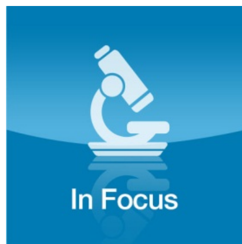
HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 22, 2018



RFP CALENDAR

HMA News

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THIS WEEK

- IN FOCUS: MEDICAID COMMUNITY ENGAGEMENT, WORK REQUIREMENT AND CONSUMER EMPOWERMENT PROGRAMS: KEY IMPLEMENTATION AND OPERATIONS ISSUES AND CONSIDERATIONS
- NORTH CAROLINA RELEASES MEDICAID MANAGED CARE RFP
- D.C. RELEASES RFP TO REPROCURE MEDICAID MCO CONTRACTS
- ARIZONA RELEASES RFI CONCERNING POTENTIAL INTEGRATED HEALTH CARE PROGRAM FOR FOSTER KIDS
- ARKANSAS RESIDENTS SUE CMS OVER WORK REQUIREMENTS
- OHIO TO TRANSITION PBM CONTRACTS TO TRANSPARENT PRICING
- KANSAS JUDGE DENIES TEMPORARY INJUNCTION IN MEDICAID MANAGED CARE AWARDS DISPUTE
- GAO, CMS CALL FOR SCRUTINY OF MEDICAID MANAGED CARE
- INNOVAGE ACQUIRES OF FOUR PENNSYLVANIA PACE CENTERS
- SIMPLURA HEALTH GROUP ACQUIRES HELPING HAND
- HMA WELCOMES: RICHARD CHAMBERS (LOS ANGELES) AND DR. R. COREY WALLER (LANSING)
- NEW THIS WEEK ON HMA INFORMATION SERVICES (HMAIS)
- THE HMA WEEKLY ROUNDUP WILL BE OFF NEXT WEDNESDAY, AUGUST 29TH. WE WILL RESUME OUT REGULAR WEEKLY PUBLICATION ON SEPTEMBER 5TH.

IN FOCUS

MEDICAID COMMUNITY ENGAGEMENT, WORK REQUIREMENT AND CONSUMER EMPOWERMENT PROGRAMS: KEY IMPLEMENTATION AND OPERATIONS ISSUES AND CONSIDERATIONS

This week, our *In Focus* section highlights HMA Medicaid Market Solutions' (MMS) efforts to support state flexibility in designing and implementing Section 1115 Demonstration Waivers promoting member engagement and personal responsibility. Over the coming weeks, HMA MMS will present a series of articles providing in-depth analyses of the many facets of these new Medicaid models. This week, we examine important issues and considerations for implementing Medicaid consumer empowerment, community engagement, and work requirements.

Across the country, several states are actively pursuing the incorporation of community engagement, work requirements, and consumer empowerment strategies into their Medicaid programs. Requiring able-bodied low-income adults to work or engage in other meaningful community-oriented activity to access or maintain Medicaid coverage has already been approved in four states: Arkansas, Indiana, Kentucky and New Hampshire. Moreover, even though the long-term impact of the recent federal court ruling on Kentucky's 1115 waiver is not clear, interest in Medicaid consumer empowerment, community engagement and work requirement initiatives is not diminishing. For instance, in June, Virginia lawmakers approved Medicaid expansion with the condition that the Commonwealth apply for federal permission to include work requirements (last month the Commonwealth issued a request for information related to this initiative).

Irrespective of the specific program designs being implemented in various states, based on HMA's experience working with Indiana and Kentucky, we believe it is important to address operational and technological implications of such new programming to ensure the program's successful implementation.

Issues and Considerations

- ✓ **Information system design, configuration and integration are important considerations when developing these programs. Because of their design, t**hese programs include more data requirements than traditional Medicaid managed care or fee-for-service programs. As an example, these programs may require new or additional methods for verification of self-reported activities. Typical MMIS, MCO systems, and HIPAA compliant transaction types (e.g. 834/enrollment data) are not designed to maintain, and thus exchange, newly required data values. Additionally, non-typical interface designs may be required. Interfacing between program partners, such as MCO-to-State eligibility and enrollment (E&E) systems, may require a rethinking of system interfaces and, in some instances, system changes. Finally, the development and implementation of new data use and data exchange agreements will be critical for successful program implementation. These agreements tend to be very resource-intensive, can involve attorneys from multiple parties, require adherence to multiple laws and regulations that are not necessarily "harmonized", and may entail considerable consumer outreach and education for them to be accepted.

- ✓ A major risk in planning and implementing Medicaid community engagement, work requirements, and consumer empowerment initiatives is the **failure to obtain participation and input from all program partners and IT resources in initial project phases**. This can lead to risks, implementation delays, and potential change orders. Therefore, states should include representation from all stakeholders, including other agencies and contracted partners, in project governance from project inception. An integrated project management organization (PMO), with representation from these stakeholders, is valuable in addressing program design and operational decisions. Publishing and distributing design and requirement decisions often, along with frequent status, can be helpful in keeping all stakeholders informed. It is also critical that business and technical requirements development include both business and IT resources.
- ✓ **Addressing compliance aspects of new community engagement initiatives requires early identification of the "best", "leak-proof" mechanisms for managing program information**, particularly data used to verify certain eligibility requirements. This should be based on cost, reach/coverage/availability, and ability to implement and maintain solutions. Again, it is valuable to engage representation from all stakeholders and a strong team of analysts that can conduct persuasive, defensible alternatives/cost-benefit assessments of the various feasible ways in which different aspects of the proposed program can be operationalized.
- ✓ **Addressing critical issues and considerations should enable states to align requests for IT/systems funding, including Advanced Planning Documents (APDs) with the implementation plan and budget for the entire initiative**. Including the team that normally works on APDs in deliberations regarding program design as early as possible can ensure that the optimal mix of information systems and related functionality is built into the APD funding request.
- ✓ **Traditional "member portals" may not support required communication and exchange of information with Medicaid beneficiaries**. Community engagement initiatives call for enhanced member engagement modalities and functionalities. New system functionalities and capabilities for consumer reporting of activities required to maintain eligibility will be required. The development and implementation of new consumer facing technologies and work flow capabilities will also be required.
- ✓ **Increased capacity for various business functions will be needed**. Modeling staffing needs and associated technology supports based on the impact of program design on contact centers, grievances and appeals staff, vendor management, and the aforementioned compliance, monitoring and evaluation functions should be done as early in the design of the program as possible. The modeling should account for 1115 waiver evaluation requirements that will increase data needs and analysis.

How HMA Can Help

HMA is uniquely positioned to help states exploring or already committed to implement consumer empowerment, community engagement and work requirements programs. Our Medicaid Market Solutions (MMS) and Information Technology Advisory Services (ITAS) teams can collaborate with state officials on these types of projects by bringing together expertise and experience in program policy and design, program operations and evaluation, and information technology.

HMA has worked with the states of Indiana and Kentucky on the design, implementation and operation of Medicaid consumer empowerment, community engagement and work requirement programs. Most recently, in Kentucky HMA's role in the implementation of the 1115 waiver has encompassed:

+ Supporting the Commonwealth in the development of the 1115 waiver. This included facilitating State policy decision-making, waiver drafting and technical support through the CMS waiver negotiation process.
+ Reviewing requirements and associated system design, interface and business process flow documentation to ensure compliance with 1115 Waiver, Special Terms and Conditions and Kentucky HEALTH program policy.
+ Verifying and validating that Kentucky HEALTH program policies and requirements are accurately addressed throughout information system design, development and implementation activities.
+ Monitoring test planning and execution activities.

Additionally, HMA is currently supporting the evaluation plan design for Indiana's Healthy Indiana Plan (HIP) and New Hampshire Granite Advantage (GA) Health Care Program; following CMS approval of these plans HMA will conduct monitoring activities and produce evaluation reports per said plans.

For more information on HMA's capabilities and experience, please contact Senior Consultant Chip Cantrell at ccantrell@healthmanagement.com.

HMA Medicaid Roundup

Arizona

Arizona Transition to Complete Care is On Schedule. The Arizona Health Care Cost Containment System (AHCCCS) reported on August 8, 2018, that the state's transition to Complete Care, a Medicaid managed care program that integrates physical and behavioral health, is on schedule for an October 1, 2018, launch. The update came out of the August meeting of the State Medicaid Advisory Committee (SMAC), a 17-member committee presided over by AHCCCS director Tom Betlach.

Arizona Releases RFI Concerning Potential Integrated Health Care Program for Foster Kids. On August 8, 2018, the Arizona Health Care Cost Containment System (AHCCCS) issued a request for information (RFI) regarding a potential integrated managed care program for children in foster care. Responses are due no later than September 17, 2018. A study commissioned by the state and released earlier this year recommended a move to "CMDP Integrated Care," and according to the RFI, one proposed model involves an Administrative Services Organization in which "designated health plan functions are delegated to a private sector service delivery provider contracted…to provide a robust statewide physical and behavioral health network tailored to the unique needs" of the Comprehensive Medical and Dental Program (CMDP) population."

Currently, foster children in Arizona obtain acute care coverage through CMDP, a plan operated by the state Department of Child Safety. Separately, AHCCCS contracts with three Regional Behavioral Health Authorities (RBHAs) – Cenpatico Integrated Care, Mercy Maricopa Integrated Care, and Health Choice Integrated Care – for behavioral health benefits. Foster children with chronic and disabling medical conditions are enrolled in the Children's Rehabilitative Services, which is contracted to UnitedHealthcare Community Plan, for behavioral services.

Arkansas

Arkansas Residents, Advocates File Lawsuit Against CMS Over Medicaid Work Requirements. *CQ Health* reported on August 14, 2018, that health care advocates filed a federal lawsuit on behalf of three Arkansas residents, seeking to block the state's new Medicaid work requirements. The lawsuit, filed in U.S. District Court for the District of Columbia, argues that the Centers for Medicare & Medicaid Services (CMS) exceeded its authority in approving the rule. Arkansas is the first state to implement Medicaid work requirements. Read More

Arkansas Medicaid Work Requirements Not Met By 29 Percent of Adults. *Health Affairs* reported on August 13, 2018, that of the 26,000 Medicaid adults required to meet or designated exempt from Arkansas Medicaid work requirements, 29 percent did not meet the requirements in the first month. Arkansas requires individuals to report 80 hours of work or volunteering per month to be eligible for Medicaid coverage. The state will gradually phase in work requirements for adults aged 30 to 49 in 2018 and adults aged 19 to 29 in 2019, with nearly 125,000 adults impacted. Read More

California

Lawmakers Pass Bill to Ban Short-Term Health Insurance Plans. *The San Francisco Chronicle* reported on August 20, 2018, that the California legislature has passed a bill to ban short-term health plans, which offer consumers low-premium coverage with less comprehensive benefits than plans offered on the Affordable Care Act Exchanges. The bill, which would be effective January 2019, was authored by Senator Ed Hernandez (D-West Covina); it now heads to Governor Jerry Brown's desk. Read More

California Counties Are Sitting on $1.6 Billion Earmarked for Mental Health. *The Los Angeles Times* reported on August 19, 2018, that California counties are sitting on at least $1.6 billion in surplus funds from the state's 2004 Mental Health Services Act, despite a growing need for expanded mental health services. Observers blame the Act's complexity, spending requirements, and lack of guidance from state government. Pending legislation would require more active oversight. Read More

District of Columbia

District of Columbia Releases RFP to Reprocure Medicaid Managed Care. On August 14, 2018, Washington DC released a request for proposals (RFP) for Medicaid managed care organizations (MCOs) to serve the District of Columbia Healthy Families Program (DCHFP); Alliance program, covering low-income residents not eligible for Medicaid; and the Immigrant Children's Program (ICP), covering low-income immigrant children not eligible for Medicaid. The RFP comes after an administrative law judge ruled in December 2017 that the District failed to treat all bidder's equally and "undermined the integrity of the procurement process," ordering DC to reevaluate the bids. The state awarded contracts to AmeriHealth Caritas, Trusted Health Plan, and Anthem/Amerigroup in May. Incumbent MedStar was not awarded a contract and filed a protest. DC expects to award up to three new contracts. Proposals are due September 13, 2018. As of July 2018, there were approximately 186,000 Medicaid beneficiaries and 13,300 Alliance beneficiaries.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

DCF Secretary Mike Carroll to Step Down. *Health News Florida* reported on August 13, 2018, that Florida Department of Children and Families (DCF) Secretary Mike Carroll is leaving the agency effective September 6. He has served in the position since 2014. Governor Rick Scott says plans for replacement will be announced soon. Read More

Florida Ranks Low for Cost, Accessibility, Health Outcomes, WalletHub Report Says. *The Naples Daily News* reported on August 7, 2018, that Florida ranked 42nd among all U.S. states for health care based on costs, accessibility and outcomes, according to an annual report released by WalletHub. The WalletHub report analyzed the status of health care across the United States using 40 metrics and provided a score for each state. WalletHub analyst Jill Gonzalez said, “There is a correlation between states that ranked low with those choosing not to expand Medicaid to a larger segment of poor patients under the Affordable Care Act.” The data was obtained from the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention, U.S. Census Bureau and other federal agencies. The report listed Vermont, Massachusetts, New Hampshire, Minnesota, and Hawaii among the top states for affordability, access to care and outcomes. Read More

Illinois

Illinois Governor Amends Medicaid Eligibility Backlog Bill to Limit State Liability. *The State Journal-Register* reported on August 14, 2018, that Governor Bruce Rauner is seeking to limit Illinois’ liability before signing legislation that would help address the state’s Medicaid eligibility determination backlog. The General Assembly recently passed a bill that would make nursing home residents provisionally eligible for Medicaid until an eligibility determination is made. Some 15,000 nursing home residents are awaiting such determinations. Rauner proposed changes, stating that “under this bill, the state would be on the hook for 100 percent of the costs of nursing home stays while an application is under review.” Rauner also proposed that provisional eligibility would be repealed after the state reduces the backlog by 80 percent and recovers any overpayments. Lawmakers must now vote on Rauner’s changes. Read More

Iowa

Medicaid Members to Receive Specialized Wheelchairs. *The Des Moines Register* reported on August 20, 2018, that individuals with disabilities in the Iowa Medicaid program will receive specialized wheelchairs paid for by UnitedHealthcare, after the managed care plan lost a series of legal battle over whether it was required to cover the equipment. In three separate cases, the Iowa Department of Human Services had sided with the members who had been denied coverage of the specialized equipment. United had appealed the state rulings in court. Read More

Kansas

Judge Denies Temporary Injunction in Medicaid Managed Care Awards Dispute. *The Lawrence Journal-World* reported on August 13, 2018, that Kansas Judge Franklin Theis refused Anthem/Amerigroup's request for a temporary injunction that would have blocked Kansas from implementing newly awarded Medicaid managed care contracts. However, Theis plans to schedule a hearing regarding the possibility that the bidding process was flawed. In June, the Kansas Department of Health and Environment awarded three new KanCare contracts to Centene/Sunflower State Health Plan, United Healthcare Midwest, and Aetna Better Health of Kansas, rejecting Amerigroup's proposal. KanCare provides health coverage to more than 400,000 individuals in the state. Read More

Kentucky

Kentucky Faces Legal Setback in Attempt to Validate Medicaid Work Requirements. *ABC News* reported on August 20, 2018, that U.S. District Judge Gregory Van Tatenhove dismissed a lawsuit filed by Kentucky Governor Matt Bevin, which had sought to validate the state's proposed Medicaid work requirements. The countersuit was filed against 16 Medicaid recipients who had successfully sued to block the work requirements in June. Bevin will continue to pursue a separate lawsuit in federal court in Washington, D.C. Read More

Maine

Residents Still Waiting for Health Coverage Under Voter-Approved Medicaid Expansion. *U.S. News/Associated Press* reported on August 20, 2018, Maine residents are still waiting for Medicaid expansion, with Governor Paul LePage refusing to confirm whether the state will approve applications for coverage. Maine's high court is expected to comment soon on pending litigation that would force the state to seek federal funding for expansion. Last November, Maine voters approved Medicaid expansion for adults under age 65 with incomes at or below 138 percent of the federal poverty line. Read More

Attorney General Believes LePage Should Implement Medicaid Expansion. *U.S. News* reported on August 15, 2018, that Maine Attorney General Janet Mills believes the state's voter-approved Medicaid expansion law should be implemented, according to a spokesperson. Governor Paul LePage has steadfastly refused to implement expansion, which was approved by voters in a ballot measure. Mills, who is running for governor, has declined to defend the state in a lawsuit filed by supporters of expansion, who are attempting to force LePage's hand. Expansion would cover about 80,000 individuals. Read More

Maryland

Maryland Wins Federal Approval of Exchange Reinsurance Program. *The Associated Press* reported on August 22, 2018, that the federal government granted Maryland approval to create a reinsurance program aimed at holding down Exchange plan premiums. The program had bipartisan backing, with the Republican Governor Larry Hogan collaborating with Democratic legislative leaders. Read More

Medicaid Information is Vulnerable to Unauthorized Access, OIG Finds. *HealthData Management* reported on August 15, 2018, that Medicaid information in Maryland is vulnerable to unauthorized access and disclosure that could potentially put sensitive data at risk and disrupt critical operations of the program, according to an audit by the U.S. Office of Inspector General (OIG). The audit found that the state has failed to secure its Medicaid Management Information System (MMIS) in accordance with federal requirements and guidance. Maryland concurred with the report's findings and has outlined corrective measures. Read More

Mississippi

Mississippi Delays Discontinuation of NEMT Broker Program for LTC Residents. Mississippi announced that it has delayed until February 2019 plans to discontinue the state's Non-Emergency Transportation Broker program for long-term care residents. Until then, long-term care facilities can still arrange for transportation services through MTM Inc., which is the state's non-emergency medical transportation broker. The Mississippi Division of Medicaid had previously proposed that beginning Aug. 1, 2018, long-term care facilities would have to arrange and pay for non-emergency transportation for residents and then report the costs for reimbursement. Read More

Mississippi Amends Medicaid Work Requirement Waiver; CMS Reopens for Public Comment. *The Washington Post* reported on August 9, 2018, that the Centers for Medicare & Medicaid Services (CMS) reopened the Mississippi Medicaid work requirements waiver for public comment at the same time as it did for the Kentucky work requirements waiver last month. Mississippi, a non-expansion state, is seeking to require low income, "able-bodied" adults to work, volunteer or train for a job to receive Medicaid. The state amended its waiver request to extend the transitional Medicaid period from one year to two. The new comment period ends on August 18. Read More

Medicaid Made $616,000 in Improper Medicaid Managed Care Payments, State Auditor Finds. *The Clarion Ledger* reported on August 9, 2018, that Mississippi made more than $616,000 in improper payments to Medicaid managed care plans UnitedHealthcare and Centene/Magnolia Health, according to a report from the state auditor. The improper payments may have been to cover beneficiaries who had either transferred to a long-term care facility or died, the report found. The state is working to recover the funds. Read More

Montana

Court Rejects Request to Change Wording of Medicaid Expansion Ballot Measure. *KRTV* reported on August 15, 2018, that the Montana Supreme Court rejected a request to change the wording of a ballot measure that would raise tobacco taxes in order to extend the state's Medicaid expansion program. The measure, if approved, would also make Medicaid expansion in Montana permanent. The request to alter the wording was made by Montanans Against Tax Hikes, a group largely funded by two tobacco companies. The court ruled that the current language of the ballot measure is not misleading or confusing. Read More

Nevada

Chambers of Commerce to Launch Association Health Plan Through UnitedHealth. *Modern Healthcare* reported on August 17, 2018, that three chambers of commerce in Clark County, Nevada, will jointly launch an association health plan through UnitedHealth beginning September 1. The Henderson, Boulder City, and Latin Chambers, which represent more than 2,000 businesses with less than 10 employees, will offer HMO, PPO and POS plan options. Premiums will vary by employer group based on factors like age, occupation, size of group, and geographic location. Read More

Nevada Eases Restrictions on Medicaid Mental Health Policy. *The Las Vegas Review Journal* reported on August 14, 2018, that Nevada revised a new policy on Medicaid mental health care access, now requiring fee-for-service providers to submit a prior authorization form after five pre-approved sessions, as opposed to three previously. The regulation, which is still being called restrictive by opponents, could affect up to 162,500 fee-for-service Medicaid members. The prior authorization regulation is an attempt by the state to reduce Medicaid fraud. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Receives Federal Approval, Funds for Individual Health Plan Reinsurance Program. The New Jersey Department of Banking and Insurance (DOBI) announced on August 16, 2018, that the state has received federal approval and funding to support a reinsurance program designed to lower future individual health plan premium rates by up to 15 percent. According to DOBI Commissioner Marlene Caride, "The reinsurance program is an innovative way to increase stability in the insurance market and reduce costs to consumers. Ultimately, this is about creating greater access for residents in the state to the coverage and care they deserve." The state requested $218 million in federal pass-through funds to support the program under a Section 1332 State Innovation Waiver. The reinsurance program, which will apply to both Exchange and off-Exchange individual plans, was created through the New Jersey Health Premium Security Act, which Governor Murphy signed into law in May 2018. The program will enable DOBI to reimburse individual plans for certain high cost claims, which will help to reduce overall individual premiums. DOBI is actively reviewing proposed premium rates from carriers for 2019. New Jersey is one of 14 states that were approved to implement such a reinsurance program. Read More

New Mexico

New Mexico to Transition 85,000 UnitedHealth Medicaid Enrollees to Presbyterian. *The Albuquerque Journal* reported on August 16, 2018, that Presbyterian Health Plan has agreed to take on 85,000 Medicaid members and 340 employees from UnitedHealthcare of New Mexico. Financial terms of the transaction were not disclosed. UnitedHealthcare also confirmed that its appeal against the state's recent Medicaid managed care contract awards has been dismissed. The New Mexico Human Services Department awarded five-year contracts to Presbyterian Health Plan, Blue Cross, and Centene's Western Sky Community Care. Presbyterian already has 217,000 Medicaid members in the state. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

NYS Health Foundation Report Explores Coverage Options for Immigrants. The New York State Health Foundation released a report prepared by the Community Service Society that explores approaches to providing health coverage to unauthorized immigrants. The report notes that despite the New York's commitment to coverage and expansive public insurance programs, as many as 457,000 unauthorized, uninsured immigrants remain ineligible for coverage. The report explores three coverage options: a comprehensive "Essential Plan" for undocumented adults with incomes below 200 percent of the Federal Poverty Level; a Young Adult plan for undocumented immigrants between the ages of 19 and 29 that builds on the Child Health Plus program; and a high deductible "Bronze Plan" with first dollar preventive care and emergency services for undocumented adults who are eligible for Emergency Medicaid. For each option, the paper describes the kind of benefits offered, who would be covered, and how much it would cost. The first option, which opens the state's Essential Plan to all low-income New Yorkers, would cost the most, $462 million, but it would also cover the most people, roughly 111,100 New Yorkers. The second option, offering coverage to 27,900 young adults, is the most affordable at $78 million. The final option, purchasing a Bronze Plan for very low income immigrants, would cost $307 million, and would provide free preventive and emergency care to 85,000 New Yorkers.

Independent Practice Association Named to New York Value-Based Payment Innovator Program. Somos Independent Practice Association has been designated as an Innovator under New York's Value Based Payment (VBP) Roadmap, a key component of the Delivery System Reform Incentive Payment (DSRIP) Program. Somos-IPA is the first physician-led group in the state to reach VBP Innovator status. The VBP Innovator Program allows providers to contract with managed care plans at the most advanced payment levels, taking on additional management and administrative functions, and receiving an increased portion of the monthly Medicaid premium. The VBP Roadmap builds on DSRIP's Performing Provider Systems (PPS) and moves New York's Medicaid program toward value-based payment. The Somos-IPA, is comprised of three community based physician IPAs: Corinthian, Excelsior, and Eastern Chinese American Physicians. The Innovator network will partner with Montefiore Health System & St. Barnabas Hospital, MEDISYS Health System, NYU Health System, and Wycoff Heights Hospital. Through contracts with seven Medicaid managed care plans, the SOMOS-IPA will care for an estimated 180,000 Medicaid members in its first year. Somos-IPA is the third VBP Innovator designated by the state. Earlier this year, the Department of Health designated Montefiore ACO-IPA and NYU-Langone IPA, two hospital-led systems, as VBP Innovators. Read More

New York Launches New Semester of Value-Based Payment University. The New York Department of Health has launched the second semester of the second year of its on-line learning program, VBP University. VBP University is an educational resource designed to raise awareness, knowledge and expertise in the move to Value Based Payment (VBP). VBP University combines informational videos and supplemental materials that stakeholders interested in VBP can use to advance their understanding of topic. The program consists of four semesters, and individuals who successfully complete all four semesters will be awarded a certificate of completion. Semester One provided a deeper dive into VBP fundamentals. Semester Two is dedicated to the importance of addressing Behavioral Health and Substance Use Disorder through VBP. The curriculum includes an overview of VBP and Behavioral Health/Substance Use Disorder, VBP Integrated Primary Care and Health and Recovery Plan (HARP) arrangements, and key principles of VBP and Behavioral Health. Read More

Department of Corrections Seeks Electronic Health Records Vendor. The New York Department of Corrections and Community Supervision (DOCCS) has released a request for information (RFI) to inform its planning for replacing a number of legacy electronic medical record systems with a single comprehensive, integrated Electronic Health Record system. The RFI seeks feedback on the interest and capabilities of vendors that can provide electronic health records software and supporting services for use in a correctional system setting. This will also include the installation, training, technical support, application hosting, and software maintenance for all facilities. The system includes 49,500 individuals under custody held at 54 state facilities and 35,500 parolees. DOCCS maintains 54 outpatient clinics, 31 infirmaries, and 5 Regional Medical Units, handling over 1 million primary care visits and 120,000 specialty visits/year. Responses to the RFI, which is not binding, are due September 12. Read More

New York Revises Children's Medicaid System Transformation. 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 to the Medicaid benefit. New York had originally intended to move the various and disparate authorizations for home and community-based services (HCBS) now provided under six separate Section 1915(c) waivers to New York State's 1115 Medicaid Redesign Team Waiver (1115 Waiver). The Centers for Medicare & Medicaid Services (CMS) has advised the state that it would not approve amendments to the state's 1115 waiver that would be required to move forward, indicating 1115 waiver authority should only be used when an alternative 1915(c) children's waiver authority is not available. As a result, the state is now proposing the Children's Medicaid System Transformation be implemented under concurrent 1915(c) Waiver and 1115 Waiver amendments. The state has posted a draft 1915(c) Children's Waiver for public comment. Comments are due by September 23. The state will be hosting a webinar to provide an overview of the draft children's waiver on Monday, August 27 from 2 – 3 pm. Read More

New York Files Lawsuit Against Maker of OxyContin. *New York Times* reported on August 14, 2018, that New York filed a lawsuit in state supreme court against OxyContin maker Purdue Pharma, claiming the drug maker misled consumers while marketing opioids. New York, which joined at least 26 other states and Puerto Rico that have filed lawsuits against Purdue Pharma over opioids, is seeking to impose fines. Purdue sold an estimated $1.74 billion of OxyContin in 2017. Read More

UnitedHealthcare Loses Risk Adjustment Lawsuit against Department of Financial Services. *Crain's New York Business* reported on August 14, 2018, that a federal judge has ruled that New York has the authority to adjust federal risk adjustment payments made under the Affordable Care Act, concluding that state insurance law and regulation is not preempted by federal law. The New York Department of Financial Services (DFS) had used its regulatory authority to address the adverse effects of the federal risk adjustment program on New York's health insurers. The federal risk adjustment program is intended to result in financial transfers among insurers to account for the health of the insured populations. The program has resulted in transfers by insurers of upwards of 30% of premium to other insurers, rewarding larger insurers over smaller entities. Under a DFS regulation issued in 2017, DFS evaluates whether CMS risk adjustment calculations will have an adverse impact on New York's small group health insurance marketplace, and if so, implement a "market stabilization pool" taking into account certain factors relevant to the New York market. Utilizing these additional factors, insurers who received money from the risk adjustment program will pay an allocable percentage of that money into a fund administered by DFS. DFS will then transfer that money to those insurers who paid into the risk adjustment program and were adversely impacted. United Healthcare was due to receive $216 million in federal risk adjustment payments, while many smaller plans owed tens of millions of dollars. Read More

North Carolina

North Carolina Releases Medicaid Managed Care RFP. On August 9, 2018, the North Carolina Department of Health and Human Services, Division of Health Benefits, released the state's much-anticipated Prepaid Health Plan Services request for proposals (RFP). Through the procurement, North Carolina will transition its Medicaid fee-for-service program to Medicaid managed care, integrating physical and behavioral health. Most North Carolina Medicaid and NC Health Choice populations will be mandatorily enrolled in Prepaid Health Plans (PHPs), with exceptions including duals, medically needy, and Program of All-Inclusive Care for the Elderly (PACE) beneficiaries, among others. The state has established six Medicaid Managed Care Regions, called PHP Regions, and strongly encourages PHPs to submit a bid for more than one region. The state is planning a two-phase approach with two distinct open enrollment periods to help ensure each region has an appropriate balance of enrollees, PHPs, and other considerations. Phase 1 is scheduled to begin on November 1, 2019, and Phase 2 is scheduled to begin on February 1, 2020. Proposals are due October 12, 2018, and contracts will be awarded on February 4, 2019. Following the awards, the state will announce which Regions will be selected for Phase 1 and Phase 2. Read More

Ohio

Ohio Medicaid Releases 2018 Medicaid Expansion Assessment. The Ohio Department of Medicaid released on August 21, 2018, its 2018 Medicaid Expansion Assessment. The assessment concluded Medicaid expansion has been beneficial to enrollees by facilitating continued employment, new employment, and job-seeking; increasing primary care and reducing emergency department use; lessening medical debt and financial hardship; improving mental health; assisting in addressing unhealthy behaviors; and enabling enrollees to act as caregivers for family members. The report also noted a higher percentage of all Group VIII enrollees are now employed compared to the previous 2016 assessment. Read More

Ohio to Transition Medicaid PBM Contracts to Transparent Pricing. *Cleveland.com* reported on August 14, 2018, that Ohio will require it's contracted Medicaid managed care organizations (MCOs) to change their contracts with pharmacy benefit management (PBM) companies from a spread pricing model to a transparent, pass-through pricing model beginning January 2019. A state-commissioned report shows that PBMs billed MCOs $223.7 million more for prescription drugs during 2017 than they reimbursed pharmacies. Under the transparent pricing model, PBMs will charge MCOs the amount they paid the pharmacy plus an administrative fee. Read More

Oklahoma

Medicaid Work Requirements Could Threaten Coverage for Families. *MedPage Today* reported on August 7, 2018, that Oklahoma Medicaid work requirements would be harmful to both children and parents enrolled in the program, according to a report from the Georgetown University Center for Children and Families and the Oklahoma Policy Institute. The report found that the new work requirements would predominantly impact lower-income mothers with barriers to employment like child-care and transportation. Oklahoma, a non-expansion state, proposed work requirements on parents with incomes at or below 45 percent of the federal poverty level. Read More

Oregon

Medicaid Program Considers Ending Coverage of Opioids for Chronic Pain Patients. *STAT News* reported on August 15, 2018, that Oregon state officials are considering a proposal that would end coverage of opioids for chronic pain patients enrolled in the state's Medicaid Program. The proposal suggests that, beginning in 2020, those using prescription opioids would have their doses tapered to zero over a 12-month period. This proposal is the first of its kind and a point of concern for Medicaid beneficiaries who use opioids to manage chronic pain. Read More

Pennsylvania

Pennsylvania Provides Electronic Visit Verification Update. The Pennsylvania Department of Human Services has announced that its approach to the 21st Century Cures Act's electronic visit verification (EVV) requirement will be to use an open system. Providers who already have an EVV system will be able to submit information to DXC, the state's EVV vendor. Providers who do not have their own EVV will be able to utilize the Department's system for compliance. The tentative timeline for Pennsylvania's implementation of EVV for personal care services (PCS) is as follows:

- January 2019 – PA guidance will be distributed
- Spring 2019 – Provider training will be offered with phased-in system use
- Summer 2019 – Full implementation of system

PCS includes Personal Assistance Services and Respite (unlicensed settings only). Read More

Texas

Medicaid Committee to Require Disclosure of Ties to Drug Makers. *NPR* reported on August 17, 2018, that individuals who speak during Texas committee hearings on the formulary status of Medicaid drugs will now be required to disclose additional details about their ties to pharmaceutical companies. The change follows a joint *Center for Public Integrity/NPR* investigation into how physicians serving on state Medicaid committees are influenced by drug companies. States like Arizona, Colorado and New York have made similar changes. Read More

Texas to Receive $110 Million in Settlement with AstraZeneca. *HealthLeaders* reported on August 8, 2018, that AstraZeneca has agreed to pay Texas $110 million to settle claims of improper off-label marketing of the antipsychotic drug Seroquel and the cholesterol drug Crestor to Medicaid providers. During this time, AstraZeneca was already under a 2010 federal corporate integrity agreement resulting from prior allegations of Medicaid fraud. According to the state, AstraZeneca also made illegal payments to two former state hospital doctors to unduly influence the use of Seroquel in the state hospital system. The drugs were mainly promoted to treat children and adolescents, the state said. Read More

National

GAO, CMS Call for Scrutiny of Medicaid Managed Care in Expansion States. *Modern Healthcare* reported on August 21, 2018, that Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma and U.S. Comptroller General Gene Dodaro urged a Senate panel to tighten oversight of Medicaid managed care in expansion states in an effort to reduce improper payments. Verma and Dodaro made the remarks to the Senate Homeland Security and Governmental Affairs Committee. Improper Medicaid payments were estimated at $37 billion in fiscal 2017; however, the bulk of the improper payments appear to be in fee-for-service Medicaid. Dodaro acknowledged that even if all Medicaid fraud was eliminated, it would have only a marginal impact on total program spending. Read More

CMS Issues Proposed ACO Rules Designed to Encourage Upside, Downside Risk. The Centers for Medicare & Medicaid Services (CMS) issued a proposed set of new Accountable Care Organization (ACO) rules specifically designed to encourage participants in the Medicare Shared Savings Program "to transition to two sided models (in which they may share in savings and are accountable for repaying shared losses)." The new rules would be implemented in 2019. Existing ACOs would receive a 6-month extension on agreements that expire at the end of 2018. Public comments on the new rules, called Pathways to Success, are due on October 16. The proposal, which is estimated to result in $2.2 billion in Medicare savings over 10 years, would consolidate the number of ACO tracks to two, Basic and Enhanced; create participation options that reflect ACO's degree of control over total Medicare Parts A and B fee-for-service (FFS) expenditures for assigned beneficiaries; lengthen the term of ACO participation agreements from three to five years; modify the current risk adjustment approach to allow changes in health status to be more fully recognized; change the program's assignment methodology and process for allowing beneficiaries to voluntarily align to ACOs; incorporate regional spending into ACO targets earlier; and authorize termination of ACOs with multiple years of poor financial performance. The proposed regulations also promote beneficiary engagement; leverage new CMS authorities under the Bipartisan Budget Act of 2018, and solicit comments on how to improve coordination of pharmacy care for Medicare FFS beneficiaries and on quality measures that support the agency's Meaningful Measures initiative. Read More

CMS Speeds Approval Time for 1915 Waivers, Special Plan Amendments. The Centers for Medicare & Medicaid Services (CMS) announced on August 16, 2018, "significant improvement" in approval turnaround times for state Medicaid 1915 waivers and special plan amendments (SPAs). CMS reported a 23 percent decrease in the median approval time for SPAs between 2016 and the first quarter of 2018. Median approval times for home and community-based services waivers decreased by seven percent over the same time period. CMS also reported that 84% percent of SPAs were approved within 90 days. Read More

Senator Grassley Calls for 'Careful Analysis' of PBM, Health Plan Mergers. *Fierce Healthcare* reported on August 15, 2018, that Senator Chuck Grassley (R-Iowa) has urged the U.S. Department of Justice to conduct a "careful analysis" of the competitive impact of the planned mergers of CVS and Aetna and of Cigna and Express Scripts. Grassley, who chairs the Senate Judiciary Committee, stated in a letter, "we must ensure that these transactions do not foreclose competition and consumer access, or hinder innovation, especially in underserved rural areas." Read More

CMS Is Expected to Approve Medicaid Work Requirements in Arizona, Wisconsin, Maine, Limited Drug Testing in Wisconsin. *Politico* reported on August 16, 2018, that the Centers for Medicare & Medicaid Services (CMS) is expected to approve Medicaid work requirements in Arizona, Maine, and Wisconsin, as well as limited drug testing in Wisconsin, according to individuals with knowledge of the process. CMS is also expected to deny Arizona's attempt to exempt Native Americans from work requirements. CMS declined to comment. Read More

Federal Judge to Hear Arguments in Lawsuit to Overturn ACA. *Politico* reported on August 8, 2018, that a U.S. District Court in Texas will hear oral arguments on September 10 in a federal lawsuit that aims to overturn the Affordable Care Act as unconstitutional. The 20 Republican state attorneys general who filed the lawsuit in U.S. District Court in Texas are seeking a preliminary injunction halting enforcement of the law. Read More

CMS Urges States to Allow Sale of Off-Exchange Plans Without CSR Load. *Kaiser Health News* reported on August 14, 2018, that the Centers for Medicare & Medicaid Services (CMS) wants states to allow insurers to offer individual health plans outside the Exchanges that don't raise premiums to offset the loss of cost-sharing reduction (CSR) payments. The CSR "load" was added by plans in response to the Trump administration's decision to discontinue the payments. According to CMS, "Allowing issuers to offer and market plans that are available exclusively off-Exchange that do not include the CSR load would provide unsubsidized enrollees the opportunity to purchase a plan at a lower premium." Read More

State Governors Release Evidence-Based Pharmaceutical Intervention Strategies Report. On August 10, 2018, the National Governors Association released a report aimed at identifying strategies to address the cost of pharmaceutical interventions, including enhancing purchasing power, utilizing alternative payment mechanisms, fostering transparency and conducting value assessments, among others. Potential strategies were vetted by 11 states: California, Delaware, Louisiana, Massachusetts, New Mexico, New York, Ohio, Oregon, Rhode Island, Virginia and Washington. Read More

Trump Administration Closes Loophole on Medicaid Drug 'Line Extensions'.
The Washington Examiner reported on August 9, 2018, that the Trump administration has ended a Medicaid loophole, which had allowed drug companies to lower rebates to states by making superficial changes to existing drugs and treating them as new medications under the rebate calculation. The U.S. Department of Health & Human Resources issued new rules concerning the practice – called "line extensions" – in response to federal legislation enacted in February. Read More

Demand for NEMT is Growing. *The New York Times* reported on August 9, 2018, that there is growing demand for non-emergency medical transportation (NEMT). The article cites research showing that approximately 30 percent of patients miss their doctor appointments because of the lack of transportation, resulting in $150 billion in lost revenues annually for health care providers. Read More

CMS Issues Proposed Rule to Readopt Exchange Plan Risk Adjustment Methodology. *Health Affairs* reported on August 10, 2018, that the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule aimed at readopting part of its risk adjustment methodology for Exchange plans. While the proposal doesn't substantively alter the risk adjustment regulations, it does provide a more thorough explanation of the assumptions behind the methodology. Comments due by September 7, 2018. CMS had temporarily suspended the risk adjustment program after a federal judge found it to be arbitrary and capricious. Read More

CMS Moves to Curtail ACOs. *The Washington Post* reported on August 9, 2018, that that Trump administrative is proposing limits on Accountable Care Organizations (ACOs) serving Medicare, a change that is projected to result in more than 100 fewer ACOs over 10 years. Under the change, ACOs would be able to receive upside-only incentives for two years, compared to six years currently. More than 80 percent of the 561 ACOs in the Medicare Shared Savings Program receive upside-only incentives, without downside risk. Read More

States Question Costs of Medicaid Pharmacy Benefit Managers. *NPR* reported on August 8, 2018, that states like Ohio, West Virginia, and Iowa are questioning the cost of using pharmacy benefit management companies to manage Medicaid drug benefits. Data released by Ohio, for example, shows that PBMs charge the state 8.8 percent more than they pay to pharmacies to fill prescriptions. CVS Health, one of the state's Medicaid PBMs, countered that Ohio also found that the company saved the state about $145 million compared to an alternative system where the state pays a fee per prescription filled. Read More

Industry News

St. John's Riverside to Join the Montefiore Health System. *Crain's New York Business* reported on August 17, 2018, that St. John's Riverside Hospital, a 378-bed hospital based in Yonkers, has voted to begin exclusive negotiations to join Montefiore Health System. One of the last two independent community hospitals in Westchester County, St. John's Riverside announced in March that it was seeking a partnership with a larger health network. NY has seen a steady consolidation of its hospital market over the last several years, as the major hospital networks, including Montefiore, New York-Presbyterian and Northwell Health have increased their networks through purchases or affiliation agreements. Montefiore first entered a clinical affiliation with St. John's Riverside in 2014 and the hospital has been a partner in its Montefiore Hudson Valley Collaborative, a network participating in the state's $7.4 billion Delivery System Reform Incentive Payment program. Over the past five years, Montefiore has increased its reach in the Hudson Valley, adding hospitals in Mount Vernon, New Rochelle, Nyack, Newburgh, Cornwall and White Plains to its health system. The health system now cares for more than 1 million people. Read More

Google Parent Alphabet to Invest $375 Million in Oscar Health. *The Hill* reported on August 8, 2018, that Google parent company Alphabet will invest $375 million in Oscar Health, which offers Affordable Care Act Exchange plans in six states. Read More

Top Health Insurers Post 24 Percent Increase in First-Half Earnings. *FierceHealthcare* reported on August 13, 2018, that net income of top health insurers rose 24 percent to $16.6 billion in the first half of 2018, compared to $13.4 billion for the same period last year, a tally of results from eight health insurers shows. Revenues rose 8 percent to $285.2 billion. The figures include all lines of business. Molina Healthcare notched an impressive comeback, reporting net income of $309 million in the first half, compared to a net loss of $153 million loss last year. Plans tallied included Aetna, Anthem, Cigna, Centene, Humana, Molina, UnitedHealth, and WellCare. Read More

Integris/USP Health Ventures to Buy Controlling Interest in HPI Holdings. *Modern Healthcare* reported on August 17, 2018, that Integris/USP Health Ventures will acquire a controlling interest in HPI Holdings. The combined entity will create an affiliated group of more than 1,300 specialty physicians in the Oklahoma City metro area. Integris/USP Health Ventures is a joint venture of Integris Health and United Surgical Partners International (USPI). The deal is expected to close in the fourth quarter of 2018. Read More

Simplura Health Group Acquires Helping Hand. One Equity Partners announced on August 10, 2018, that portfolio company Simplura Health Group has completed the acquisition of Helping Hand Home Health & Hospice Agency, a Philadephia-based provider of non-medical home care services for seniors. Helping Hand will become part of CareGivers America. Financial terms of the transaction were not disclosed. Read More

Cigna Reaffirms Support for Proposed Express Scripts Merger. *FierceHealthcare* reported on August 8, 2018, that Cigna Corp. has reaffirmed its support of a proposed merger with pharmacy benefit management (PBM) company Express Scripts, after investor Carl Icahn called the deal a "huge bailout" for the PBM. Cigna shareholders are scheduled to vote on the merger on August 24. Read More

InnovAge Finalizes Acquisition of Four Pennsylvania LIFE Centers for Seniors. InnovAge announced on August 7, 2018, that it has finalized its acquisition of four Living Independently for Elders (LIFE) program centers in Pennsylvania from NewCourtland Senior Services. LIFE is known nationally as the Program of All-Inclusive Care for the Elderly (PACE). The LIFE centers in the acquisition are located in Allegheny, Germantown, Roosevelt, and St. Bart's. Financial terms of the transaction were not disclosed. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
Summer 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
August 2018	New Hampshire	RFP Release	181,380
September 1, 2018	Virginia Medallion 4.0 - Central	Implementation	189,438
September 13, 2018	Washington DC	Proposals Due	~200,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 12, 2018	New Hampshire	Proposals Due	181,380
October 12, 2018	North Carolina	Proposals Due	1,500,000
October 1, 2018	Virginia Medallion 4.0 - Northern/Winchester	Implementation	178,416
November 1, 2018	Virginia Medallion 4.0 - Charlottesville/Western	Implementation	88,486
November 1, 2018	Puerto Rico	Implementation	~1,300,000
December 1, 2018	Virginia Medallion 4.0 - Roanoke/Alleghany	Implementation	72,827
December 1, 2018	Virginia Medallion 4.0 - Southwest	Implementation	46,558
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	181,380
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)
February 4, 2019	North Carolina	Contract Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
January 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
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
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000

HMA Welcomes

Richard Chambers, Principal – Los Angeles, CA

Richard Chambers is an experienced healthcare executive with vast expertise in Medicaid, Medicare Advantage, Program for All-Inclusive Care for the Elderly (PACE), and Marketplace managed care, who knows how to navigate the changing landscape and nurture federal and state government relations.

His public agency senior positions and health plan executive leadership roles have provided him with unique skills to work with a wide variety of clients including health plans, government agencies, foundations, and associations on strategic planning around publicly financed healthcare programs and innovations for coordinated and integrated care.

Prior to joining HMA, Richard led corporate policy direction as senior vice president for Policy and Government Affairs at Molina Healthcare, Inc., a multi-state healthcare organization providing managed care for Medicaid, Medicare, Duals demonstrations, and Affordable Care Act (ACA) Marketplaces. Prior to that role, he spent four years as president of the Molina California managed care plan, which grew to serve 700,000 low-income families, children, seniors, and persons with disabilities in Medicaid and Medicare, and Covered California. His strategic vision and ability to foster strong relationships ensured access to quality healthcare services for members, including implementation of the Coordinated Care Initiative Duals Demonstration for dual eligible health plan members.

Previously, Richard was the CEO at CalOptima, a public managed care system delivering healthcare to more than 300,000 Medicaid and Medicare members in Orange County, California. He worked hand-in-hand with the board of directors during his eight years as CEO to develop the strategy that would determine the entity's budget and operational course. His strategic leadership resulted in start-up of a Duals Special Needs Plan (DSNP) and development of the first PACE program in Orange County. During his tenure as the COO, he was responsible for day-to-day operations including CalOptima's contract compliance with the State Department of Health Care Services and oversight of the integrated healthcare delivery networks.

Richard received his bachelor's degree in psychology from the University of Virginia.

Dr. R. Corey Waller, Principal – Lansing, MI

R. Corey Waller MD, MS, FACEP, DFASAM is a nationally recognized addiction expert and an actively practicing addiction, pain, and emergency medicine specialist. As a principal at Health Management Associates and chairman of the Legislative Advocacy Committee for the American Society of Addiction Medicine (ASAM), he is directly responsible for consultation regarding treatment system development and education as well as all Washington, DC-related matters for ASAM.

In his immediate past role of senior medical director for education and policy at the National Center for Complex Health and Social Needs, Dr. Waller was responsible for developing and maintaining all training and in-person technical assistance delivered by the National Center. This covered addiction, pain and behavioral health treatment system development, correctional medicine, payment model implementation, and healthcare policy.

He earned a Master of Science in biology with a neuro-molecular focus at Southwest Texas State University and earned his Medical Degree at the University of Texas Medical School in San Antonio. Dr. Waller completed his emergency medicine residency at Thomas Jefferson University in Philadelphia and is board certified in emergency medicine and addiction medicine.

HMA News

Former HHS Secretary Mike Leavitt to Give Morning Keynote Address At 2018 HMA Medicaid Conference in Chicago

Mike Leavitt, who served as Secretary of Health and Human Services during the administration of President George W. Bush, will be the morning keynote speaker at 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.

Leavitt, who is currently founder and general partner of Leavitt Partners, will provide much-needed perspective on developments in Medicaid, including a look at the practical and political implications of renewed efforts to reform the program.

A total of 400 are expected to attend the event, which is the third annual Medicaid conference organized by HMA. The event will feature a total of more than 45 high-level industry speakers who will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations. There will also be a Pre-Conference Workshop on Sunday, Sept. 30.

Visit our website to register and to obtain a complete agenda and list of speakers: https://conference.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Arizona AHCCCS Population Demographics, Aug-18 Data
- California Medicaid Managed Care Enrollment is Down 1.2%, Jul-18 Data
- Colorado RAE Enrollment is 1.2 Million, Aug-18 Data
- Florida Medicaid Managed Care Enrollment is Flat, Jul-18 Data
- Iowa Medicaid Managed Care Enrollment is Up 5.9%, Jul-18 Data
- Illinois Medicaid Managed Care Enrollment is Up 17.9%, Jun-18 Data
- MLRs at Illinois Medicaid MCOs Average 97.5%, 2017 Data
- Indiana Medicaid Managed Care Enrollment is Down 2.5%, Jun-18 Data
- Indiana Medicaid Managed Care Enrollment is Down 2.9%, Jul-18 Data
- Kentucky Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Louisiana Medicaid Managed Care Enrollment by Plan, Region, and Subprogram, Jun-18
- Massachusetts Dual Demo Enrollment is Up 13.1%, Jul-18 Data
- Maine Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Nebraska Medicaid Managed Care Enrollment Rises 1.2%, Aug-18 Data
- MLRs at Nevada Medicaid MCOs Average 84.9%, 2017 Data
- Ohio Medicaid Managed Care Enrollment is Down 1.8%, Jul-18 Data

- Ohio Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Oklahoma Medicaid Enrollment by Age, Race, and County, Jun-18 Data
- Pennsylvania Medicaid Managed Care Enrollment is Flat, Jun-18 Data
- South Carolina Medicaid Managed Care Enrollment is Down 1.9%, Aug-18 Data
- Tennessee Medicaid Managed Care Enrollment is Down 5.2%, Jul-18 Data
- MLRs Average 87.5% at Virginia Medicaid MCOs, 2017 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 2.5%, Jul-18 Data
- Wyoming Medicaid Fee for Service vs. Managed Care Penetration, 2014-17

Public Documents:
Medicaid RFPs, RFIs, and Contracts:

- Maine ASO RFP, Proposals, Scoring, and Contracts, 2016-18
- Arizona 2019 Integrated Health Care RFI, Aug-18
- DC Medicaid Managed Care RFP, Aug-18
- Massachusetts Outpatient Procedures Utilization Management RFR, Jul-18
- Michigan Behavioral PIHP Contract, FY 2018
- Mississippi Non-Emergency Transportation (NET) Brokerage Services IFB and Award, 2018
- Mississippi Third Party Data Matching and Recovery Services IFB and Award, 2018
- North Carolina Medicaid Integrated Modular Solution RFI, Aug-18
- North Carolina Prepaid Health Plan Services RFP, Aug-18
- Texas Medicaid and CHIP Dental RFI, Responses, 2016

Medicaid Program Reports and Updates:

- Arizona Medicaid Advisory Committee Meeting Materials, Aug-18
- California Medi-Cal Managed Care 2015–16 Disparities Focused Study 12-Measure Report, Jul-18
- California Medi-Cal Provider Rates, Aug-18
- Colorado Department of Health Care Policy & Financing Annual Reports, 2015-17
- Colorado Medicaid Managed Care Rate Books, FY 2019
- Delaware Diamond State Health Plan 1115 Waiver Documents, 2014-18
- Florida Managed Medical Assistance (MMA) 1115 Demonstration Waiver Approval and Pending Amendments, 2018
- Georgia Medicaid Managed Care Analyses of Hospital Statistical and Reimbursement (HS&R) Report Submissions SFY 2018, Apr-18
- Idaho Medicaid Facts, Figures, and Trends Reports, 2013-18
- Healthy Louisiana Program Actuarial Rate Certification and Data Book, Effective Feb-18 through Jan-19
- Michigan Medicaid Health Plan CAHPS Reports, 2015-17
- Michigan Medicaid Health Plan HEDIS Reports, 2016-17
- Missouri Medicaid Managed Care Rate Development May 1, 2017 through June 30, 2018 Presentation, Jun-16
- Nebraska Acute Hospital APR-DRG Rates, 2015-18
- NGA State Strategies on Pharmaceuticals Report, Aug-18

- North Carolina Medical Care Advisory Committee Meeting Materials, Aug-18
- Ohio Joint Medicaid Oversight Committee Meeting Materials, Aug-18
- Ohio Medicaid Executive Summary Report on PBM Performance, Jun-18
- Ohio Medicaid 2018 Group 8 Assessment, Aug-18
- Oklahoma Program of All-Inclusive Care for the Elderly Fast Facts, Jun-18
- Pennsylvania HealthChoices Medical Assistance Quality Strategy Report, Apr-17
- Rhode Island Comprehensive Demonstration 1115 Waiver Approval and Pending Extension, 2018
- Rhode Island Medical Care Advisory Committee Meeting Materials, Jun-18
- South Carolina Medical Care Advisory Committee Meeting Materials, Aug-18
- Tennessee Medicaid Quality Assessment and Performance Improvement Strategy Reports, 2013-17
- Wyoming HCBS Transition Plan and CMS Final Approval, Jun-18

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

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