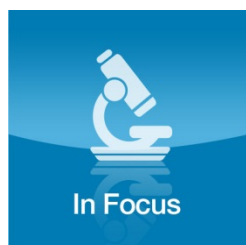


HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... September 26, 2018



In Focus



HMA Roundup



Industry News

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THIS WEEK

- **IN FOCUS: COMPANION MEDICAID AND MEDICARE ADVANTAGE DUAL ELIGIBLE SPECIAL NEEDS PLANS**
- HAWAII RELEASES RFI FOR QUEST INTEGRATION MEDICAID MANAGED CARE PROGRAM
- NEW MEXICO TO TRANSITION TO STATE-BASED HEALTH INSURANCE EXCHANGE IN 2021
- VIRGINIA FILES WAIVER REQUEST FOR MEDICAID WORK REQUIREMENTS, MONTHLY PREMIUMS
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- LIFEPOINT HEALTH CEO CARPENTER TO RETIRE
- **NEW THIS WEEK ON HMA INFORMATION SERVICES (HMAIS)**

IN FOCUS

COMPANION MEDICAID AND MEDICARE ADVANTAGE DUAL ELIGIBLE SPECIAL NEEDS PLANS

This week, our *In Focus* section reviews Medicare-Medicaid integration opportunities through Dual Eligible Special Needs Plans (D-SNPs). States are motivated to expand their capacity to address the needs of dually eligible beneficiaries through integrated care. They are increasingly requiring health plans that operate Medicaid managed long-term services and supports (MLTSS) programs to become Medicare Advantage (MA) D-SNPs. A few states require D-SNPs to be Medicaid MLTSS health plans.¹

¹ E.g. New Jersey requires D-SNPs to also have a Medicaid managed care contract with the state.

In states where this is happening, health plans must operate both Medicaid MLTSS and D-SNP plans to continue serving dually eligible beneficiaries.

Health plans operating both Medicaid MLTSS and D-SNP plans, or “companion plans,” will need to gain and demonstrate expertise in understanding the unique and diverse medical, behavioral health, LTSS, and social determinants of health needs of these beneficiaries, providing services that meet those needs and complying with the administrative requirements of both programs.

In this article written by Principals Sarah Barth and Ellen Breslin, we share: 1) the current regulatory landscape that strengthens Medicare-Medicaid integration opportunities through D-SNPs, 2) counts of the dually eligible population in the 10 states that require plans to operate companion plans, and 3) plan considerations for obtaining the expertise needed to serve dually eligible beneficiaries in companion MLTSS and D-SNP plans.

Current Regulatory Landscape for D-SNPs

The 2018 permanent authorization of D-SNPs, followed by the regulatory guidance for default enrollment issued by the Centers for Medicare and Medicaid Services (CMS), supports state’s efforts to align Medicare and Medicaid through D-SNPs.

Permanent authorization. The February 2018 Bi-Partisan Budget Act (BBA), which gave permanent authorization of Medicare Advantage Special Needs Plans including D-SNPs, represents the most significant regulatory change supporting the integration of Medicare and Medicaid services through D-SNPs.

Prior to permanent authorization, D-SNPs were subject to annual reauthorization. States may now consider the use of D-SNPs as a permanent pathway to integrate Medicare and Medicaid services for their dually eligible beneficiaries. The BBA additionally gave the CMS Medicare and Medicaid Coordination Office (MMCO) authority to develop rules and guidance related to the integration or alignment of Medicare and Medicaid policy and oversight for D-SNPs and provide resources to states interested in using D-SNPs as a model for integration.

Regulatory guidance – default enrollment. On August 31, 2018, CMS issued guidance for default enrollment, or automatic enrollment, of dually eligible beneficiaries who are enrolled in a Medicaid managed care plan and are newly eligible for Medicare, into an integrated D-SNP offered by the same organization. D-SNPs may now submit new default enrollment proposals to CMS October 1, 2018, with effective dates of January 1, 2019, and later.

The process was formerly referred to as “seamless conversion.” CMS provided only two states, Arizona and Tennessee, the authority to seamlessly convert members before it placed a moratorium on giving additional states permission to use the process. The CMS guidance signals support for automatic enrollment in companion plans. States with MLTSS health plan requirements to operate D-SNPs, becoming companion plans, will likely want or require these plans to apply for default enrollment, providing those plans an opportunity to see their D-SNP market share increase.

1.7 Million Dually Eligible Beneficiaries in States Requiring Health Plans to Operate as Companion Plans

Ten states – Arizona, Hawaii, Massachusetts, New Mexico, Minnesota, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin – require Medicaid MLTSS health plans to become D-SNPs in order to operate as Medicaid MLTSS health plans. The dually eligible beneficiaries in these states account for nearly 25 percent of all dually eligible beneficiaries in the country. Similarly, dually eligible beneficiaries who receive full Medicaid benefits or “full duals” account for 23 percent of all full-benefit dually eligible beneficiaries. Three of these 10 states – Massachusetts, Pennsylvania, and Texas – represent close to 60 percent of the total dually eligible beneficiary count in the 10 states. Table 1 on the next page lists the 10 states and the composition of their dually eligible beneficiary populations, including the three states with the largest share of the total.

Table 1: State-Level Counts of Medicare-Medicaid Dually Eligible Beneficiaries

State	QMBs		SLMBs		All Other		Total	Full Medicaid Benefits
	Qualified Medicare Beneficiaries (QMB)-only	QMB plus Full Medicaid Benefits	Specified Low-income Medicare Beneficiaries (SLMB)-only	SLMB plus Full Medicaid Benefits	Qualifying Individuals (QI)	Other Dual Full Medicaid Benefit	Total for All Dually Eligible Beneficiaries	Total for Beneficiaries with Full Medicaid Benefits
Arizona	29,215	53,085	20,817	4,543	10,478	9,887	128,025	67,515
Hawaii	560	29,185	3,514	547	1,623	5,215	40,644	34,947
Massachusetts	1,655	220,650	12,981	7,843	6,820	59,443	309,392	287,936
Minnesota	2,357	74,932	9,734	10,990	5,028	36,185	139,226	122,107
New Mexico	23,172	41,262	6,483	4,500	4,818	17,249	97,484	63,011
Pennsylvania	6,601	286,937	51,375	18,437	30,930	64,246	458,526	369,620
Tennessee	66,419	50,467	58,711	12,086	225	90,148	278,056	152,701
Texas*	190,621	315,113	87,116	14,512	37,316	54,290	698,968	383,915
Virginia	28,872	94,958	22,381	6,387	10,967	26,305	189,903	127,650
Wisconsin	10,581	80,869	7,868	13,929	3,669	49,916	166,832	144,714
Total for 10 States	360,053	1,247,458	280,980	93,774	111,874	412,884	2,507,056	1,754,116

Source: HMA, based on data from the Centers for Medicare and Medicaid Services (CMS).

Data as of March 2017. Data for Qualified Disabled Working Individuals (QDWI) is excluded; Virginia count was 33.

*Texas requires MLTSS health plans to have D-SNPs in geographic regions in which the capitated financial alignment initiative (aka dual demonstration) does not operate.

Health Plan Considerations

The dually eligible beneficiary population is diverse in age, gender, race, ethnicity, language, chronic conditions, and disabilities, which include cognitive, behavioral and physical disabilities. Close to 60 percent were 65 years of age and older. About 40 percent were male, and 61 percent were female.² Dually eligible beneficiaries are among the poorest of Medicare beneficiaries, and they face many adverse social determinants of health (SDOH), (e.g., housing, transportation, food security, employment, health literacy).

It will be crucial that health plans operating companion plans have provider networks and care coordination and management systems tailored to the unique medical, behavioral health, LTSS, and SDOH needs of those they serve.

Health plans can work with states and stakeholders including dually eligible beneficiaries, their family/caregivers, providers, and community-based organizations to advance policies, processes, and communication strategies to support dually eligible beneficiary enrollment in companion plans. Serving these individuals requires successfully locating and engaging them in health plan services and supports to meet their needs. Provider network capacity will be crucial, including establishing relationships with providers and community-based organizations in the communities in which dually eligible beneficiaries live. Staff will need to be expert in *both* Medicare and Medicaid program requirements and be ready to engage in value-based payment approaches to improve cost and quality outcomes. Health plans have an important opportunity now to build the right infrastructure.

For more information, contact Sarah Barth at sbarth@healthmanagement.com and Ellen Breslin ebreslin@healthmanagement.com

² *Beneficiaries Dually Eligible for Medicare and Medicaid, Data Book*, jointly produced by Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), January 2018.



HMA MEDICAID ROUNDUP

Alabama

Medicaid Work Requirement Proposal to Be Reviewed by CMS. *The Hill* reported on September 21, 2018, that the Centers for Medicare & Medicaid Services (CMS) will review Alabama's proposal to implement Medicaid work requirements. The proposal would require Medicaid beneficiaries to work or participate in certain community activities for 35 hours per week. Parents with children under six years old would have to work 20 hours a week. The administration has approved work requirements in three other states. Alabama would be the first state that didn't expand Medicaid to impose work requirements. [Read More](#)

Hospital Association Launches Campaign to Push for Medicaid Expansion. *U.S News* reported on September 20, 2018, that the Alabama Hospital Association has launched a campaign to push for Medicaid expansion in the state, arguing that the program would benefit the local economy as well as the 300,000 individuals who would gain coverage. Anne Howard, chief policy officer of the Alabama Hospital Association, said that expansion would represent an investment in the state's health care infrastructure, helping hospitals remain solvent and ensuring adequate access for individuals. [Read More](#)

Arkansas

Medicaid Members May Not Be Aware of Work Requirements. *The New York Times* reported on September 24, 2018, that Arkansas is finding out that informing individuals of their responsibilities under new Medicaid work requirements is as challenging as getting people to go out and find a job. Only 1,200 beneficiaries reported meeting Medicaid work requirements in August. To avoid coverage losses, the state exempted two-thirds of beneficiaries, and nearly 16,000 of the remaining 20,000 failed to report. Advocates say the low compliance numbers suggest that people don't know the program exists. [Read More](#)

California

Governor Signs Ban on Short-term Health Plans, Medi-Cal Work Requirements. *The VC Star* reported on September 22, 2018, that California Governor Jerry Brown signed bills banning Medicaid work requirements and short-term health plans offering less than 12 months of coverage. Both bills were sponsored by state Senator Ed Hernandez (D-Azusa). [Read More](#)

Florida

Florida Releases SMMC Managed Medical Assistance Provider Service Network ITNs. The Florida Agency for Health Care Administration (AHCA) released on September 25, 2018, Invitations to Negotiate (ITN) for the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance Provider Service Network (PSN). The ITNs are for Regions 3, 4, 5, 6, and 7 of the state's 11 managed care regions, where no PSNs were awarded contracts in the recent procurement. The contract term is expected to run through September 30, 2023.

Guam

Guam Expects Medicaid Budget Shortfall in Fiscal 2020. *The Pacific Daily News* reported on September 22, 2018, that the Guam Medicaid program expects a budget shortfall in fiscal 2020, according to Terri Gumataotao, program administrator for the Bureau of Healthcare Financing Administration. The shortfall stems from a decision by the territory to direct \$19 million normally earmarked for Medicaid to help subsidize Guam Memorial Hospital. [Read More](#)

Hawaii

Hawaii Releases RFI for QUEST Integration Medicaid Managed Care Program. Hawaii released a request for information (RFI) on September 20, 2018 to solicit feedback regarding procurement of the state's QUEST Integration (QI) Medicaid managed care program. Responses are due October 20, 2018. An RFP is expected in 2019, with a contract term of January 2020 to December 2025. An estimated 360,000 individuals are enrolled in QI, including pregnant women, children, and adults with disabilities. Current contract holders include UnitedHealthcare Community Plan, WellCare/Ohana, Kaiser, Hawaii Medical Service Association (HMSA), and AlohaCare. [Read More](#)

Iowa

Iowa Study Finds Costs Accelerated Under Medicaid Managed Care. *The Des Moines Register* reported on September 19, 2018, that per member per month Medicaid costs in Iowa have risen 4.4 percent since fiscal 2017, compared to 1.5 percent in the prior six years, according to an analysis by the state Legislative Services Agency. However, the Iowa Department of Human Services, which oversees Medicaid, notes that the data can be misleading because costs incurred in one year might be paid for the next. Iowa Governor Kim Reynolds said she remains confident that Medicaid managed care will yield savings. [Read More](#)

Maine

Maine Advocates Urge CMS to Approve Medicaid Expansion. *The Hill* reported on September 19, 2018, that supporters of Maine's voter-approved Medicaid expansion measure are urging the Centers for Medicare & Medicaid Services (CMS) to approve the initiative. Outgoing Maine Governor Paul LePage has asked federal regulators to reject the application. [Read More](#)

New Mexico

New Mexico to Transition to State-based Health Insurance Exchange in 2021. *The Albuquerque Journal* reported on September 22, 2018, that New Mexico will transition to a state-based health insurance Exchange for the 2021 plan year, making it the second state, after Nevada, to move away from the federally run marketplace. A request for proposals is expected to be released early 2019 for an Exchange vendor, with a contract start date of 2020. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

New York Releases Request for Applications for Environmental Health Intervention. The New York State Department of Health has issued a Request for Applications (RFA) to solicit applications to participate in the Healthy Neighborhoods Program (HNP). The HNP is designed to provide preventive environmental health services to targeted geographic areas. These areas sometimes include environmental justice communities and are usually home to at-risk populations, including low-income and often minority families, living in homes and neighborhoods with a disproportionate number of residential hazards. The "Healthy Neighborhoods Preventive Health Cornerstones" will provide funding in targeted areas to provide a healthier home. To address the environmental health needs in these neighborhoods, the grant funds are to be used to implement a HNP, with emphasis on reducing residential injuries, childhood lead poisoning, hospitalizations due to asthma, and exposure to indoor air pollutants. The total anticipated funding available for distribution is \$3,920,052 annually. Funding is limited to full-service county and city health departments with qualified environmental health staff. It is anticipated that 15-20 contracts will be awarded as a result of this RFA. Contracts will be issued for a five-year cycle (April 1, 2019 – March 31, 2024) with annual budgets and workplans required. Applications are due November 2. [Read More](#)

New York State Health Foundation Announces Consumer Empowerment Conference. The New York State Health Foundation announced its annual conference on empowering health care consumers, to be held on November 5, 8:30 – 12:30. The conference, "Partnering Together to Empower Health Care Consumers," includes a key note address by Dr. Eric Manheimer, former Medical Director at Bellevue Hospital and author of the book *12 Patients: Life and Death at Bellevue Hospital*. The conference also includes two panel discussions: "Partnership in Action: Patients and Providers" and "How Listening to Patients Leads to Innovation." The conference will be held at the Stewart Hotel, 371 Seventh Avenue in New York. For more information and to register, click [here](#).

North Carolina

North Carolina Planned Transition to Medicaid Managed Care Makes Progress Toward Mid-2019 Launch. *The Laurinburg Exchange* reported on September 26, 2018, that North Carolina is in the “home stretch” for a mid-2019 transition to Medicaid managed care for 2 million beneficiaries. Bids are due in October for the state’s procurement of up to four statewide Medicaid managed care plans and 12 regional, provider-led entities. Contracts will be awarded in February. [Read More](#)

Ohio

Ohio Panel Approves Medicaid Plan for Behavioral Health Provider Background Checks. *The Plain Dealer* reported on September 18, 2018, that a state panel approved rules that will require anyone who provides behavioral health and addiction services to register as a Medicaid provider for billing purposes. This includes undergoing a criminal background check, which could mean that some providers may no longer be able to offer their services, either for a particular timeframe, or at all. These rules have a large effect on peer recovery providers, many of whom do have criminal backgrounds. There is a process for getting around a waiting period for those who qualify for one, but many people report that the process is difficult, or that they didn’t know there was a process. [Read More](#)

Pennsylvania

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

Pennsylvania Awarded \$55.9 Million Federal Grant to Fight Opioid Epidemic. The Pennsylvania Department of Drug and Alcohol Programs (DDAP) was awarded a \$55.9 million State Opioid Response (SOR) grant from the federal Substance Abuse and Mental Health Services Administration. SOR funding is used for practices and services that have a demonstrated evidence-based approach and are appropriate for the populations of focus. The Wolf Administration plans to announce details of how the grant will be used in the coming weeks. [Read More](#)

Virginia

Virginia Files Waiver Request for Medicaid Work Requirements, Monthly Premiums. *Modern Healthcare* reported on September 24, 2018, that Virginia is the most recent state to submit an 1115 waiver application asking for federal approval to implement Medicaid work requirements, member premiums, and emergency room co-pays. Premiums would be \$5 for beneficiaries with incomes of 100 percent to 125 percent of the federal poverty level and \$10 for those at 126 percent to 138 percent. Expansion members would have a \$5 co-pay for avoidable emergency room use. Work requirements would be 20 hours per month initially and then ramping up to 80 hours. Children under age 19, students, seniors and dual eligible would be exempt. [Read More](#)

National

Medicaid Expansion States See Sharp Reduction in Rural Uninsured Rate, Report Finds. *CQ Health* reported on September 25, 2018, that the uninsured rate in Medicaid expansion states for low-income adults living in rural areas dropped to 16 percent in the 2015-16 timeframe, compared to 35 percent in 2000-09, according to a report from Georgetown University. In non-expansion states, the uninsured rates declined from 38 percent to 32 percent over the same time period. An estimated 14 percent of nonelderly Americans live in rural communities, which have a high number of uninsured and a shortage of health care providers. [Read More](#)

Courts Push Medicaid to Cover Hepatitis C Treatments. *The PEW Charitable Trusts/Associated Press* reported on September 25, 2018, that a U.S. District Judge in Indiana ruled that it is unconstitutional to withhold or delay hepatitis C treatment to Medicaid beneficiaries and inmates. The decision follows similar cases in Florida, Massachusetts, and Colorado. An estimated 700,000 to 1 million Medicaid recipients have Hepatitis C. [Read More](#)

November Gubernatorial Elections May Decide Future of Medicaid Expansion in Several States. *Modern Healthcare* reported on September 22, 2018, that November gubernatorial elections could boost prospects for Medicaid expansion in several states. A total of eight non-expansion states will be choosing a new governor in November, with solid prospects for Democratic victories in several. The elections will also impact some expansion states, with Ohio and Michigan fielding candidates in favor of implementing work requirements for expansion members. [Read More](#)

DHS Proposal Could Deny Residency to Immigrants Enrolled in Public Benefit Programs. *Reuters* reported on September 22, 2018, that the U.S. Department of Homeland Security is proposing a regulation that would expand the ability of immigration officers to deny visas or legal permanent residency to individuals enrolled in federal assistance programs, including Medicaid and Medicare Part D. The regulation, which would broaden the definition of "public charge," would affect more than 382,000 low-income individuals annually. [Read More](#)

CMS to Update 2016 Medicaid Managed Care Rules. *CQ Health* reported on September 21, 2018, that the Centers for Medicare & Medicaid Services (CMS) is expected to propose an update to the broad-based 2016 Medicaid managed care rule, which was the first major update in more than a decade. Changes could impact minimum medical loss ratios for Medicaid managed care plans, consumer protections, access, and rate setting. [Read More](#)

Medicaid Spending Rose 2.6 Percent to \$592 Billion in 2017. *Modern Healthcare* reported on September 20, 2018, that Medicaid spending rose an estimated 2.6 percent to \$592 billion in 2017, according to the latest actuarial report from the Centers for Medicare & Medicaid Services (CMS). Spending on Medicaid expansion alone rose 6 percent to \$70.8 billion. Of the nearly 74 million total Medicaid enrollees covered in 2017, 12.2 million were expansion enrollees. The federal share of total spending was 63 percent. The report predicts Medicaid spending will grow nearly 6 percent annually over the next decade, with enrollment reaching 82.3 million by 2026. [Read More](#)

DHHS Awards More Than \$1 Billion to Combat Opioid Crisis. *The Hill* reported on September 19, 2018, that the U.S. Department of Health and Human Services (DHHS) has awarded more than \$1 billion in grants to states and organizations to help address the opioid epidemic. The grants are intended to provide prevention services (\$930 million), increase substance abuse and mental health services in community health centers (\$352 million), and promote research (\$194 million). [Read More](#)



INDUSTRY NEWS

LifePoint Health CEO to Retire After Merger With RCCH HealthCare Partners. LifePoint Health announced on September 26, 2018, that chairman and chief executive William Carpenter III will retire following the company's merger with RCCH HealthCare Partners, a deal that is expected to close later this year. Carpenter will join the merged company's board. David Dill, LifePoint's president and chief operating officer, will take over as CEO of the merged company. Tennessee-based, LifePoint Health provides inpatient, outpatient, and post-acute services in 22 states. [Read More](#)

Private Equity Helps Drive Home Health, Hospice Deals. *Home Health Care News* reported on September 24, 2018, that private equity firms are helping to drive an acceleration in the number and size of home health, hospice, and personal care deals in 2018. Also driving mergers and acquisitions in the sector are efforts by health care companies to diversify. There have been 84 home health transactions in 2018, according to data from Mertz Taggart, and valuations are high. [Read More](#)

Gilead to Release Generic Versions of Hepatitis C Drugs. *The Wall Street Journal* reported on September 25, 2018, that Gilead Sciences, Inc. will release generic versions of its Epclusa and Harvoni hepatitis C drugs, resulting in price reductions of up to 60 percent. The drugs currently cost approximately \$24,000 per treatment. "Our country's complex drug supply chain means that a drug's list price does not always fully reflect the price paid by insurers – let alone a patient's out-of-pocket cost," Gilead chief executive John Milligan said. [Read More](#)

WellCare Appoints Bobby Jindal to Board of Directors. WellCare Health Plans, Inc. announced on September 24, 2018, the appointment of former Louisiana governor Bobby Jindal, to its board of directors. Jindal also served as U.S. House of Representatives for Louisiana, assistant secretary of the U.S. Department of Health and Human Services, and secretary of the Louisiana Department of Health and Hospitals. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 1, 2018	Virginia Medallion 4.0 - Northern/Winchester	Implementation	178,416
October 12, 2018	New Hampshire	Proposals Due	181,380
October 12, 2018	North Carolina	Proposals Due	1,500,000
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)
2019	Hawaii	RFP Release	360,000
January 1, 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
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	Implementation	~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	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	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

COMPANY ANNOUNCEMENTS

ConcertoHealth® Achieves Double-Digit Improvements in Decreased Admissions and Readmissions, and Increased Primary Care Visits for Michigan's Most Vulnerable Patient Population

HMA NEWS

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- California Medicaid Managed Care Enrollment is Down 1.4%, Aug-18 Data
- Iowa Medicaid Managed Care Enrollment is Up 4.7%, Aug-18 Data
- Louisiana Medicaid Managed Care Enrollment is Flat, Aug-18 Data
- Michigan Dual Demo Enrollment is Down 3.7%, Aug-18 Data
- Mississippi Medicaid Managed Care Enrollment is Down 7.2%, Jul-18 Data
- Ohio Dual Demo Enrollment is Flat, Sep-18 Data
- Rhode Island Dual Demo Enrollment is 13,058, Sep-18 Data
- South Dakota Individuals Eligible for Medicaid by Age and County, 2015-17, Aug-18
- Texas Dual Demo Enrollment at 40,537, Sep-18 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 2.3%, Aug-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arkansas Non-Emergency Medical Transportation (NET) Services Draft IFB, Sep-18
- Florida Statewide Medicaid Managed Care Re-procurement ITN, Awards, Data Book, Detailed Scoring, Proposals, Protests and Related Documents, 2017-18
- Florida Children's Medical Services Managed Care Plan Scoring Documents, Jul-18
- Hawaii QUEST Integration RFI, Sep-18
- Kansas MMIS Award, Contract, and Cost Workbook, 2015-18
- Wisconsin Independent Ombudsman and Supplemental Security Income External Advocacy RFP, Sep-18

Medicaid Program Reports, Data and Updates:

- Arizona Hospital Assessment Reports, SFY 2015-18
- California Managed Care Advisory Group Meeting Materials, Sep-18
- Colorado Department of Health Care Policy and Financing Enacted Budget, SFY 2019
- Florida Medicaid Managed Care HEDIS Scores, 2012-17
- Florida Medicaid Eligibility by County, Age, Sex, Aug-18 Data
- Hawaii QUEST Integration, CCS External Quality Review Reports, 2016-17
- Maryland HealthChoice Evaluations, 2009-18
- Ohio Medicaid Inpatient Hospital Base Rates, 2011-17, Apr-18
- Ohio Enacted Budget, FY 2018-19
- Oklahoma Medical Advisory Meeting Materials, Jul-18
- Pennsylvania Medical Assistance Advisory Committee Meeting Materials, Jul-18
- Texas HHSC Legislative Appropriations Request, Sep-18
- Utah Medical Care Advisory Committee Meeting Materials, Sep-18
- Virginia 1115 Demonstration Waiver Extension Application, Sep-18
- Virginia Commonwealth Coordinated Care (CCC) Plus Medicaid Operations Analysis, 2017-18
- Wyoming Medicaid County Reports, SFY 2016-17

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