers to leave behind naloxone
- Waiving the face-to-face physician requirement for Narcotic Treatment Program (NTP) admissions
- Waiving annual licensing requirements for high-performing drug and alcohol treatment facilities Read More

Texas

Senate Health and Human Service Committee Chair Supports Medicaid Work Requirements. The *Statesman* reported on January 11, 2018, that Texas Senate Health and Human Services Committee chair Charles Schwertner (R-Georgetown) supports imposing work requirements on Medicaid recipients. "We need to explore all available options to put this program on a more sustainable fiscal trajectory, including co-payments, health savings accounts, and work requirements," Schwertner said. State Sen. Kirk Watson (D-Austin) who also sits on the state Senate's Health and Human Services Committee said the impact of such a policy would be minimal because most working adults are ineligible for Medicaid in Texas. Read More

Virginia

Governor Calls on Lawmakers to Expand Medicaid. The *Richmond Times-Dispatch* reported on January 16, 2018, that Virginia Governor Ralph Northam used his first speech to the state General Assembly to call for Medicaid expansion, encouraging the legislators to tap into the federal funds available under the Affordable Care Act. Republicans have consistently rejected calls for expansion in the state. Read More

Hospital Suffers Fallout from Medicaid Expansion Battle. *The Roanoke Times* reported on January 17, 2018, that Virginia Democrats voted against an emergency bill that would have reopened Pioneer Community Hospital in Stuart, VA, after Senator Bill Stanley (R-Franklin) resisted calls to support Medicaid expansion. Democrats had called for Stanley to support Medicaid expansion in exchange for their votes on the legislation, which would have extended Pioneer's license for another year. Stanley is a vocal opponent of expansion, favoring legislation that blocks a sitting governor from expanding Medicaid without action from the General Assembly. Read More

West Virginia

West Virginia Expands Addiction Treatment for Medicaid Recipients. *U.S. News & World Report* reported on January 16, 2018, that West Virginia expanded addiction treatment for Medicaid recipients this week. The state will now cover a new screening tool to identify treatment needs, increase access to methadone, and increase availability of naloxone. Read More

National

SAMHSA Discontinues National Registry of Substance Abuse, Mental Health Programs. *The Hill* reported on January 10, 2018, that the Substance Abuse and Mental Health Services Administration (SAMHSA) has stopped updating a national registry established in 1997 to provide information to the public about evidence-based mental health and substance use interventions and programs. SAMSHA said that the contract for the National Registry of Evidence-based Programs has ended. Read More

CMS Releases Guidance on Medicaid Work Requirements. *The Washington Post* reported on January 11, 2018, that the Centers for Medicare & Medicaid Services (CMS) issued guidance to state Medicaid directors on Medicaid work requirements. The guidance supports works requirements, but allows states flexibility to define exemptions and also exempts pregnant and medically frail individuals. CMS recommends that states assist individuals in meeting the work requirements but does not allow Medicaid funds be used to do so. Ten states are awaiting federal permission to impose work requirements, with Kentucky expected to be the first state to receive approval. Read More

Individuals File Lawsuit Over Exchange Plan Network Adequacy. *The New York Times* reported on January 11, 2018, that a group of individuals who purchased Exchange plans from Centene Corp. in 15 states filed a federal lawsuit alleging that the plans didn't provide adequate network access. The lawsuit was filed in federal court in Washington state. Read More

Dental Management Company Is Fined $24 Million for False Medicaid Claims. *Chron* reported on January 11, 2018, that Benevis LLC, a dental management company, was fined $24 million by federal authorities for submitting false Medicaid claims. According to the U.S. Department of Justice, 130 Kool Smiles clinics affiliated with Benevis submitted false claims for medically unnecessary treatments in 17 states between 2009 and 2011. Read More

Alexander Expects Congress to Pass Bipartisan Exchange Fix. The *Tennessean* reported on January 12, 2018, that Congress is expected to pass bipartisan legislation aimed at stabilizing the Affordable Care Act Exchanges, according to Senator Lamar Alexander (R-TN). He added that President Trump supports the measure, which would fund Exchange cost sharing reduction payments for two years and allow states to establish a reinsurance fund. The measure, which was sponsored by Alexander and Senator Patty Murray (D-WA), is expected to pass as part of an omnibus government spending bill in February or March. Read More

Advocacy Groups Prepare to Fight Medicaid Work Requirements in Court. *The Hill* reported on January 15, 2018, that advocacy groups are preparing a court battle against the Trump administration over work requirements for Medicaid recipients. At issue is whether the administration has authority to approve work requirements without an act of Congress. Read More

Hospitals Urge Congress to Delay Disproportionate Share Hospital Payment Cuts. *Modern Healthcare* reported on January 16, 2018, that hospitals are urging Congress to delay cuts to disproportionate share hospital (DSH) payments. According to America's Essential Hospitals, hospitals are expected to see a financial shortfall of $2 billion in 2018 and $8 billion by 2024 unless the DSH payment reductions are delayed. Read More

House to Vote on CHIP Funding as Part of Budget Patch. *Modern Healthcare* reported on January 16, 2018, that the House will vote on a short-term budget patch to avoid a government shutdown, a measure that will include funding for the Children's Health Insurance Program (CHIP) for six years. The vote, which will take place on January 18, would also delay the Cadillac tax on high-cost health plans along with other Affordable Care Act taxes on medical devices and health plans. Read More

Industry News

Aetna Collaborates with Community Care Of North Carolina to Deliver Integrated Care to State Medicaid Beneficiaries. Aetna (AET) and Community Care of North Carolina. Inc. (CCNC) today announced a new agreement to combine Aetna's expertise in Medicaid managed health care services with CCNC's medical home and care management services, Community Care Physician Network, LLC (CCPN), and Community Pharmacy Enhanced Services Network (CPESN) USA. Read more

Maximus Names Bruce Caswell CEO, Replacing Richard Montoni. Maximus announced on January 16, 2018, that MAXIMUS has named Bruce Caswell chief executive effective April 1, 2018. He will replace Richard A. Montoni, who is retiring. Caswell currently serves as president of Maximus and has previously held other senior leadership positions at the company. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
January 25, 2018	Arizona	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Texas STAR+PLUS Statewide	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

COMPANY ANNOUNCEMENTS

ODG and Peers Health Expand Partnership to Include Data Collection and New Products. ODG, the leader in return to work and occupational health treatment guidelines, and Peers Health are proud to announce an extension of their multi-year partnership. In addition to providing technology and sales support, Peers will now supply ODG with new data it collects from industry participants and, through a data-sharing agreement, develop its own proprietary products applying advanced technologies in machine learning and artificial intelligence. Read more

HMA WELCOMES…

Nicole Bongiovanni – Senior Consultant

Nicole Bongiovanni joins HMA most recently from Total Health Care where she served as Quality Improvement Manager. In this role, Nicole served as project manager for the annual HEDIS administrative and medical record review project for Medicaid, commercial, and marketplace product lines of business and was responsible for the NCQA accreditation process and survey submission for all three product lines. Nicole created and oversaw the multi-year population health management and health equity plan. She collaborated with Health Michigan Dental to create a care integration program to increase utilization of dental benefits and coordinate care for Healthy Michigan Plan members who are seen in the emergency department for dental related diagnoses. Nicole was responsible for the annual submission of the Quality Improvement Strategy for the Qualified Health Plan (Marketplace) line of business. Additionally, Nicole was the Project Manager for the annual Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Qualified Health Plan project for all three lines of business.

Prior to Total Health Care, Nicole served as Director of Case Management at Detroit Medical Center (DMC). In this role, Nicole was responsible for a 380-bed tertiary care center that provided sub-specialty care to patients from across the country and around the world. Clinical services included obstetrics and gynecology, perinatology, neonatology, neuroscience, cardiology, and bariatric surgery. Nicole oversaw hospital utilization performance improvement and operational management of the Case Management Department. She promoted effective utilization of hospital resources, ensured processes supported appropriate reimbursement for services rendered, supported efficient patient throughput, and ensured compliance with all state and federal regulations related to case management services. Nicole integrated national standards for case management scope of services, including utilization management supporting medical necessity and denial prevention, transition management promoting appropriate length of stay, readmission prevention and patient satisfaction, care coordination by demonstrating throughput efficiency while assuring care is the right sequence and at appropriate level of care, compliance with state and federal regulatory requirements, accreditation standards and Tenet policy, and education provided to physicians, patients, families, and caregivers. Nicole managed department operations, lead the implementation and oversight of the hospital utilization management plan using data to drive hospital utilization performance improvement, ensured medical necessity review processes are completed accurately and in compliance with CMS regulations and Tenet Policy, and ensured timely and effective patient transition and planning to support efficient patient throughput and implemented and monitored processes to prevent payer disputes. In addition, Nicole reduced the readmission rate from 21 percent to 14.9 percent by focusing on transitional assessments on high-risk patients and improving transitional care coordination by partnering with community agencies to increase resources for patients with chronic diseases and other socio-economic issues.

Prior to this, Nicole served as Interim Vice President of Case Management at DMC. In this role, Nicole led the company strategy and execution for case management, including the clinical and financial operations. She collaborated with numerous executive stakeholders, including operations, ethics and compliance, audit, legal, and regulations, and developed and executed the case management strategy and delivery model. Nicole established and led dedicated teams that provided specialized support in key focus areas, including care coordination, discharge planning, utilization review, education, finance, technology, and analytics. In conjunction with the regulations and legal departments, Nicole was responsible for setting the operational strategy for case management policies and processes in accordance with regulatory and compliance requirements. This included defining the strategy, implementation, monitoring, and division/facility support. Nicole prepared budgets and business plans, monthly reporting and results, and managed related costs, including technology fees for systems and clinical criteria.

Additional roles Nicole has held at DMC include Regional Director of Utilization Management, Manager of Clinical Resource Management, Management Specialist, Access Management Specialist, and Lead Case Management Specialist.

Nicole earned a bachelor's degree in nursing from Eastern Michigan University and has more than 22 years of experience as a registered nurse. She is Lean Daily Management certified.

Maddy Shea - Principal

Maddy Shea joins HMA Community Strategies most recently from the Centers for Medicare and Medicaid Services (CMS) Office of Minority Health (OMH) where she served as Deputy Director. In this role, Maddy was responsible for developing, implementing, and evaluating initiatives set forth in the CMS Equity Plan for Improving Quality in Medicare and other CMS equity innovations. She analyzed CMS regulations, policies, and standards to embed data stratification and increase beneficiary and partner engagement. She consulted on the design of new models addressing social health determinants and designed a process to develop and continuously refine priorities to reach OMH strategic objectives, including engagement of CMS regional offices in enhancing care delivery for racial and ethnic minorities, people with limited English proficiency, and persons with disabilities. Maddy consulted and collaborated across the federal government and with other public and private sector organizations to increase the ability of the healthcare workforce to meet the needs of vulnerable populations, including participating in the development of a proposed new physician fee schedule payment to increase physical accessibility of care settings.

Prior to CMS, Maddy served as Director of Disparities National Coordinating Center at Delmarva Foundation for Medical Care. In this role, Maddy led Medicare disparities analytics and the diffusion of evidence based interventions to reduce racial and ethnic disparities in chronic disease, adverse drug events, and preventive healthcare access. She coached 53 Quality Improvement Organizations to align their efforts with State Innovation Models, national public health initiatives, and other delivery transformation efforts to reduce disparities in cardiac health, diabetes self-management, medication safety, prevention services' implementation, and community engagement. She developed partnerships with academic centers, healthcare

providers, national associations, hospitals, and federal offices to align work to improve Medicare health outcomes.

Maddy also served as Director of the Office of Population Health Improvement at Maryland Department of Health and Mental Hygiene. In this role, she directed the development and diffusion of Maryland's State Health Improvement Process, the state's framework for health reform, where she oversaw the development of performance measures to chart the state's progress in meeting population health goals. This included 39 measures stratified by race and ethnicity representing healthcare utilization, access, and community determinants. She coached 24 local health improvement coalitions to align the actions of hospitals, public health, behavioral and primary care providers, and community resource organizations to meet locally determined health equity targets, including social risk factors for preventable utilization. Additionally, she led Maryland's public health accreditation preparation, including a Robert Wood Johnson Foundation funded Public Health Quality Improvement initiative.

Prior to Maryland Department of Health and Mental Hygiene, Maddy served as Assistant Commissioner for Baltimore City Health Department. In this role, she built the first U.S. city healthy homes division to reduce asthma, injury, lead poisoning, malnutrition, and infant deaths in low-income, racial, and ethnic minority Baltimore communities. Maddy developed partnerships with hospitals, health clinics, housing providers, public safety responders, universities, and energy assistance programs to comprehensively improve social health determinants. She developed and executed a funding strategy that quadrupled and diversified resources in a time of public health funding retraction, including Medicaid reimbursement for home visiting services.

Maddy has served on numerous national and state committees, advisory groups, and boards and has taught courses at several colleges and universities. She is a published author and champion of performance measurement, improving social health determinants, and advocacy for disadvantaged groups. Maddy's service career started in the Peace Corps in Liberia.

Maddy earned her PhD in public policy from the University of Maryland Baltimore County. She earned her Master of Advanced Study in Management from The Johns Hopkins University and her bachelor's degree in economics from Trinity College.

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

http://healthmanagement.com/about-us/

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