HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 11, 2018

RFP CALENDAR

HMA News

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THIS WEEK

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- Alabama Awards Integrated Care Network Contract
- Arizona Releases Integrated Health Care Choice Plans RFP
- Florida Awards Medicaid Prepaid Dental Program Contracts
- Kansas Medicaid Managed Care Awards Face Protest
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- New This Week on HMA Information Services (HMAIS)

IN FOCUS

MISSISSIPPI RELEASES CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) RFQ

This week, our *In Focus* reviews the Mississippi Children's Health Insurance Program (CHIP) request for qualifications (RFQ) issued by the state's Division of Medicaid on June 8, 2018. The Mississippi CHIP program provides statewide health coverage in all 82 counties to children in families with incomes up to 209 percent of the federal poverty level (FPL). As of March 2018, 46,958 children were enrolled in CHIP. (Continued on Page 3)

Early Bird Registration Discount Expires July 26 for HMA Conference on Rapidly Changing World of Medicaid, October 1-2 in Chicago: Nearly 200 Already Registered to Attend

Be sure to register soon for HMA's conference on *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers and States*, October 1-2, at The Palmer House in Chicago. The Early Bird registration rate of $1495 per person expires on July 26. After that, the rate is $1795.

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

A high-level list of close to 40 industry speakers, including health plan executives, state Medicaid directors, and providers will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations. There will also be a Pre-Conference Workshop on Sunday, Sept. 30.

Sample Speakers (In alphabetical order; see website for complete speaker list)

- Catherine Anderson, SVP, Policy & Strategy, UnitedHealth Community & State
- John Baackes, CEO, L.A. Care Health Plan
- Leanne Berge, CEO, Community Health Plan of Washington
- Mari Cantwell, Chief Deputy Director, Health Care Programs, California Dept. of Health Care Services
- Mandy Cohen, MD, Secretary, NC Department of Health and Human Services
- Patricia Darnley, President, CEO, Gateway Health Plan
- Bernadette Di Re, CEO, UnitedHealthcare Community Plan of Massachusetts
- David Guth, CEO, Centerstone America
- Rebecca Kavoussi, President - West, Landmark Health
- James Kiamos, CEO, CountyCare Health Plan, Cook County Health and Hospitals System
- Brent Layton, EVP, Chief Business Development Officer, Centene Corp.
- MaryAnne Lindeblad, State Medicaid Director, Washington Health Care Authority
- Scott Markovich, VP, Medicaid Growth and Provider Development, Aetna
- Stephanie Muth, Associate Commissioner, Medicaid/CHIP Medical and Social Services Division, Texas Health and Human Services Commission
- Pete November, SVP, Chief Administrative Officer, Ochsner Health System
- Justin Senior, Secretary, Florida Agency for Health Care Administration
- John Jay Shannon, MD, CEO, Cook County Health & Hospitals System
- Patrick Sturdivant, President, Virginia Medicaid Health Plan, Anthem Inc.
- Ann Sullivan, Commissioner, NYS Office of Mental Health
- Allison Taylor, Director of Medicaid, Indiana Family and Social Services Administration
- Lisa Trumble, SVP of Accountable Care Performance, Cambridge Health Alliance
- Matt Wimmer, Administrator, Division of Medicaid, Idaho Department of Health and Welfare

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Services Covered

Managed care organizations (MCOs) will provide all Medically Necessary covered services allowed under CHIP. Services include inpatient hospital, outpatient hospital, physician, behavioral/substance use disorder, and prescription drug services.

CHIP Eligible Populations

Populations who are eligible for CHIP are shown below:

Populations	Income Level
Birth to Age One (1) Year	194% FPL to 209% FPL
Ages One (1) to Six (6) Years	133% FPL to 209% FPL
Ages Six (6) to Nineteen (19) Years	133% FPL to 209% FPL

Depending on income level, some CHIP members will be responsible for cost sharing for certain services.

Network Requirements

MCOs will need to meet network adequacy requirements showing full range of medical specialties necessary to provide the covered benefits and establish Geographic Access Standards for urban and rural areas for all provider types. They will be required to contract with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The MCO networks must also include contracts with out-of-state providers for Medically Necessary Services and Indian Health Care Providers.

Population Health Management

Plans will also need to develop and execute a Population Health Management program to address the needs of both rural and urban beneficiaries as well as address race, ethnicity, income level, age, gender, language barriers and physical disabilities. The program will look to reduce the cost of care for members, improve health, help members manage their health needs and risks, support providers in delivery of care, and help modernize and execute data analytics strategies. Plans will be required to develop protocols for providing population health management services in alternative and community-based settings, including homeless shelters, public community organization facilities, homes, and schools.

Evaluation Criteria

MCOs will receive scores of up to 100 points. The Evaluation Committee will evaluate the Management and Technical qualifications independent and separate of each. Price will not be an evaluation factor; however, it will be part of the total score make-up. Each MCO will receive 35 points for price despite there not being pricing information included within the Offeror's qualification.

Qualification Section	Maximum Score
Transmittal Letter	Pass/Fail
Executive Summary/Understanding of Project	2
Corporate Background and Experience	8
Ownership and Financial Disclosures	Pass/Fail
Organization and Staffing	8
Methodology and Work Statement	31
Management and Control	8
Work Plan and Schedule	8
Price	35
Total	**100**

RFP Timeline

MCOs were required to submit a mandatory letter of intent by June 29. Proposals are due on July 27, with awards announced on September 6. Contracts will run from July 1, 2019 through June 30, 2022, with the option for two one-year extensions.

RFP Activity	Date
RFP Issued	June 8, 2018
Mandatory LOIs Due	June 29, 2018
Proposals Due	July 27, 2018
Awards	September 6, 2018
Implementation	July 1, 2019

Contract Awards

The Mississippi Division of Medicaid will contract with at least two MCOs. MCOs can submit protests within seven days of the award.

Current CHIP Market

UnitedHealthcare of Mississippi and Magnolia Health Plan currently serve the 46,968 children as of March 2018.

Link to Mississippi CHIP RFQ

HMA Medicaid Roundup

Alabama

Alabama Announces Contract Award for Integrated Care Network. On June 29, 2018, the Alabama Medicaid Agency issued an Intent to Award Notice (ITN) to Alabama Select Network, LLC for the Alabama Medicaid Agency Integrated Care Network (ICN) program. The contract will be effective October 1, 2018 through September 30, 2020, with three optional one-year extensions. The ICN program establishes a new Medicaid long-term care program focusing on a person-centered approach to care delivery using the Primary Care Case Management Entity delivery model. Read More

Arkansas

Arkansas to Terminate Contracts with Preferred Family Healthcare; Transition Planning Is Underway. The Arkansas Department of Human Services (DHS) announced on July 6, 2018, that it will terminate three contracts with Medicaid provider Preferred Family Healthcare (PFH) effective August 4. The contracts are with the state Division of Children and Family Services (DCFS) for children in family-like settings who require emergency shelter services; residential treatment for youth who need behavioral, mental, or emotional care; and counseling for parents. PFH is appealing. Read More

Arkansas Launches New Medicaid Behavioral Health Program July 1. The Arkansas Department of Human Services announced on June 28, 2018, that the state will launch a new Medicaid behavioral health program on July 1. The new program will replace the Rehabilitative Services for Persons with Mental Illness program and expand substance use disorders services. High-needs clients will need an assessment before they can get services. As of June 21, Arkansas completed over 30,000 assessments. Under the new program, master's level counselors and counselors with the 13 child advocacy centers in Arkansas can now become Medicaid providers.

Arizona

Arizona Releases Integrated Health Care Choice Plans RFP. On June 25, 2018, the Arizona Department of Economic Security, Division of Developmental Disabilities released the Integrated Health Care Choice Plans request for proposals (RFP). Arizona is seeking plans to implement, manage, and provide integrated services and supports for members for the Arizona Long Term Care System-Developmental Disabilities (ALTCS-DD) Program Contract for DDD Choice Plans Contractors. The plans will offer physical health care services, behavioral health care services, and Long Term Services and Supports (LTSS). Contracts will be effective October 1, 2019. Read More

California

UnitedHealthcare to Exit Sacramento, CA, Medi-Cal Managed Care Market. UnitedHealthcare Community Plan of California announced its intent to exit the Sacramento County, California, Medi-Cal managed care market, effective October 31, 2018. The state will begin contacting United Healthcare's 4,400 Medi-Cal beneficiaries in Sacramento County by August 1, 2018, regarding their transition options. UnitedHealthcare will continue to serve the Medi-Cal market in San Diego County.

Connecticut

Governor Malloy to Cut $2 Million from Senior Meals Program. *The CT Mirror* reported on June 29, 2018, that Connecticut Governor Dannel P. Malloy plans to cut $2 million from a senior meals program to help meet budget savings mandates for a second fiscal year in a row. Legislators appropriated $4.6 million in the budget for the program. Last year, meals were reduced from two per day to one as a result of Malloy's cuts. House Minority Leader Themis Klarides (R-Derby) stated that the Governor should instead scale back administrative costs across agencies. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Awards Medicaid Prepaid Dental Health Program Contracts. The Florida Agency for Health Care Administration announced on June 28, 2018, that it will award Statewide Medicaid Prepaid Dental Health Program contracts to DentaQuest, Liberty Dental Plan, and Managed Care of North America (MCNA). Contracts will run from no later than March 1, 2019, through September 30, 2023. The Florida Statewide Medicaid Managed Care (SMMC) program covers more than 3.2 million individuals. Read More

Florida Budget Increases Funding for Nursing Homes, Mental Health Services. *The Dayton Beach News-Journal* reported on July 1, 2018, that under Florida's 2018-19 fiscal year budget, Medicaid payments to Florida nursing homes will increase by $128.5 million and nursing home patients' allowance will increase to $130 a month. The Marjory Stoneman Douglas High School Public Safety Act (SB 7026), new legislation passed after the February 14 mass shooting, aims to provide mental health programs and an array of different school services totaling $331 million. Florida also allocated $53.6 million to deal with the opioid crisis. Read More

Illinois

Backlog of Medicaid Eligibility Determinations to Force Nursing Home Closure. *The St. Louis Post-Dispatch* reported on July 8, 2018, that a backlog of cases awaiting Medicaid eligibility determinations in Illinois will result in the closure of Pleasant Hill Village nursing home in Girard on September 1, 2018. Pleasant Hill says it is owed more than $2 million in Medicaid reimbursements. A federal judge ruled that cases older than 45 days should be considered eligible and claims should be paid. Read More

Hospital Serving Cook County Jail Is No Longer Under Federal Oversight. *The Chicago Sun Times* reported on June 27, 2018, that Cermak Health Services, which provides correctional health services to detainees at Cook County jail, has been released from federal oversight. Cermak, which is part of the Cook County Health and Hospitals System, has since 2010 been bound by a decree with the U.S. Department of Justice, which had originally cited the hospital for failing to provide adequate care, fire safety and sanitation. Read More

Kansas

Kansas Governor to Push for Medicaid Work Requirements Despite Kentucky Ruling. *KCUR 89.3* reported on July 3, 2018, that Kansas Governor Jeff Colyer will continue to push for Medicaid work requirements despite the ruling by U.S District Judge James Boasberg blocking implementation in Kentucky. Kansas lawmakers approved a budget proviso allowing Colyer's administration to continue work requirement negotiations but prohibiting implementation without legislative approval. Read More

Kansas Medicaid Managed Care Awards Face Protest from Amerigroup. *The Kansas City Star* reported on July 10, 2018, that Anthem/Amerigroup has filed a formal protest against the contract awards for the new Kansas Medicaid managed care program, KanCare 2.0, after its bid was rejected. Amerigroup says that KanCare 2.0 changed the requirements after its bid submission, adding that the company should have been allowed to revise its bid for the five-year contract. Incumbents who were awarded contracts are: Sunflower State Health Plan, United Healthcare and Aetna. Amerigroup has about 127,000 Medicaid members in the state. Read More

Kentucky

Governor Threatens to Curtail Supplemental Dental, Vision Benefits Following Ruling. *Modern Healthcare* reported on July 2, 2018, that Kentucky Medicaid beneficiaries will continue to receive existing dental and vision benefits, according to a state spokesman. Kentucky Governor Matt Bevin announced that he was going to eliminate dental and vision services after Friday's court ruling invalidating the work requirement waiver. However, a spokesman for the state Cabinet for Health and Family Services subsequently clarified that existing limited dental and vision benefits would remain in place. Supplemental vision and dental benefits that would have been available to Medicaid beneficiaries that earned reward points if they met the work/volunteer requirement under the waiver, will not be available. Read More

Medicaid Work Requirement Struck Down By Federal Judge. *The Courier Journal* reported on June 29, 2018, that U.S District Judge, James E. Boasberg, struck down Kentucky Governor Matt Bevin's Medicaid work requirement, blocking the July 1 implementation of the program. Under Bevin's work requirement, Medicaid recipients would be required to work or volunteer at least 20 hours a week to keep health coverage. *The Kaiser Family Foundation* released a study which found adverse implications of a Medicaid work requirement, estimating potential coverage losses due to the new rules. Bevin plans to cut dental and vision benefits and terminate the expansion if the federal government blocks changes to Medicaid, eliminating health coverage for 500,000 Kentucky Medicaid recipients. Read More

Maine

Maine House Sustains Medicaid Expansion Funding Veto. *The Portland Press Herald* reported on July 9, 2018, that the Maine House sustained Governor Paul LePage's seventh veto of a bill that would have provided $60 million in funding to implement the state's voter-approved Medicaid expansion. The bill included state funding that would have been supplemented by over $500 million in federal funds to expand Medicaid to 70,000 to 80,000 individuals. Read More

Governor Recommends Higher Hospital Tax to Cover Medicaid Expansion. *The Charlotte Observer* reported on July 4, 2018, that Maine Governor Paul LePage has suggested a proposed hospital tax increase to pay for voter-approved Medicaid expansion after vetoing multiple legislation attempts to fund expansion. Currently, Maine's hospitals pay $100 million in annual taxes at a tax rate of 2.23 percent. Under the proposal, the tax rate could go up to six percent. Read More

Maryland

Maryland Enters Into All-Payer Health Care Contract. *The New York Times* reported on July 9, 2018, that Maryland Governor Larry Hogan has signed a five-year, all-payer health care contract with the Centers of Medicare & Medicaid Services (CMS), the first in the nation in which a state is at full risk for total Medicare costs. Maryland has operated an all-payer model for hospitals for decades, and recently shifted the model from fee-for-service to a fixed budget. The new contract aims to coordinate care across the state's entire health care system. Maryland will need to meet benchmarks for improving health quality and access, and if successful, the new contract could provide a total of $1 billion in savings by the year 2023. Read More

Massachusetts

Medicaid Drug Formulary Proposal Is Rejected. *WBUR 90.9* reported on June 27, 2018, that Massachusetts' request to develop a Medicaid prescription drug formulary based on cost and efficacy has been rejected. In a letter to the Executive Office of Health and Human Services, the Centers for Medicare & Medicaid Services (CMS) rejected Massachusetts' efforts to exclude coverage for certain prescription medications while continuing to collect rebates from manufacturers. CMS also denied the transfer of 140,000 MassHealth members who earn more than 100 percent of the federal poverty line to ConnectorCare, which would have saved the state $120 million a year. This proposal was part of an approved amendment that sought to remove veteran annuities to calculate Medicaid eligibility and allow veterans to stay in MassHealth. Read More

Minnesota

Minnesota Medicaid Market Is Eyed by At Least One For-Profit Plan. *Modern Healthcare* reported on July 6, 2018, that the Minnesota Medicaid market is being eyed by at least one for-profit managed care plan. Minnesota will allow for-profit HMOs to enter the state in 2019. UnitedHealthcare and Aetna/Allina Health will expand in the Medicare and commercial markets in Minnesota, and according to *Modern Healthcare*, "at least one of them has its eye on the managed Medicaid market as well." The state has more than one million Medicaid members. Read More

Mississippi

Mississippi Revamps Medicaid Work Requirements Proposal Following Kentucky Ruling. *Modern Healthcare* reported on July 5, 2018, that Mississippi has revamped its Medicaid work requirements request to address federal concerns regarding potential loss of coverage. Specifically, Mississippi's amended waiver proposal stipulates that beneficiaries will receive up to 24 months of coverage if they comply with the proposed work requirements. Mississippi Governor Phil Bryant will continue to push for the waiver even after the recent Kentucky ruling. An estimated 56,000 people would be eligible for the work requirements, many of who are parents and caregivers. Read More

Missouri

Missouri Cuts Out-of-Network Medicaid Provider Reimbursement Rates. *The St. Louis Post-Dispatch* reported on July 2, 2018, that Missouri will pay out-of-network providers 10 percent less in Medicaid reimbursements. In a public meeting held by the Missouri Department of Social Services, providers protested the cuts. The department stated that the decision was an effort to increase provider participation in managed care plans. Missouri currently contracts with Home State Health Plan (Centene), UnitedHealthcare, and WellCare. Read More

Hospitals Oppose Rate Cut for Facilities Not in Medicaid Managed Care Network. *The Kansas City Star* reported on June 27, 2018, that Missouri hospitals are opposing a proposed rule that would cut reimbursements to 90 percent of Medicaid fee-for-service rates for hospitals that are out-of-network for Medicaid managed care plans. The proposed change is scheduled to take effect July 1. Currently, out-of-network hospitals receive 100 percent of the Medicaid fee-for-service rate. Every hospital in Missouri has a provider contract with at least one Medicaid managed care plan, and all but 12 have contracts with all three. Read More

Nebraska

Medicaid Expansion Ballot Initiative Meets Signature Threshold. *Forbes* reported on July 5, 2018, that over 133,000 signatures in support of the Nebraska Medicaid expansion ballot initiative will be submitted to the Nebraska Secretary of State's office, exceeding the requirement of 85,000 signatures. If approved by voters, Nebraska would extend Medicaid eligibility to 90,000 currently uninsured individuals. Nebraska joins Utah and Idaho among states where Medicaid expansion will be put to voters in upcoming elections. Read More

Nebraska Senator Files Lawsuit to Keep Medicaid Expansion Initiative Off Ballot. *Forbes* reported on July 10, 2018, that Nebraska Senator Lydia Brasch (R-Bancroft) and former Senator Mark Christensen (R-Imperial) have filed a lawsuit to keep state voters from putting a Medicaid expansion initiative on the November ballot. This lawsuit comes after Nebraska-based Insure the Good Life announced it had obtained the necessary number of signatures to ensure the initiative would appear on the ballot. If the ballot initiative passes, expansion would cover a projected 90,000 individuals up to 135 percent of the federal poverty level. Read More

Ohio

Ohio Medicaid Opioid Use Examined By HHS Inspector General. *The Plain Dealer* reported on July 10, 2018, results from a study by the U.S. Department of Health and Human Services (HHS) Inspector General's office (OIG). The HHS OIG found evidence of pill mills and doctor shopping in Ohio. The study found nearly 5,000 Medicaid recipients getting large amounts of drugs without cancer or hospice diagnoses, 700 recipients appeared to be in serious danger of misusing or overdosing, slightly more than 40,000 Ohio children on Medicaid were prescribed opioids, and 50 providers prescribed narcotics to at-risk Medicaid beneficiaries. HHS also released a toolkit for other investigators for use in flagging patients who may be misusing opioids. Read More

Ohio Medicaid Pharmacy Benefit Managers Fees Higher Than Industry Standard. *The Columbus Dispatch* reported on June 27, 2018, results from a study commissioned by Ohio Medicaid that showed two Ohio Medicaid pharmacy benefit managers (PBMs) charged as much as $187 million more than the typical cost of administering pharmacy benefits. The report included a recommendation to lower PBM fees, eliminate spared-pricing, and implement a pass-through billing model that sets appropriate price discounts to be passed onto taxpayers. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Medicaid Expands Coverage for Hepatitis C Treatment. Beginning July 1, 2018, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) will expand its coverage of hepatitis C treatment based on the latest recommendations of the American Association for the Study of Liver Disease (AASLD). The change in policy was facilitated by increased funding in the state's 2019 budget. According to DHS Commissioner Carole Johnson, Medicaid will now cover hepatitis C curative drug treatment once someone is diagnosed with the virus; individuals will no longer have to wait until they experience liver damage to access this treatment. Prior to this policy change DMAHS relied on coverage determinations using Metavir scores that relate to different stages of liver findings from F0-F1 (absent or mild fibrosis) to F4 (Cirrhosis). Whereas coverage was approved for individuals with a Metavir score of F0 – F2, claims on July 1, 2018 or after will include coverage for individuals with a Metavir score of F0 – F4 with limited exceptions. This removes certain constraints related to drug coverage, such as lifetime limits and concomitant drug and/or alcohol use. A DMAHS newsletter about this change can be found here. Read More

New Jersey Approved 2019 Budget Releases $21 Million in Charity Care Payments to Hospitals. *NJ Spotlight* reported on July 3, 2018, that the New Jersey last-minute budget deal reached for the new fiscal year included charity care revenue for 70 acute-care hospitals to help treat uninsured patients. A total of $262 million, which is $10 million more than last year, is in the budget for charity care with $21 million to be distributed this week. These funds were frozen in June of this year during a budget cut back. Read More

New Jersey FY 2019 Budget Continues Medicaid ACO Funding. The three-year Medicaid ACO Demonstration Project authorized in August 2011 and implemented July 2015, which was scheduled to conclude on June 30, 2018, has been funded for an additional year. The State's 2019 fiscal year budget includes an allocation of up to $1.5 million to cover administrative expenses of the three certified Medicaid ACOs. Requirements for ongoing certification and reporting will be waived during this period.

New Jersey Medicaid Removes Prior Authorization Requirements on Tobacco Cessation Treatment. On July 3, 2018 the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued a provider newsletter to ease access to over-the-counter and prescription tobacco cessation medications by requiring that Medicaid managed care organizations discontinue prior authorization practices for members needing these services beginning July 1, 2018. This policy is already in effect for individuals covered under Medicaid fee-for-service. According to the newsletter, products requiring prior authorization have included nicotine nasal sprays, nicotine oral inhalers and varenicline (Chantix). Read More

Personal Care Assistant Services Hourly Rate Increases Under Medicaid Fee-for-Service. According to the New Jersey 2019 fiscal year budget resolution, the hourly rate for personal care services under New Jersey's Medicaid fee-for-service program has been raised from $18.00 to $19.00. The resolution states that the hourly rate for the same services provided through a Medicaid managed care organization must be no less than $16.00 per hour. The increase is consistent with a State Plan Amendment that the Centers for Medicare & Medicaid Services approved in October 2017 to implement a provision of the New Jersey State Fiscal Year 2018 Appropriations Act.

Law Enforcement Partnerships Promote Recovery with Helping Hands Program. *NJ Spotlight* reported on June 28, 2018, that a pilot program that began in Bergan County, New Jersey called Operation Helping Hands to connect drug offenders with recovery services has led to an alliance between law enforcement officials and recovery specialists in Northern New Jersey. *NJ Spotlight* reported on the success of one pilot program across five counties that has become a model for replication throughout the state and the nation. The model focuses on low-level drug offenders, by addressing both law enforcement and addiction as a public health crisis. Read More

DURB Disseminates Opioid Prescription Guide to Medicaid Providers, MCOs. On July 5, 2018, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) published an Educational Newsletter prepared by the State's Drug Utilization Review Board (DURB) to give providers and Medicaid MCOs information to help them consider the addiction potential of opioid medications. The Newsletter includes a guide for using Morphine Milligram Equivalents (MMEs) when initially prescribing or re-assessing a patient's clinical needs. MME values represent their relative potency compared to 30 mg of morphine. A copy of the newsletter can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Prepares Expanded State Health Insurance Risk Adjustment Program. In response to the Trump Administration's suspension of the Affordable Care Act's Risk Adjustment Program, New York Governor Andrew Cuomo directed the Department of Financial Services to review the impact and implement an affordable health access action plan. The federal risk adjustment program is designed to stabilize insurance markets by inhibiting the ability of health plans to seek out only the healthiest members, thereby increasing the cost of insurance for higher-need individuals. If the federal risk adjustment program is not reinstated, the Affordable Health Access Action Plan would implement an expanded state risk adjustment program in order to control health insurance cost increases as much as possible. Read More

New York Medicaid Managed Care Advisory Review Panel Holds Quarterly Meeting. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for New York's Medicaid managed care program, held its quarterly meeting on June 21st. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the New York Department of Health, provided an update on Plan Mergers, Acquisitions, Expansions, and Closures. The meeting also included updates on behavioral health, managed long-term care, and the newly established Bureau of Social Determinants of Health. Slides are available on the HMAIS website, or by request.

Program Update:

Four applications for new plans are under review:

- New York Quality Healthcare Corporation, a subsidiary of Centene Corporation has applied to be certified as an Article 44 HMO in New York State. This application is currently under review.
- Partners Health Plan, which operates the plan participating in the duals demonstration program (Fully Integrated Duals Advantage) for individuals with intellectual/developmental disabilities (FIDA-IDD) has applied to become a mainstream Medicaid managed care plan. Partners operates in NYC, Long Island, Westchester, and Rockland Counties. The FIDA-IDD plan, which began operations in April 2016, currently has 764 members.
- Hamaspik Choice – currently a managed long-term care plan operating in 6 counties, serving 2,200 members, has applied to become a mainstream Medicaid managed care plan. The Hamaspik Association is a statewide non-profit organization representing a network of member agencies that provide health and human services primarily serving families in the Orthodox Jewish community.
- iCircle Care – currently a managed long-term care plan operating in 22 counties in Central New York, serving 2,600 members, has applied to become a mainstream Medicaid managed care plan. Their roots are in the I/DD provider community.

One plan request for geographic expansion has been approved:

- CDPHP – 4-county expansion for Medicaid, Child Health Plus (CHP) and the Health and Recovery Plan (HARP) (Essex, Clinton, Franklin and Warren)

Four plan requests for geographic expansion are under review:

- CDPHP – 4-county expansion for Medicaid, CHP and HARP (Essex, Clinton, Franklin and Warren).
- YourCare – 5-county expansion for Medicaid, CHP, and HARP (Orleans, Genesee, Livingston, Wayne and Seneca) – the state is conducting network validation before approving the expansion.
- United Healthcare – 2-county expansion for CHP (Erie, Sussex) – the state has concerns about network adequacy and is conducting network validation.
- VNS Choice – 2-county expansion for MLTC (Nassau and Westchester) – the state is reviewing network adequacy.

Behavioral Health Update

- Health and Recovery Plans are now serving 111,000 Medicaid beneficiaries with a serious mental illness and/or substance use disorder.
    - Of those, only 18,500 have been assessed for eligibility for the enhanced home and community-based services (HCBS) that HARPs were designed to provide.
    - Only 2,584 individuals have been authorized to receive HCBS services.
    - Less than 2 percent of HARP enrollees have received a behavioral health HCBS service.
- New York has developed a new process to augment the assessment and authorization for these services, targeting individuals who are not enrolled in a health home.

Social Determinants of Health

The newly formed Bureau of Social Determinants of Health outlined its goals for 2018. These include:

- Implementation of the Value-Based Payment (VBP) Roadmap requirements as they related to social determinants of health and community-based organizations (CBOs);
- Stakeholder engagement, including learning collaboratives with managed care plans, VBP contractors, community based organizations and health care providers;
- Improving measures of social determinants in population health and payment reform;
- Introducing a VBP pilot to focus on aspects of the Prevention Agenda that are faltering;

- Creation of a new housing referral process that integrates the Medicaid Redesign Team supportive housing initiatives with Performing Provider Systems, VBP contractors, and health systems.

New York Medicaid Managed Long Term Care Plan at Risk for Closure. *Crain's HealthPulse* reported on June 28, 2018, that Independence Care Systems (ICS), a Medicaid managed long-term care plan that specializes in treating people with physical disabilities, is in danger of closing before the end of the year. ICS, which lost $33 million last year, has advised its 6,300 members that the New York Department of Health will probably announce in the early fall that ICS will cease operations by the end of the year. A memo shared with the plan Member Council indicated that members will be given 90 days to choose another plan, after which they will be enrolled in VNSNY Choice. ICS was created to serve the needs of people with significant physical disabilities, and its commitment to keeping people in the community has led to selection of ICS by a disproportionate number of high-acuity members, many receiving more than 12 hours/day of home care services. The state recognizes that its current risk adjustment methodology for managed long-term care does not adequately capture the expense of providing this level of care. As part of this year's budget, the Department of Health agreed to approach CMS to discuss the possibility of establishing a high-needs rate cell for community-based long-term care, but those discussions have not achieved resolution to date. Advocates worry that other plans are not prepared to provide the specialized level of support to people with disabilities that ICS offers. Read More

New York Children's Medicaid System Transformation Derailed. The New York Department of Health has been working on a Children's Medicaid System Transformation for several years, with implementation scheduled to begin in January 2019. The transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new Home and Community Based Services (HCBS) to the Medicaid benefit. The Centers for Medicare & Medicaid Services (CMS) recently advised the state that it would not approve amendments to the state's 1115 waiver that would be required to move forward. New York had intended to move the various and disparate authorizations for HCBS now provided under six separate Section 1915(c) waivers to New York State's 1115 Medicaid Redesign Team Waiver (1115 Waiver). CMS has indicated to the state that 1115 waiver authority should only be used when an alternative 1915(c) children's waiver authority is not available, and so the state's plan to move the services currently available through 1915(c) authority is not acceptable. The state is working with CMS to determine how to proceed.

At a meeting of the Children's Medicaid Redesign Team subcommittee, the state indicated to stakeholders that it was working with CMS to determine a path forward. They also indicated that they will be moving forward with implementing new State Plan services for children, as agreed to in the 2018-19 budget, beginning in January 2019. Also unchanged, at least for now, are the planned carve-in of behavioral health benefits for children into Medicaid managed care, and the carve-in of the foster care population, both effective July 2019.

Web Tool Provides Information on New York Hospital Maternity Practices. The Northeast Business Group on Health has launched a new web site that provides a user-friendly source of educational information and publicly reported hospital data on maternity procedures and practices. The site provides hospital-specific maternity metrics for every hospital in New York City and Long Island, as well as the average value across the 50 hospitals for each metric, and relevant benchmarks from Healthy People 2020 and the American College of Obstetrics and Gynecology. The site allows users to view comparisons across hospitals in a given geographic area. It also provides links to additional information on maternal health.

Metrics include:

- NTSV (Nulliparous, Term, Singleton, Vertex) C-section measure (the rate at which C-sections occur among first-time mothers at low risk of experiencing labor complications)
- Total C-section measure (the percentage of all live births born via C-section)
- Exclusive breast milk feeding measure (the percentage of newborns that were fed only breast milk during their time in the hospital after birth)
- Epidural pain relief measure (the percentage of woman who received epidural pain relief while having a vaginal birth)
- Incidence of episiotomy measure (the rate at which women who deliver vaginally have episiotomies)
- Labor induction measure (how often women giving birth at a particular hospital have labor that is induced using medicine)
- Vaginal Birth After C-Section measure (how many of the women who have had one or more C-sections in the past go on to give birth vaginally at that hospital)
- Birth attended by licensed midwife measure (the percentage of births that were attended by a licensed midwife at a particular hospital)

The site, called ExpectNY, was developed with funding from the NYS Health Foundation. Read More

North Carolina

UnitedHealthcare Reaches Agreement with Community Care Physician Network in North Carolina. UnitedHealthcare Community Plan of North Carolina and Community Care Physician Network LLC (CCPN), a statewide network of 2,200 independent primary care providers, announced on July 9, 2018, that they will collaborate to create an Advanced Care Medical Home for North Carolina Medicaid beneficiaries under the managed care system that will launch in 2019. The Advanced Care Medical Home will focus on value-based care, designed to help keep people healthy through care coordination and data sharing about patients' medical conditions, past treatments, missed care opportunities, medications prescribed and future care needs. CCPN already provides health care services to 40 percent of North Carolina's 700,000 Medicaid beneficiaries through the state's primary care case management program. Read More

Provider-Owned Plans to Partner with Community Care Physicians Network. *The Triangle Business Journal* reported on June 29, 2018, that the North Carolina Provider Owned Plans (NCPOP) will partner with Community Care Physicians Network, ahead of the transition to Medicaid managed care. NCPOP, a collaboration of 11 health systems and Presbyterian Healthcare Services, intends to bid on the managed care procurement, along with Aetna, BCBS-NC, Carolina Complete Health, UnitedHealthcare, and WellCare. Contracts are expected to take effect July 1, 2019. Read More

Oklahoma

Medicaid Value-Based Arrangements with Drug Makers SPA Approved by CMS. The Centers for Medicare & Medicaid Services (CMS) reported on June 27, 2018, that it has approved an Oklahoma State Plan Amendment to allow the state to negotiate specific Medicaid value-based purchasing arrangements with drug makers. Oklahoma is the first state to receive approval for such an arrangement. The amendment will allow Oklahoma to link the payment of a drug to its effectiveness and the outcomes it achieves. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Budget Includes Additional $2.1 Million to Protect Older Pennsylvanians. Pennsylvania's 2018-2019 budget includes over $2.1 million in additional funding for Older Adults Protective Services in Pennsylvania's 2018-19 budget. The increase in funding is in response to a decade of annual increases in reports of elder abuse. The Department of Aging maintains a statewide system of protective services for older adults, working collaboratively with 52 local Area Agencies on Aging. To address the rise in reports of elder abuse, the department has been working to increase and improve necessary training and technical assistance, allocate additional staff to support protective service workers as needed, and improve policies to ensure compliance with laws and regulations. The Department of Aging is also working with the Department of Banking and Securities to educate professionals on elder financial abuse/exploitation, working with the PA Attorney General's Office on Medicaid fraud prevention, and working with PA's Department of Health and Department of Human Services on mandated reporting provisions. Read More

Pennsylvania Receives Funding for SUD Treatment Facilities, Evidence-Based Care. Pennsylvania's Section 1115 Demonstration Waiver Amendment, which allows the Department of Human Services (DHS) to continue to receive federal Medicaid funding to be used for the treatment of individuals in substance-use disorder (SUD) treatment facilities, received federal approval. The waiver amendment was submitted by DHS and the Department of Drug and Alcohol Programs (DDAP) to provide over 12,000 Pennsylvanians access to treatment for SUD. PA will continue to receive more than $55 million per year in Medicaid funding for the treatment of individuals in SUD residential treatment facilities for more than 15 days in a month who had been adversely impacted by the changes in the federal Medicaid managed care rules in May 2016. In addition, the waiver approval recognizes the transition from the Pennsylvania Client Placement Criteria (PCPC) to the evidence-based

American Society of Addiction Medicine (ASAM) criteria as a placement tool and guide for clinical care. The ASAM eases coordinated care for individuals needing treatment for a co-occurring behavioral health condition. Read More

Puerto Rico

Puerto Rico Awards Medicaid Managed Care Contracts to 4 Incumbents, 1 Newcomer. Puerto Rico announced on July 9, 2018, that it has awarded Medicaid managed care contracts to Molina Healthcare of Puerto Rico, Triple-S, First Medical, MMM and Mennonite Plan, effective November 1, 2018. All were incumbents except Mennonite. The contracts, awarded by the Puerto Rico Health Insurance Administration (in Spanish: Administracion de Seguros Salud de Puerto Rico or ASES), run for three years with an optional one-year extension. The contracts allow each plan to compete island-wide. Prior contacts were for specific regional areas. Read More

Tennessee

Tennessee Seeks New Strategy for DSH Funding Distribution. *Modern Healthcare* reported on July 3, 2018, that Tennessee is seeking public comments on a proposed state plan amendment (SPA) to update how Medicaid distributes disproportionate share hospital (DSH) funds in the state. The SPA would allow recovered excess DSH funds from hospitals to be redistributed to other DSH-eligible hospitals. The state currently receives an estimated $53 million in Medicaid DSH funds each year. Read More

Texas

Texas Cancels STAR+PLUS RFP. On Friday July 6, 2018, the Texas Health and Human Services Commission cancelled its request for proposals (RFP) for STAR+PLUS, the state's Medicaid managed care program for individuals who are aged, blind or disabled. Texas released the RFP in December 2017, with proposals submitted by bidding MCOs in March 2018. The current STAR+PLUS plans are Amerigroup/Anthem, Cigna, Centene, Molina, and UnitedHealthcare. Read More

Texas Releases RFP for Medicaid Dental Managed Care for Children. Texas released a request for proposal (RFP) on July 9, 2018, for statewide dental managed care services for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The Texas Health and Human Services Commission expects to award contracts to at least two dental plans with implementation set for January 1, 2020. Current dental plans are MCNA Dental and DentaQuest. Read More

House Committee Holds Hearings on Medicaid Managed Care. *The Texas Tribune* reported on June 27, 2018, that the Texas House General Investigating and Ethics committee heard from patients, advocates, and executives of five health plans during a hearing on reported problems in the state's Medicaid managed care program. A panel of insurance executives from Superior HealthPlan, Amerigroup, Cigna HealthSpring, Molina Healthcare, and United Healthcare suggested several program improvements, including use of telemedicine, changes in how provider network adequacy is calculated, and improved dental benefits. The hearings followed a *Dallas Morning News* investigation that uncovered evidence that some of the state's most vulnerable Medicaid recipient didn't have adequate access to care. Read More

Washington

Psychiatric Hospital Loses Federal Funding Amid Violations. *The New York Times* reported on June 27, 2018, that Western State Hospital, which is a state-run psychiatric facility serving individuals with serious mental illness in Washington, was stripped of federal funding after an inspection revealed continued health and safety violations. Federal funds account for about 20 percent of the hospital's budget. The Washington Department of Social and Health Services, which operates the hospitals, is analyzing the inspection report. Read More

Wisconsin

Wisconsin to Implement Statewide Children's LTS Rate-Setting Methodology in January 2019. Wisconsin announced that effective January 1, 2019, it will implement a statewide rate-setting methodology primarily for Children's Long-Term Support Waiver Program (CLTS) services. The rate-setting initiative was the result of a corrective action plan issued by the Centers for Medicare & Medicaid Services (CMS) to ensure the state complied with federal Home and Community-Based Services regulations. The CLTS Waiver Program Rate-Setting Initiative will replace the existing rate methodology for services including case management, child care, and transportation, among others. Read More

National

HMA Principal Mary Hsieh and Former Addus CEO Mark Heaney See Home Care Opportunity in Medicare Advantage. *Home Health Care News* reported on July 9, 2018, that home care providers have an opportunity for growth by working with Medicare Advantage plans, according to Mark Heaney, former Addus HomeCare chief executive. Heaney was reacting to news that Medicare Advantage plans can cover non-skilled in-home care, effective 2019. His viewpoint was echoed by Mary Hsieh, managing principal of Health Management Associates, who noted that there are about 19 million Medicare Advantage members and growing. Read More

CMS Takes Aim at Rule Allowing State Medicaid Programs to Pay Union Dues of Home Health Providers. *Modern Healthcare* reported on July 10, 2018, that state Medicaid programs will no longer be able to divert a portion of home health worker payments to pay union dues, according to a rule change announced by the Centers for Medicare & Medicaid Services (CMS). Unions collect as much as $71 million from Medicaid payments, according to CMS estimates. The 2014 rule also allows states to divert Medicaid payments to cover court-ordered wage holdings, child support orders, and other state legal judgments. Read More

Insurers to Increase ACA Exchange Presence. *Modern Healthcare* reported on July 9, 2018, that health plans are likely to expand their presence on the Affordable Care Act Exchanges in 2019, with a net gain in participating exchange carriers and no announcements of market exits so far for 2019, according to an analysis by the Robert Wood Johnson Foundation. States with new insurers entering the Exchanges market include Arizona, Florida, Iowa, Maine, Michigan, New Mexico, North Carolina, Ohio, Oklahoma, Tennessee, Utah, Virginia, and Wisconsin. Insurers looking to expand include Centene, Molina, Oscar and potentially Anthem, among others. Read More

State Prisons Don't Treat 97% of Hepatitis C Cases, Survey Says. *Kaiser Health News* reported on July 9, 2018, that state prisons in the U.S. aren't treating 144,000 inmates who have hepatitis C, according to a survey of state corrections departments. The figure represents 97 percent of infected inmates. States cited high drug prices as reason for denying treatment to inmates. The survey also found that prisons in states like Florida were not following their own care guidelines. Read More

Trump Administration Freezes Billions of Dollars in ACA Risk Adjustment Payments. *Modern Healthcare* reported on July 8, 2018, that the Trump administration has frozen billions of dollars in risk adjustment payments earmarked for health plans competing on the Affordable Care Act Exchanges. The Centers for Medicare & Medicaid Services cited conflicting court rulings regarding the program, which is designed to reduce incentives for plans looking to serve only the healthiest members. Read More

More Individuals Received Subsidies to Buy Private Insurance in 2017, CMS Report Says. *Bloomberg* reported on July 2, 2018, that 62 percent of Americans received government assistance to buy private health insurance coverage in 2017 compared to 55 percent in 2014, according to a report released by the Centers for Medicare & Medicaid Services. Last year, over 8 million individuals received subsidies to buy plans under the Affordable Care Act and 5 million bought coverage without subsidies. Read More

Medicaid Work Requirements Could Cause Up to 4 Million to Lose Coverage, Study Finds. According to an analysis released by *the Kaiser Family Foundation* on June 27, 2018, Medicaid work requirements could cause 1.4 million to 4.0 million people to lose coverage. Lack of reporting was identified as the primary cause for disenrollment rather than not complying with the new requirement. More than six in ten nonelderly, non-dual, non-SSI Medicaid adults are already working. Those that are not are largely in fair/poor health or report illness or disability, are caregivers, or are going to school. The Centers for Medicare & Medicaid Services (CMS) has approved work requirements in Arkansas, Indiana, Kentucky, and New Hampshire. Read More

Supreme Court Decision on Union Fees Could Weaken Advocacy for Publicly Sponsored Health Care. *Modern Healthcare* reported on June 27, 2018, that a U.S. Supreme Court ruling that prohibits public sector unions from collecting mandatory fees for representing non-members in contract negotiations could weaken advocacy for publicly sponsored health care. Nearly 1.5 million health care workers are unionized, and according to *Modern Healthcare*, unions "are one of the strongest political forces advocating for protecting Medicare, Medicaid and other social programs." Read More

CMS Cuts $26 Million in Navigator Funding in 2018. *Modern Healthcare* reported on July 10, 2018, that the Center for Medicare & Medicaid Services (CMS) will reduce annual funding for federal Exchange navigators to $10 million in 2018, down from $36 million last year. CMS will award a minimum of $100,000 to each state that uses the federal HealthCare.gov Exchange. Funding for Exchange navigators is down from $62.5 million in 2016. Applications for navigator funding are due August 9 and awards are expected to be announced September 12. Read More

Industry News

Centene Completes Acquisition of Fidelis Care. Centene announced on July 2, 2018, that it has completed its acquisition of Fidelis Care, effective July 1, for $3.75 billion. Fidelis Care is the leading government-sponsored health plan in New York State. Read More

Civitas Solutions Completes Acquisition of Creative Connections. Civitas Solutions announced on July 10, 2018, that it has completed the acquisition of Creative Connections, Inc. (CCI), a Bakersfield, CA, community-based organization that serves individuals with intellectual and developmental disabilities. The acquisition complements Civitas' Family Home Agency program, which connects adults in need of support with caregivers. Read More

Medica Expanding into MO, OK Individual Markets. *The Star Tribune* reported on June 29, 2018, that Minnesota-based Medica is expanding into the Affordable Care Act (ACA) marketplaces in Missouri and Oklahoma. Medica will offer health plans to individuals in three counties in Missouri and statewide in Oklahoma starting in 2019. Medica will also offer a marketplace product in North Dakota in 2019 after only offering an "off-exchange" product this year. Medica currently offers individual marketplace products in Kansas, Iowa, and Nebraska. Read More

CareSource to Expand Services for Veterans Seeking Healthcare Outside the VA System. *Dayton Day News* reported on July 6, 2018, that CareSource, an Ohio-based insurer, was chosen by Amvets to develop a privately managed health insurance plan for veterans seeking healthcare outside the Veterans Health Administration system. This option results from passage of the VA Mission Act last month. CareSource is planning on using the managed care model for the veteran health plan, expanding access to specialty care to Dayton's veteran population. Read More

Humana, TPG, Welsh Carson Complete the Acquisition of Kindred Healthcare. Humana announced on July 2, 2018, that it has completed the acquisition of Kindred Healthcare. Under the terms of the transaction, Humana has acquired a 40 percent ownership of Kindred at Home, Kindred's home health, hospice and community care business. The remaining 60 percent of Kindred at Home, as well as Kindred's long-term acute care hospital and rehabilitation facilities business, Kindred Healthcare, have been acquired by TPG Capital (TPG) and Welsh, Carson, Anderson & Stowe (WCAS). Read More

The Ensign Group Acquires ID Skilled Nursing Facility. The Ensign Group announced on July 3, 2018, that it has acquired McCall Rehabilitation and Care Center, an Idaho-based skilled nursing facility. This acquisition adds to Ensign's portfolio of 185 skilled nursing facilities. The acquisition was effective July 1, 2018. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
August/September 2018	North Carolina	RFP Release	1,500,000
Summer 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 29, 2018 (Delayed)	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
July 2018	New Hampshire	RFP Release	160,000
July 17, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
November 1, 2018	New Hampshire	Proposals Due	160,000
November 1, 2018	Puerto Rico	Implementation	~1,300,000
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
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	160,000
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
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
January 1, 2020	Texas STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
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	TBD

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Arizona AHCCCS Population Demographics, Jul-18 Data
- Arizona Medicaid Managed Care Enrollment is Down 2.6%, Jul-18 Data
- Kansas Medicaid Managed Care Enrollment is Flat, May-18 Data
- Montana Medicaid Managed Care Enrollment is Down 0.4%, Jun-18 Data
- Minnesota Medicaid Managed Care Enrollment is Up 2.2%, Jul-18 Data
- North Carolina Medicaid Enrollment by Aid Category, 2015-17, Jun-18
- Nebraska Medicaid Managed Care Enrollment Rises 1.4%, Jul-18 Data
- New York Medicaid Managed Care Enrollment is Down 1.1%, Jun-18 Data
- South Carolina Medicaid Managed Care Enrollment is Down 4.3%, Jun-18 Data
- Tennessee Medicaid Managed Care Enrollment is Down 3.0%, Jun-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 2.3%, Jul-18 Data
- Virginia Medicaid MLTSS Enrollment is Over 210,000, Jun-18 Data
- Bed Days per 1000 Members Average 951 for MN Medicaid MCOs, 2017 Data
- Bed Days per 1000 Members Average 439 for MD Medicaid MCOs, 2017 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arizona Integrated Health Care Choice Plans RFP, Jun-18
- Texas Dental Services for Children's Medicaid and CHIP RFP and Related Documents, Jul-18
- Kansas KanCare 2.0 Medicaid & CHIP Capitated Managed Care RFP, Proposals, Contracts, and Related Documents, 2017-18
- Pennsylvania Medicaid Management Information System (MMIS) 2020 Platform Project Services for Electronic Data Interchange RFP, Jun-18
- Iowa Technical Assistance and Waiver Support Services for Iowa Medicaid RFP, Jul-18
- Washington 2019/2020 Integrated Managed Care (IMC) RFP, Award, Scoring Sheets, and Proposals, 2018
- Florida Statewide Medicaid Prepaid Dental Health Program ITN, Award, Evaluation Documents, Proposals and Related Documents, 2017-18
- Florida Children's Medical Services Managed Care Plan ITN, Rankings, Proposals, Scoring and Related Documents, Jul-18

Medicaid Program Reports and Updates:

- California Managed Care Advisory Group Meeting Materials, Jun-18
- Georgia Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, FY 2017
- Iowa Managed Care Annual Performance Reports, 2016-17
- Michigan Medical Care Advisory Council Meeting Materials, Feb-18
- Maryland Medicaid Advisory Committee Meeting Materials, Jun-18
- Mississippi External Quality Review (EQR) Protocol 4 Reports, May-18
- Mississippi Medicaid Managed Care Quality Strategy Initial Draft Report, Jun-18

- Pennsylvania Managed Care External Quality Review Reports, 2017
- Pennsylvania HealthChoices HEDIS Performance Measures Rate Charts, 2015-17
- Texas Medicaid Managed Care and CHIP External Quality Review Report, 2017
- Washington Apple Health Managed Care Children with Chronic Conditions CAHPS Report, 2017
- Wisconsin Children's Long-Term Support (CLTS) Waiver Renewal and Program Rate Schedule, 2017-18
- Florida Medical Care Advisory Meeting Materials, Jul-18
- Florida Statewide Medicaid Managed Care Update Presentation, Jul-18

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- RFP calendar

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COMPANY ANNOUNCEMENTS

Centauri Health Solutions Continues Growth with Acquisition of NHI Billing Services. Read More

HMA Welcomes

Mark Bell – Principal, Raleigh

Mark Bell joins HMA from a statewide healthcare association where he served for 20 years as chief information officer. At the statewide healthcare association he implemented numerous programs in public health, telemedicine, broadband, and data governance in North Carolina. He has built several health information exchanges, helped establish the premier real-time syndromic surveillance system in the country, and was the architect for a statewide telepsychiatry network to provide care to 80 hospital emergency departments using EHR Meaningful Use standards.

Mark has authored or co-authored a dozen books about information technology, including operating system platforms, multimedia, and internet services. He is focused on information services operations using Lean process improvement methods and Agile development techniques.

Mark earned a master's degree in religion from Duke University and an undergraduate degree in humanities from Middle Tennessee State University. He served in the US Naval Reserve and has been a volunteer firefighter. In 2015, he was elected to the Town Board of Commissioners of Hillsborough, North Carolina, where he is a delegate to several boards and commissions regarding tourism and economic development, water and sewer infrastructure, solid waste and recycling, and regional transportation. He also is a member of the advisory boards for the Master of Science in Health Informatics and Information Management degree program at East Carolina University, as well as the NC Telehealth Network.

Tom Friedman – Principal, Raleigh

Tom Friedman joins HMA from Relias, where he was the group product manager for Payer, Performance and Community Health. During that time, his efforts to project healthcare trends to meet future market needs served as a driver for long-term growth. During his time at Relias he was published in McKnight's, Becker's Hospital Review, and Medical Economics.

Tom has extensive data analytics expertise and a proven ability to translate data to reimbursement strategy and policy development. It was as an expert in healthcare analytics that he was appointed as a member to the North Carolina Health Information Exchange Advisory Board in 2016. In this role, he has provided strategic guidance on the NCHIE implementation and development of recommendations for improving data analytics.

Previously, Tom served as the director of Policy, Planning & Analysis for the State Health Plan of North Carolina. While there, he led and developed policy, financial strategic initiatives, and a provider network and reimbursement strategy. He directed external relationships with providers, vendors, and stakeholder groups and built benefit and premium design strategies for over 700,000 state employees and retirees.

In addition to his vast expertise related to healthcare payment and reimbursement, data analytics, and commercial health plans, Tom is a skilled strategist. He has a proven track record of developing and leading high

performing teams and cultivating relationships among diverse groups of stakeholders to drive profitability.

Tom earned his Master of Public Administration, with a specialization in health policy and financial management, from the University of Delaware. He received his bachelor's degree from the University of Arizona.

Michele Melden – Principal, Los Angeles

Michele Melden joins HMA from Health Consumer Alliance (HCA), where she was the coordinator of a collaborative partnership of legal services organizations serving healthcare consumers throughout California. She has extensive expertise in Medicaid coverage, the Affordable Care Act, long-term services and supports, and Medi-Cal managed care, with a focus on helping consumers overcome barriers to qualifying for coverage and accessing services. Michele has worked closely with safety net healthcare providers and other stakeholders serving low-income and culturally diverse consumers. In addition to her work for HCA, she has served as the director of policy, training, and development for the healthcare unit of the Legal Aid Society of San Diego since 2006.

Michele's prior work experience includes teaching healthcare and contracts law at the Thomas Jefferson School of Law, launching the Health Consumer Center of Los Angeles at Neighborhood Legal Services of Los Angeles County, working on Medicaid and Medicare reimbursement issues for hospital providers at Hooper, Lundy & Bookman, and providing national legal services support work at the National Health Law Program.

Michele has published articles on healthcare policy in law reviews and practitioner publications, testified in Congress and for the California legislature on numerous occasions, and has acted as lead counsel in successful class action/impact lawsuits.

Michele graduated from Harvard Law School and Wellesley College, and she clerked on the New Jersey Supreme Court.

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