HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 24, 2018

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

THIS WEEK

IN FOCUS

CMS GUIDANCE ON ACA SECTION 1332 WAIVERS

This week, *our In Focus* section comes to us from Principal Nora Leibowitz, reviewing the Centers for Medicare & Medicaid Services (CMS) guidance on Section 1332 waivers. The *State Relief and Empowerment Waivers* guidance, published in the Federal Register on October 24, 2018, updates the guidance related to Section 1332 of the Patient Protection and Affordable Care Act (PPACA) and its implementing regulations. Section 1332 establishes State

Innovation Waivers, the authority by which a state can make changes impacting:[1]

- The employer mandate (Internal Revenue Code Section 5000A)
- Marketplaces and Qualified Health Plans (ACA Title I, Subtitle D, Parts I and II)
- Benefits and subsidies (ACA Section 1402; Internal Revenue Code Section 36B)

The new guidance, which supersedes the December 2015 guidance, covers requirements on the application review procedures, the calculation of pass-through funding, certain analytical requirements, and operational considerations. In addition, the new guidance refers to the previously-named State Innovation Waivers as State Relief and Empowerment Waivers.

PRINCIPLES

The guidance lays out five principles for future Section 1332 waiver applications. State applicants must explain how their proposal will advance some or all of the following principles:

- Provide increased access to affordable private market coverage, including promotion of association health plans, short-term/limited duration plans, and efforts to increase issuer competition
- Encourage sustainable spending growth by promoting "cost-effective" health coverage and eliminating regulatory barriers
- Foster state innovation that meets the needs of consumers and markets in the state
- Support and empower those in need, including people with low income or high health care needs
- Promote consumer-driven healthcare, helping people to make informed choices and seek value

[1] Section 1332 also allows changes to the individual mandate (Internal Revenue Code Section 4980H), but this is effectively moot as the mandate penalty was legislatively eliminated in 2018.

GUIDANCE CHANGES

The Affordable Care Act requires that waivers do not reduce the number of state residents with health insurance coverage or the comprehensiveness or affordability of that coverage. In addition, a waiver may not increase the federal deficit. The new guidance alters the federal interpretation of these "guardrails".

ACA Section 1332 Guardrail	Previous Guidance	October 24, 2018 Guidance
As many people must have health insurance coverage with a waiver program as without	Based on minimum essential coverage; must meet standard for each waiver year; identify impact on "vulnerable" populations, including low-income, elderly, and those with serious health issues or with a greater risk of developing serious health issues	All private and public coverage, including private coverage that may not meet minimum essential coverage standard; allows temporary reduction in coverage if state can provide rationale; assess for all groups, including low-income and those with high expected health care costs
Coverage under a waiver must be as comprehensive as without the waiver	Assessed based on coverage purchased by state residents; considered on its own	Assessed based on coverage made available to state residents (access); assessed in conjunction with comprehensiveness
Coverage under a waiver must be as affordable as without the waiver	Assessed based on coverage purchased by state residents; considered on its own	Assessed based on coverage made available to state residents (access); assessed in conjunction with affordability
The waiver program must not increase the federal deficit	Does not include Medicaid savings or costs.	Maintains previous requirements but expands allowable costs and savings to focus on aggregate waiver effects. Does not include Medicaid savings or costs.

Coverage Guardrail. Previous guidance required that at least as many residents be covered under the waiver as without it. This continues under the new guidance but does not require that the coverage be as comprehensive or affordable as before. A waiver that will not meet the coverage guardrail on "day 1" can still be approved if the state can justify a ramp-up period.

Comprehensiveness and Affordability Guardrails. The guidance changes the requirement to show that *available* coverage under the waiver is as comprehensive (scope of benefits is no less broad) and affordable (cost relative to income), rather than showing that coverage *purchased* meets those requirements as previously required. Comprehensiveness and affordability will be considered together rather than assessed separately. This will likely make it easier for states to show the guardrails are met under a proposal and is designed to encourage states to promote what the Department of Health and Human Services (HHS) describes as "innovative coverage" that may be less comprehensive than ACA-approved coverage.

Deficit Neutrality. The calculation of impact on federal revenue and spending can include any changes in federal premium tax credits and small business credits; employer shared responsibility payments and taxes on high cost employer coverage; changes in income and payroll taxes related to tax exclusions for employer-sponsored coverage and deductions for medical expenses; and Internal Revenue Service administrative costs, federal Exchange administrative costs, or other administrative costs associated with the waiver or alleviated by the waiver. This is broader than the previous requirement that only federal provider tax expenditures be assessed. The guidance also affirms previous guidance that Medicaid savings cannot be considered in the assessment of federal savings.

FEDERAL PASS-THROUGH FUNDING

Pass-through funding is money the federal government will give the state to implement the waiver, based on the amount of federal financial assistance (premium tax credits, small business tax credits, cost sharing reductions) that would have been paid for participants without a waiver but will not be paid due to the waiver provisions. This is consistent with previous guidance. States must explain why the change in federal spending is expected and how the funds will be used.

ANALYSIS AND METHODOLOGY

Actuarial analyses, economic analyses, data and assumptions, targets, and implementation timeline are all still required to show how the proposed waiver will comply with requirements. Federal analysis will generally rely on federal estimates of population, economic, and health care cost growth estimates, unless the state can make a case for a state-specific data set.

OPERATIONAL CONSIDERATIONS

Previously, the Federally-facilitated Marketplace (FFM) was unable to accommodate state eligibility and enrollment rules that differed from the federal standard. Going forward HHS will allow the FFM to support state variation, including a state using an industry partner to create its own consumer-facing technology paired with FFM back-end technology. HHS is assessing the plan management, financial assistance, and consumer assistance flexibilities it can support and encourages states to engage early in the Section 1332 waiver application process to determine if the federal platform can meet state needs. States will be responsible for technology build costs. Federal budget neutrality calculations will include HHS costs for technology management and administration and Internal Revenue Service administrative costs for tax provision changes.

APPLICATION TIMING

To ensure sufficient time for public comment, departmental review, and state implementation of a waiver, states are encouraged to apply during the first quarter of the year prior to the year changes would take effect. Additional time may be required if technology changes are included in the proposal.

STATE AUTHORITY

The guidance amends the requirement that state legislation authorize the Section 1332 waiver and program to be implemented, allowing states with existing legislative authority to pursue a waiver to apply for a specific waiver using state regulation or an executive order.

For more information, contact Nora Leibowitz at nleibowitz@healthmanagement.com.

Link to Guidance

HMA Medicaid Roundup

Florida

Florida, Lighthouse Health Plan Appear to Be 'On Right Track' to Settle Medicaid Auto Assignment Dispute, Attorney Says. *Health News Florida* reported on October 24, 2018, that an administrative law judge gave the state of Florida and Lighthouse Health Plan an additional two weeks to settle a dispute over the state's decision to automatically assign Medicaid beneficiaries in the northwestern part of the state to Humana Medical Plan. Lighthouse attorney Edward Philpot stated that the parties appear to be "on the right track" toward a settlement. Both Lighthouse and Humana were awarded contracts by the Florida Agency for Health Care Administration to serve the state's Medicaid Managed Medical Assistance and Long-Term Care programs in regions one and two. Read More

Florida Healthy Kids to Consider Waiving Premiums After Hurricane Michael. *The News Service of Florida/CBS 12* reported on October 17, 2018, that the Florida Healthy Kids Corporation may waive children's health insurance premiums for the next three months in twelve Florida counties impacted by Hurricane Michael. The proposed premium waiver, backed by Governor Rick Scott, state CFO Jimmy Patronis, and Agency for Health Care Administration Secretary Justin Senior, would affect approximately 5,600 children in three insurance programs and cost the state an estimated $3.58 million. The counties include Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Taylor. Read More

59 Percent of Voters Want Medicaid Expansion, Kaiser Poll Finds. *The Tampa Bay Times* reported on October 18, 2018, that 59 percent of voters surveyed in Florida want Medicaid expansion in the state, according to the Kaiser Family Foundation's latest tracking poll. The majority of respondents also indicated that they were more likely to support a candidate who plans to continue protections for individuals with pre-existing health conditions. Kaiser surveyed 599 Florida residents and 522 registered Florida voters. Read More

Iowa

Medicaid Transportation Change Impacting Disabled Beneficiaries, Providers. *The Des Moines Register* reported on October 17, 2018, that a new Iowa Medicaid tier rate system that replaced the state's transportation waiver is impacting disabled Medicaid beneficiaries, according to a *Des Moines Register* investigation. The new system places Medicaid recipients into divisions based on the number of hours of assistance and type of care they need. The investigation found longer commute times, tighter living arrangements, and fewer outings for beneficiaries. The new system replaced the Supported Community Living (SCL) transportation waiver, which helped pay for transportation services to and from work. Care providers like Candeo, a mental health services company, are assuming responsibility for administering and funding their patients' transportation needs. Read More

Maine

AG's Office Files Amicus Brief in Lawsuit Supporting Medicaid Expansion. *The Portland Press Herald* reported on October 23, 2018, that the Maine Attorney General's Office has taken sides with local health care advocates in a lawsuit against outgoing Governor Paul LePage, who has refused to implement a voter-approved Medicaid expansion program. The AG's office filed an amicus brief supporting the lawsuit, which argues that LePage is breaking the law by blocking expansion. Maine Attorney General Janet Mills, who is running for governor, has recused herself. Oral arguments are scheduled for November 7. Read More

Massachusetts

Mental Health Providers Tend to Avoid Medicaid. *The Boston Globe* reported on October 20, 2018, that only half of licensed mental health care providers in Massachusetts accept Medicaid, leaving many beneficiaries struggling to find affordable care. Medicaid plans note that they are working to increase the number of mental health clinicians in their network, and the state said it is increasing Medicaid fees to mental health providers by $100 million between 2016 and 2020. Read More

Minnesota

Minnesota to Release Medicaid Managed Care RFPs in 2019. The Minnesota Department of Human Services announced that it will release requests for proposals for several important Medicaid managed care programs in 2019, with coverage beginning in 2020. The state had already said it would rebid its Families and Children program and its MinnesotaCare expansion program for portions of the state beyond the Twin Cities area, accounting for 40 percent of the state's population. Now it has also announced that it will rebid its Senior Health Options dual demonstration program and it Senior Care Plus program as well.

Missouri

Missouri Names State House Speaker Todd Richardson Medicaid Director. *The St. Louis Post-Dispatch* reported on October 22, 2018, that Missouri governor Mike Parson has named House Speaker Todd Richardson director of MO HealthNet, the state's $10 billion Medicaid program. Missouri hasn't had a permanent Medicaid director since Joe Parks served in the position from 2013 to 2016.Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Affinity to Transition Medicare Members to EmblemHealth. *Crain's Health Pulse* reported on October 18, 2018, that Affinity Health Plan announced that it will transition its New York Medicare members at the end of 2018 to EmblemHealth. Affinity will continue to operate its Medicaid, Child Health Plus, Essential Plan, and Health and Recovery Plan products. According to a letter obtained by *Crain's Health Pulse*, Affinity had been evaluating product offerings to make sure programs are aligned with the plan's mission and goals. Affinity currently operates four Medicare plans, which are available in New York City, Long Island, and the Hudson Valley. Read More

Court Blocks DOH Soft Cap on Executive Compensation. *Modern Healthcare* reported on October 23, 2018, that the New York State Court of Appeals ruled last week that the New York State Department of Health (DOH) overstepped its authority in how it regulates executive compensation at private, state-contracted health organizations. In 2012, the governor issued executive order number 38, which prohibits state-contracted health care organizations from paying executives more than $199,000 per year or having administrative costs in excess of 15% of their total expenses. DOH also enacted a "soft cap" that placed limits on providers regardless of funding source.

The Court of Appeals ruled that the soft cap "was an impermissible attempt at public-policy making, rather than regulating existing statute." However, the court upheld the hard cap and stated "it was directly tied to a specific goal dictated by the Legislature – to efficiently direct state funds toward quality medical care for the public." Providers who exceed or expect to exceed the regulatory limitation may request a specific waiver from the state. Read More

New York Holds Hearing on CVS-Aetna Merger. On October 18, 2018, the New York Department of Financial Services (DFS) held a public hearing on the proposed merger between CVS and Aetna. On October 10, CVS and Aetna received approval from the Justice Department; however, DFS has specific approval authority concerning CVS acquisition of Aetna's New York subsidiary organizations. DFS Superintendent Maria Vullo indicated that her agency might block the proposed merger at the state level and cited a lack of evidence that the merger would result in lower prices to consumers. Read More

DOH Releases FAQs on Medicaid Drug Cap. The New York Department of Health (DOH) on Monday released its fifth Frequently Asked Questions (FAQs) document on the Medicaid Drug Cap. The drug cap intends to limit drug spending growth and authorizes DOH to negotiate enhanced rebates with drug manufacturers. The FAQ covers a range of questions, including the timeline and format for the rebate process and information on the 42 drugs and 25 manufacturers identified for possible Drug Utilization Review Board (DURB) referral. Read More

Empire Center Publishes Commentary On Single Payer Proposal. Bill Hammond and Chris Pope from New York's Empire Center, a policy think tank based in Albany, New York, published a commentary piece criticizing New York's current single payer proposal. The article focuses on outstanding questions that remain concerning provider reimbursement under a single payer system and the potential disruption it would cause for hospitals throughout the state. The New York Health Act would create a single payer healthcare system available to all New Yorkers. Read More

North Carolina

North Carolina Receives 8 Bids for Medicaid MCO Procurement. The North Carolina Department of Health and Human Services announced on October 19, 2018, that eight organizations submitted bids for the state's Medicaid managed care procurement: Aetna, AmeriHealth Caritas, Anthem/Healthy Blue, Centene/Carolina Complete Health, My Health by Health Providers, Optima Health, UnitedHealthcare, and WellCare. North Carolina released the RFP on August 9 to transition the state's Medicaid fee-for-service program to Medicaid managed care. Phase 1 is scheduled to begin on November 1, 2019, and Phase 2 is scheduled to begin on February 1, 2020. Read More

Ohio

Medicaid Paid $51M for Deceased Enrollees, According to Federal Inspector General. *The Dayton Daily News* reported on October 18, 2018, that the U.S. Department of Health and Human Services Inspector General alleges Ohio Medicaid paid insurance companies $51 million for the management of Medicaid enrollees who had died. Ohio Medicaid officials say that their systems have been updated to notify the state when someone in the program dies and have safeguards in place to prevent providers from billing for services if a person has indeed died. The state of Ohio is disputing the finding, with questions about the accuracy of the total. Read More

Ohio 21st Century Cures Act Spending Analyzed. *The Dayton Daily News* reported on October 22, 2018, that in the first year of the 21st Century Cures Act program, Ohio distributed 72 percent of the $26 million it received as grants to county addiction and mental health boards, according to an analysis by the *Associated Press*. The state received $26 million the second year of the program as well. Ohio spent 76.5 percent on treatment, 19.8 percent on prevention efforts, and 1 percent on recovery supports following treatment, though it should be noted that the Ohio Department of Mental Health and Addiction Services purposely did not distinguish between funding for treatment services and recovery support services in its reporting. In total, Ohio provided direct treatment and recovery services to 9,036 patients. Read More

Pennsylvania

Pennsylvania Announces New Program to Support Housing Needs of Individuals with OUD. Pennsylvania announced a new opioid housing initiative that will direct $15 million towards a minimum of eight pilot projects in urban and rural communities throughout the state. The project launched as part of the $55.9 million SAMHSA grant secured to bolster the state's response to the prescription opioid and heroin epidemic. The state released a Request for Applications (RFA) for support services navigation and housing services for individuals with opioid use disorder (OUD). The RFA was developed by the departments of Drug and Alcohol Programs (DDAP) and Human Services (DHS), in partnership with the Pennsylvania Housing and Finance Agency and the Department of Community and Economic Development. Read More

General Assembly Approves Bill on EMS Reimbursements. *The Indiana Gazette* reported on October 18, 2018, that the Pennsylvania General Assembly passed a bill that would allow ambulance companies to bill patients and their insurance for service rendered even when no one is taken to a hospital. House Bill 1013, ratified twice by the House, the second time after its approval with modifications in the Senate, would require insurance companies and Medicaid to reimburse emergency medical service agencies for providing care and treatment at the scene of a medical emergency. The Senate amendments required Medicaid reimbursement. The legislation has been sent to Governor Tom Wolf for his signature. Read More

Texas

Texas Releases RFI for Program Improvements to STAR Health. On October 19, 2018, the Texas Health and Human Services Commission (HHSC) released a request for information (RFI) for Program Improvements to STAR Health, which provides medical and behavioral health services to foster kids. The RFI seeks information from stakeholders on their experiences with the program and asks for suggestions for improvement. Responses are due November 19. Read More

Utah

Voters Support Medicaid Expansion, According to Recent Poll. *The Salt Lake Tribune* reported on October 18, 2018, that Utah voter support for Medicaid expansion has increased ahead of the November midterm election. A recent poll conducted by the Hinckley Institute found that 59 percent of voters favor Medicaid expansion, up from 54 percent in June. Proposition 3 would raise $90 million in state funds through a 0.15 percent sales tax increase which, combined with $800 million in federal funding, would expand Medicaid coverage to 150,000 low-income Utahns. Opponents of the proposition argue that the cost burden placed on the state and taxpayer will negatively affect the state's most vulnerable. Read More

Virginia

Virginia to File Application for Medicaid Work Requirements on November 4. *The Richmond Times-Dispatch* reported on October 19, 2018, that the public comment period for proposed Medicaid work requirements in Virginia ends October 27, with the state expected to submit the application for federal approval on November 4. The Virginia Department of Medical Assistance Services has received over 1,100 comments to date. An estimated 120,000 beneficiaries would be subject to the work requirements, according to the Joint Legislative Audit and Review Commission, with a projected 14,000 losing coverage in 2019 and another 22,500 people losing coverage in 2020. Read More

Virginia to Begin Accepting New Medicaid Enrollment Applications on November 1. *The Associated Press* reported on October 18, 2018, that Virginia will begin accepting Medicaid enrollment applications for its newly expanded Medicaid program on November 1. The new coverage is set begin January 1, 2019, with up to 400,000 individuals expected to be eligible. Read More

National

U.S. Drug Overdose Deaths Show Slight Decline in Late 2017, Early 2018, Preliminary CDC Data Show. *Politico* reported on October 23, 2018, that U.S. drug overdose deaths dropped 2.8 percent in late 2017 and early 2018, according to preliminary data from the Centers for Disease Control and Prevention. "The seemingly relentless trend of rising overdose deaths seems to be finally bending in the right direction," said Alex Azar, Secretary of the U.S. Department of Health and Human Services. Azar cited increased efforts to expand access to medication-assisted addiction treatment, prevention programs, and improve efforts to reduce illegal drug shipments. Read More

As Voters Decide on Medicaid Expansion, States Search for Ways to Pay Their Share. *Kaiser Health News* reported on October 24, 2018, that states considering Medicaid expansion through ballot measures are looking for politically palatable ways to pay for the state's share of the cost. In Montana voters are considering a ballot initiative that would fund the state's existing Medicaid expansion with a tax on alcohol. Other states have funded expansion through a tax on industry players like hospitals and health plans. Matt Salo, executive director of the National Association of Medicaid Directors, notes however, "If you're talking about why did certain states not do the expansion, the fear of the cost…has never been within the top three of the actual reasons why they actually didn't do it. It all has been political and ideological." Read More

Medicaid Managed Care Plans Focus on Homelessness. *Fierce Healthcare* reported on October 22, 2018, that Medicaid managed care plans are working to address homelessness in an effort to improve health outcomes. At a recent conference organized by trade association America's Health Insurance Plans, insurers like Kaiser Permanente and the University of Pittsburgh Medical Center Health Plan detailed efforts to coordinate social services among members who are food, housing, or income insecure. Read More

Medicaid Enrollment Drops as Economy Improves, According to Report. *Modern Healthcare* reported on October 22, 2018, that Medicaid enrollment is decreasing as the economy improves, according to a report released at the Medicaid Health Plans of America's annual conference. An average 3 percent drop was seen throughout 34 states, with Illinois showing the biggest enrollment decrease at 8.3 percent. The report attributes the enrollment decrease to fewer people being Medicaid eligible due to job growth and pay raises. Work requirements were not noted as having contributed to the drop in enrollment. Read More

MACPAC Meeting Scheduled for October 25-26. The Medicaid and CHIP Payment and Access Commission (MACPAC) announced on October 22, 2018, that the next meeting of the commission will be held on October 25-26. Topics to be discussed are:

- Disproportionate Share Hospital
- Structuring DSH Allotment Reductions
- Implementation of Work and Community Engagement Requirements in Arkansas
- Effects on Medicaid and CHIP
- Medicaid in Puerto Rico
- Medicaid Drug Coverage to Medicare Part D
- Integrating Care for Dually Eligible Beneficiaries
- Eligibility, Enrollment, and Renewal Processes. Read More

Medicaid Expansion States Go Beyond Basics With Federal Opioid Funds, AP Analysis Shows. *ABC News/The Associated Press* reported on October 22, 2018, that Medicaid expansion states are using emergency federal opioid grants to move beyond basic addiction treatment and focus on recovery, housing, and training. That's because basic addiction treatment is already covered by expansion. In contrast, states that didn't expand Medicaid are spending the funds to cover basic addiction treatment services and burning through the money at a much faster pace. According to the *Associated Press*, non-expansion state spent an average of $2,645 per patient on opioid addiction treatment, while expansion states spent $1,581. Non-expansion states have used up 71 percent of grant funds in the first year, compared to 59 percent for expansion states. Read More

CMS to Streamline 2016 Medicaid Managed Care Rules. *CQ Health* reported on October 17, 2018, that the Centers for Medicare & Medicaid Services (CMS) has made progress in reviewing the 2016 Medicaid managed care rule, the first major update in more than a decade, according to Jim Parker, a senior adviser to Health and Human Services Secretary Alex Azar and head of the Office of Health Reform. CMS is looking to streamline regulations, giving states more flexibility and speeding up the review process for state 1115 waiver proposals. Changes could impact minimum medical loss ratios for Medicaid managed care plans, consumer protections, access requirements, and rate setting rules. Read More

Providers Express Concerns Over Medicaid Buy-In Proposals. *Modern Healthcare* reported on October 17, 2018, that several states are considering Medicaid buy-in proposals that would allow individuals who do not qualify for Medicaid to buy into the program through the insurance Exchanges, regardless of their income level. However, providers in states that are considering Medicaid buy-in proposals have expressed concerns regarding potential state budget cuts, physicians leaving Medicaid networks, and increased costs to the commercial insurance market. In states like Nevada, Medicaid networks are limited due to lower provider reimbursement. Read More

Industry News

Molina Completes Sale of Pathways Health and Community Support to Atar Capital. Molina Healthcare announced on October 22, 2018, that it has completed the sale of Pathways Health and Community Support to private investment firm Atar Capital. Pathways provides home and community-based services to more than 60,000 children, adults, and families in 17 states and the District of Columbia. Read More

CareSource Names Jeff Myers As New Executive Vice President of Strategic and External Relations. *The Dayton Daily News* reported on October 17, 2018, that CareSource has appointed healthcare lobbyist Jeff Myers as executive vice president of strategic and external relations. Myers will oversee CareSource's regulatory and government affairs efforts. Most recently, Myers served as president and chief executive officer at Medicaid Health Plans of America and has previously held government affairs roles in the pharmaceutical and nursing home industries. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 1, 2018	Virginia Medallion 4.0 - Charlottesville/Western	Implementation	88,486
November 1, 2018	Puerto Rico	Implementation	~1,300,000
November - December 2018	Massachusetts One Care (Duals Demo)	RFP Release	150,000
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
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
January 1, 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract Awards	1,500,000
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	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

HMA News

Marsha Johnson – Principal, Philadelphia

Marsha Johnson is a leader in complex care program development, integrated health delivery, curriculum development, and workforce and leadership development. She is passionate about building a resilient workforce and systems to meet the demands of the safety net environment and deliver quality, comprehensive care to complex populations.

Marsha's broad clinical expertise includes individual and group psychotherapy, behavioral health consultation in the primary care environment, psychosocial interventions for group medical visits, batterers intervention, and supervision/training of students in health professions.

She spent 12 years working in the federally-qualified health center environment where she guided the behavioral health program from co-location to full integration to improve care for patients with chronic disease including mental illness and substance use disorders. She currently maintains a private practice focused primarily on the delivery of dialectical behavior therapy.

She earned a Master of Social Work from Smith College School for Social Work and has a bachelor's degree in French language and literature from Carleton College.

Uche Uchendu – Principal, Washington, D.C.

Uchenna S. Uchendu, MD is a passionate and experienced practitioner and leader who has worked in the private and public sectors. She brings her dedication, vision and pioneering contributions to evolving healthcare issues to HMA.

Dr. Uchendu's focus areas include rural, veteran and military health, health disparities and social determinants of health. Her portfolio of experience has led her to develop customized interactive virtual simulation training, manage healthcare operations, coordinate primary and mental health integrations, and lead projects centered around tele-health, health information technology, electronic medical records and the patient-centered medical home.

Prior to joining HMA, Dr. Uchendu served as chief officer for health equity at the United States Department of Veterans Affairs (VA). In this role, she established the VA Office of Health Equity, launched and led the Health Equity Coalition and led projects for the VA's health equity journey. She deployed the first-ever VA Health Equity Action Plan, published the inaugural National Veteran Health Equity Report, created data tools, and established the Focus on Health Equity and Action Webinar Series. Many of these products have reached beyond the confines of the VA as distinctive contributions to the strategies and tools of the larger health equity discourse.

Dr. Uchendu graduated from the University of Nigeria, College of Medicine and completed residency training in internal medicine at the Mount Sinai School of Medicine, Jersey City Medical Center Program. She is a graduate of the Federal Health Care Executives Interagency Institute and a certified trainer for Clinician Patient Communication.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Illinois Medicaid Managed Care Enrollment is Up 18.8%, Sep-18 Data
- Maryland Medicaid Managed Care Enrollment is Up 1.2%, Sep-18 Data
- Ohio Medicaid Managed Care Enrollment is Down 2.7%, Sep-18 Data
- South Carolina Medicaid Managed Care Enrollment is Flat, Oct-18 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 2.7%, Sep-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Georgia Families Contract, Amendment #12
- Georgia Pharmacy Benefit Manager (PBM) Services Contract and Amendments, 2016
- Kansas External Quality Review for Medicaid Managed Care RFP, Oct-18
- Louisiana Dental Program Benefit Management RFP, Oct-18
- Maryland Medicaid MCO Model Contract, CY 2018
- Maryland Total Cost of Care Model State Contract, Jul-18
- Maine Technical Services and Applications Support for Healthcare Data RFP, Sep-18
- North Carolina Prepaid Health Plan Services RFP Lis of Offerors, 2018
- Pennsylvania Support Services Navigation & Housing Services for Individuals with Opioid Use Disorder RFA, Oct-18
- Pennsylvania System Integrator/Data Hub Services for MMIS 2020 Platform Project RFP, Oct-18
- South Carolina Administrative Services Organization RFP Award, Sep-18
- Texas Program Improvements to STAR Health RFI, Oct-18
- Virginia Commonwealth Coordinated Care Plus MLTSS MCO Contracts, 2017-19

Medicaid Program Reports, Data and Updates:

- Alaska Long-Term Forecast of Medicaid Enrollment and Spending, FY 2019-39
- Colorado Children's Health Plan Plus Caseload by County, 2014-17, Sep-18
- CMS Guidance on Section 1332 Waivers, Oct-18
- CMS Key Provisions of Legislation Extending Federal Funding for the Children's Health Insurance Program, Oct-18
- DC Medicaid Hospice Rates, FY 2019
- Kansas KanCare Section 1115 Demonstration Quarterly Reports
- Minnesota Medicaid Services Advisory Committee Meeting Materials, Dec-17
- North Carolina Medical Care Advisory Committee Meeting Materials, Oct-18
- Ohio Medicaid Enrollment by Eligibility Category, 2016-17, Sep-18
- South Carolina Medicaid Enrollment by County and Plan, Sep-18
- Texas STAR Kids Managed Care Financial Statistical Reports, FY 2017
- Texas STAR Managed Care Financial Statistical Reports, FY 2017
- Texas STAR+PLUS Managed Care Financial Statistical Reports, FY 2017
- U.S. Medicaid, CHIP Enrollment at 73.2 Million, Jul-18 Data

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

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

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