HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 28, 2018

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THIS WEEK

IN FOCUS

PROPOSED POLICY CHANGES AFFECTING HEALTH REIMBURSEMENT ARRANGEMENTS

This week, our *In Focus* section comes to us from HMA Senior Consultant Ryan Mooney (Austin), who reviewed the proposed rule on Health Reimbursement Arrangements (HRAs). On October 29, 2018, the U.S. Department of the

Treasury, the Department of Labor, and the Department of Health and Human Services published a proposed rule (83 FR 54420), the purpose of which is to expand the use of HRAs. An HRA is an employer-supported account that helps employees pay for qualified medical expenses not covered by their health plans. The proposed rule is the latest component of the President's Executive Order 13813, which directed the federal government to expand and facilitate access to association health plans, short-term and limited-duration insurance products, and HRAs.

The proposed rule fundamentally would change how employees can use tax-deductible contributions towards employee health insurance, allowing employer contributions to fund individually-purchased insurance on a broad basis. The major aspects of the proposed rule are:

- HRAs can be leveraged to support the purchase of individual market coverage
- Reimbursement of premiums from employer sponsored HRAs is allowed
- Employees that have access to an HRA to purchase individual market coverage would not be eligible for premium tax credit (PTC) subsidies on an Exchange but may opt out of the employer-sponsored HRA in some circumstances.
- Employers can contribute to the purchase of their employees' individual market coverage via an HRA without such coverage being treated as a benefit plan under the Employee Retirement Income Security Act (ERISA)
- Special enrollment periods (SEPs) will be available, both on and off-Exchange, for individuals with newly-acquired access to these HRAs

1. HRAs can be leveraged to support the purchase of Individual Health Plans

An HRA is a tax-advantaged (for both employers and employees) group health plan through which employers can fund expenses for the healthcare of their employees (or their employees' dependents). The proposed rules would allow employers to fund an HRA for individual health insurance premiums if certain conditions are met. The HRA must require participants and any dependents covered by the HRA to be enrolled in individual health insurance coverage and to provide evidence or an attestation the participant and any covered dependent(s) are, or will be, enrolled in individual health insurance coverage during the plan year. The proposed rule caps employer contributions to such an HRA to $1800 annually, but requests comment on whether such a cap should be higher to account for costs to cover dependents.

To prevent a group plan sponsor from directing any enrollees toward one option or another, the proposed regulations prohibit a group plan sponsor from offering the same class of employees both a group health plan and an HRA integrated with individual health insurance coverage. The HRA used to purchase individual health insurance coverage must be offered on the same terms to all employees within the class, subject to certain limited exceptions. Employees eligible for an HRA integrated with individual health insurance coverage must have the option to opt out of such coverage and the employer must provide a detailed written notice to all eligible participants at least 90 days before the beginning of each benefit year.

Assuming certain conditions are met, employers who are subject to the Employer Shared Responsibility provisions under Section 4980H of the Code and offer an HRA to at least 95 percent of its full-time employees and their dependents would not be liable for a payment under the Employer Shared Responsibility provisions.

2. Creates Excepted Benefit HRAs

The proposed rule creates a new type of HRA, the excepted benefit HRA, which cannot be integrated with non-HRA group coverage, Medicare, TRICARE, or individual health insurance coverage. Such an HRA could be used to pay for short-term, limited duration coverage (or other types of non-minimum essential coverage (MEC)).

3. Employees that receive an HRA to purchase individual market coverage may still be eligible for premium tax credit subsidies on the Marketplace

The proposed rules indicate that an employee (or eligible family member) offered an HRA is considered eligible for MEC under an employer-sponsored plan, even if they opt out of coverage. For any month the HRA is affordable and provides minimum value, the employee would be ineligible for PTC or other Exchange-based subsidies. The Treasury Department and the IRS, however, have not yet provided guidance regarding when an HRA is considered to be affordable or to provide minimum value.

4. Individual coverage funded by HRAs are not subject to ERISA

The proposed rules clarify that the ERISA terms "employee welfare benefit plan," "welfare plan," and "group health plan" would not include individual health insurance coverage where the premiums are reimbursed by an HRA, provided that the HRA sponsor is not involved in the selection of the individual health insurance coverage (among other criteria). This clarification also would apply to arrangements that reimburse participants for the purchase of individual health insurance coverage not subject to the market requirements (including qualified small employer health reimbursement arrangements (QSEHRA) and HRAs that have fewer than two participants who are current employees on the first day of the plan year). This would apply to an arrangement under which an employer allows employees to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA with which the coverage is integrated or that is not covered by a QSEHRA by using a salary reduction arrangement under a cafeteria plan (supplemental salary reduction arrangement).

5. Employees gaining HRAs can access individual market special enrollment periods

The proposed rules establish a special enrollment period for situations when a qualified individual (QI), a Qualified Health Plan (QHP) enrollee, or a QHP enrollee's dependent, gains access to and enrolls in an HRA integrated with individual health insurance coverage or is provided access to a QSEHRA. This new SEP would not apply to an individual who newly gains access to an excepted benefit HRA. This SEP applies both on and off-Exchange.

Possible Impacts of the Proposed Rule

The effects of this proposed rule, should it be finalized in its current form, may include the following:

1. Employers would gain more flexibility to offer tax-advantaged individual market health insurance options to their employees, so long as certain conditions are met.
2. Consumers would have a new tax-advantaged method to pay for individual health insurance coverage of their choosing (rather than be constrained by their employers' choice of insurance options) and could retain their insurance should they choose to change jobs without resorting to more expensive COBRA payments.
3. This may cause an overall shift from self-insured or fully-insured employer coverage to the individual market. The impacts on risk pools in these markets will depend on employer take-up of the HRA option and how they offer it to the employer pool.
4. The impact on individual marketplaces could be positive. The proposed rules for HRAs integrated with individual health insurance would allow consumers to pay premiums for Exchange QHPs, which would benefit those with incomes above 400% of the Federal Poverty Limit (FPL) and could strengthen the Exchange risk pools by luring healthier consumers into QHPs.

For more information, please contact Ryan Mooney.

Link to Proposed Rule

HMA Medicaid Roundup

Alaska

CMS Approves Alaska Request For Behavioral Health Demonstration Waiver. On November 21, 2018, the Centers for Medicare & Medicaid Services approved Alaska's Department of Health and Social Services request for the Substance Use Disorder Treatment and Alaska Behavioral Health Program, a new section 1115 demonstration waiver, effective January 1, 2019 through December 31, 2023. This demonstration will enable the state to provide high-quality, clinically appropriate substance use treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). Read More

Arkansas

CMS to Investigate Why Thousands in Arkansas Lost Medicaid from Work Requirements. *The Hill* reported on November 27, 2018, that the Centers for Medicare & Medicaid Services (CMS) will look into why more than 12,000 people in Arkansas have lost Medicaid coverage since the state implemented work requirements. CMS Administrator Seema Verma noted that CMS will not slow down in approving other states' waiver requests to implement work requirements. Read More

Arkansas Delays Phase II of Medicaid Managed Care Transition Until March 2019. *The Arkansas Democrat Gazette* reported on November 18, 2018, that Arkansas will delay the transition to Medicaid managed care until March 2019 for 40,000 individuals with mental illness or developmental disabilities. Earlier this year, provider-led Arkansas Shared Savings Entities (PASSE) began coordinating the member care for capitated payments of $173.33 per recipient. Under Phase II, originally set to begin in January, PASSEs will receive a larger payment for covering all care, including medical care, counseling, and other services. The extra time will be used to test billing systems and for the training and enrolling of providers in networks. Read More

Arkansas Drops An Additional 3,815 Medicaid Expansion Members for Failing to Meet Work Requirements. *Modern Healthcare* reported on November 15, 2018, that Arkansas dropped an additional 3,815 Medicaid expansion members for failing to comply with the state's new Medicaid work requirements in October. Nearly 8,500 were dropped in the prior two months. Of the more than 69,000 individuals subject to the work requirement, only about 1,525 reported the necessary 80 hours of work or volunteering in October. Advocacy groups expressed concerns that individuals may be losing Medicaid coverage because of the online reporting process or may not be aware of the work requirements. Read More

California

Senate Committee Chair Asks Whether CMS Will Recoup Improper California Medicaid Payments. On November 19, 2018, U.S. Senator Ron Johnson (R-WI), chairman of the Senate Committee on Homeland Security and Governmental Affairs, sent a letter to the Centers for Medicare & Medicaid Services (CMS) asking for more information about a recent audit showing California may have made $3.3 billion in improper Medicaid payments and whether CMS intends to recoup these funds. In his letter, Johnson states that, "California spent more than $1 billion in federal Medicaid funds for 445,000 ineligible or potentially ineligible beneficiaries," and added that the state also "made $383,000 in Medicaid long-term care payments on behalf of a beneficiary who had been deceased for four years." Read More

Connecticut

Congressional Delegation Presses Governor Malloy to Apply for Telemedicine Waiver. *The CT Mirror* reported on November 20, 2018, that five Democrats representing Connecticut in the U.S. House of Representatives are pressuring Governor Dannel Malloy to apply for a waiver to incorporate telemedicine into the state's Medicaid program, especially for psychiatric care and substance abuse treatment. The Representatives are Joe Courtney, John Larson, Rosa DeLauro, Jim Himes, and Elizabeth Esty. Read More

Florida

Florida AHCA Secretary Justin Senior to Step Down. *Health News Florida* reported on November 28, 2018, that Justin Senior, secretary of the Florida Agency for Health Care Administration (AHCA), has announced that he will be leaving the agency effective January 7, 2019. He has served in the position since October 2016 and helped oversee the state's transition to Medicaid managed care. Governor-elect Ron DeSantis' transition team said that no decision on who will replace Senior has been finalized. Senior will become chief executive officer of the Safety Net Hospital Alliance of Florida in January. Read More

Judge Rejects Medicaid Managed Care Contract Award for HIV/AIDS. *Health News Florida* reported on November 21, 2018, that Florida Administrative Law Judge John Newton has recommended that the state throw out a Medicaid managed care contract it awarded to Simply Healthcare Plans for HIV and AIDS patients. Newton, who ruled that the Florida Agency for Health Care Administration didn't follow its own procurement rules, also recommended that the state reject all responses submitted and instead rebid the business. The ruling is a victory for AIDS Healthcare Foundation/Positive Healthcare, which had challenged the award. Read More

Health Plan Withdraws Legal Challenge Over Medicaid Auto Assignment. *Health News Florida* reported on November 20, 2018, that Lighthouse Health Plan has withdrawn its legal challenge over Florida's decision to automatically assign Medicaid beneficiaries in the northwestern part of the state to Humana Medical Plan. In exchange, the state agreed to eliminate a contract clause that would have prevented Lighthouse from being sold to a Medicaid HMO for 20 months. Lighthouse, which is a provider-sponsored network affiliated with Pensacola-based Baptist Health Care, was awarded a five-year contract to provide Medicaid managed medical assistance (MMA) services to beneficiaries in regions one and two of the state. Read More

Florida Adds Walgreens, CVS to Lawsuit Over Opioid Crisis. *CNBC* reported on November 18, 2018, that Florida has added Walgreens and CVS to a state lawsuit against companies alleged to have played a role in creating the opioid crisis. Florida Attorney General Pam Bondi announced the state had amended a lawsuit originally filed against OxyContin-maker Purdue Pharma and several drug distributors, accusing Walgreen and CVS of failing to stop suspicious orders of opioids and dispensing unreasonable quantities of opioids. Read More

Georgia

Governor-elect's Healthcare Agenda May Include Waivers. *Georgia Health News* reported on November 26, 2018, that Georgia's governor-elect Brian Kemp, an opponent of Medicaid expansion, may pursue waivers to pilot initiatives that would expand coverage to certain uninsured Georgia residents. For example, a waiver plan developed by Grady Health System three years ago that would use federal matching Medicaid dollars to provide coverage, with providers managing patient care, may be revisited. Another waiver discussed relates to the state's health insurance exchange and would create a reinsurance program. Read More

Illinois

ActivStyle to Exit Illinicare Medicaid Network Following Rate Cut. *Crain's Chicago Business* reported on November 15, 2018, that incontinence products supplier ActivStyle is exiting the Medicaid network of Centene's Illinicare plan in response to reimbursement rate cuts that took effect earlier this year. About 1,000 Illinicare members will be impacted. Gayle Devin, chief executive of Minneapolis-based ActivStyle, said the decision comes after "a year of operating at a loss with this particular contract." Blue Cross Blue Shield of Illinois announced a similar rate cut in May. The issue has the attention of the state legislature, where a proposed bill would require plans to reimburse in-network suppliers no less than 90 percent of the state Medicaid fee-for-service rate. Read More

Illinois Expands Medicaid Coverage for Hepatitis C. *The Chicago Tribune* reported on November 14, 2018, that the Illinois Department of Healthcare and Family Services will expand coverage for more than 7,000 Medicaid members with hepatitis C. Previously, individuals were covered only if they experienced severe liver damage as a result of the disease. Read More

Iowa

Medicaid Saved $126 Million From Managed Care Transition, Audit Finds. *The Associated Press* reported on November 26, 2018, that Iowa saved $126 million in fiscal year 2018 from the transition to Medicaid managed care, according to a state audit. That is less than half of original savings projections made by former Governor Terry Branstad, who supported the initiative. The audit also found that the Iowa Department of Human Services failed to follow state law requiring it to file quarterly financial reports on the state's Medicaid managed care program. The shift to managed care affected more than 600,000 individuals in the state. Read More

Kansas

Kansas May Still Struggle to Enact Medicaid Expansion Despite Electing Democratic Governor. *The Associated Press* reported on November 22, 2018, that Kansas may still struggle to enact Medicaid expansion despite the election of a Democratic governor who supports the measure. That's because voters in the state also elected a more conservative legislature, suggesting that the chances for the type of bipartisan Medicaid expansion bill previously passed have dimmed. Republican Governor Sam Brownback vetoed that bill. Read More

Kentucky

Medicaid MCOs, PBMs Under Scrutiny During Committee Meeting. *Spectrum News 1* reported on November 27, 2018, that during a Kentucky Medicaid Oversight and Advisory Committee, Medicaid managed care organizations (MCOs) and pharmacy benefit managers (PBMs) were scrutinized for taking eight months to compile information showing if MCOs and PBMs are fairly reimbursing independent pharmacists for filling Medicaid prescriptions. Brandon Smith, Executive Director, Office of Legislative and Regulatory Affairs for the Cabinet of Health and Family Services (CHFS), stated that CHFS can't show if "Kentucky is doing better or worse than the average state" since this data has not been collected before. Senator Stephen Meredith filed legislation last session to reduce the number of MCOs from five to three, which new Medicaid director Carol Steckel indicated is under consideration. The state had planned to release an RFP to rebid the managed care contracts this year with a start date of July 1, 2019, but that timeline has been pushed back. Read More

Medicaid Work Requirements Are Again Approved by CMS After Further Review. *Modern Healthcare* reported on November 21, 2018, that Kentucky has again received federal approval of a waiver to implement Medicaid work requirements after further review by the Centers for Medicare & Medicaid Services (CMS). In June, a federal judge sent the waiver back to CMS for review, ruling that regulators had approved the requirements without adequately considering the impact on coverage. Kentucky can implement the work requirements as early as April 1. Read More

Louisiana

Louisiana to Upgrade Computer System For Medicaid Eligibility Checks. *KATC.com/Associated Press* reported on November 17, 2018, that the Louisiana joint budget committee approved a contract to upgrade the state's computer system for Medicaid eligibility checks. The move follows release of an audit indicating the state may have spent $85 million over 20 months for Medicaid expansion enrollees who didn't qualify for coverage. The state will now do quarterly eligibility checks, instead of annual checks, and use multiple sources to track income data. Read More

Maine

Judge Orders Implementation of Medicaid Expansion; LePage To Appeal. *The Portland Press Herald* reported on November 21, 2018, that outgoing Maine Governor Paul LePage is still fighting the state's voter-approved Medicaid expansion. LePage said he would appeal a decision by Superior Court Justice Michaela Murphy ordering the state to implement the expansion by December 5. Either way, Governor-elect Janet Mills has signaled her intention to implement the program immediately upon taking office in January. The MaineCare expansion initiative is expected to cover as many as 80,000 residents. Read More

Maryland

CareFirst To Consider Offering Maryland Medicaid, Medicare Advantage Options Again. *The Baltimore Business Journal* reported on November 26, 2018, that CareFirst BlueCross BlueShield, Maryland's largest health insurer, is considering rejoining the Medicaid managed care and Medicare Advantage markets after a nearly twenty year absence. CareFirst announced it was exiting Maryland's Medicaid managed care and Medicare HMO markets in July 2000 after posting close to $20 million in losses on the two programs. Approximately 88,000 CareFirst members were affected by the decision. Brian Pieninck, CareFirst's new CEO, has indicated an interest in developing Medicaid managed care and Medicare Advantage products in order to offer a "full continuum" of health options to its 3 million members. Read More

Michigan

Michigan Medicaid Wins Approval for Value-Based Drug Purchasing Program. *Modern Healthcare* reported on November 14, 2018, that Michigan received federal approval for a value-based Medicaid drug purchasing program. Under the program, approved by the Centers for Medicare & Medicaid Services (CMS), drug companies would allow states to negotiate drug prices based on "outcomes-based" contracts with drug manufacturers. CMS approved a similar proposal in Oklahoma. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Office of Legislative Services, State Auditor Report on MLTSS Coverage Findings. The New Jersey Legislature, Office of Legislative Services (OLS) State Auditor conducted an audit of New Jersey's MLTSS eligibility and assessment processes and experience, and MLTSS service utilization for the period of July 1, 2014 to June 30, 2018. In particular, the report focused on MLTSS beneficiaries who did not use MLTSS services, who no longer met MLTSS eligibility but maintained MLTSS coverage, or whose clinical assessments were not performed timely. Highlights of the audit findings include:

- *The audit identified more than 2,700 enrollees who had opted to not receive any MLTSS services representing 16 percent of all home-based MLTSS and over $76 million in enhanced capitation payments. Yet 91 percent of this group received state plan personal care and medical day care services.*

The Division of Medical Assistance and Health Services (DMAHS) performed a separate analysis of this group and determined that shifting these beneficiaries to non-MLTSS status would not realize appreciable savings because their medical needs are greater than the average medical needs of current non-MLTSS users; a transfer to the non-MLTSS capitation category would result in a corresponding increase to non-MLTSS rates. In addition, some of these beneficiaries would lose Medicaid eligibility altogether if they lost MLTSS status which has a lower income threshold than non-MLTSS financial eligibility criteria, putting these individuals at risk for institutionalization and negating the preventive goals of MLTSS.

- *The audit identified beneficiaries who no longer met MLTSS eligibility but retained coverage.*

This was due to NJMMIS system discrepancies representing a small portion of MLTSS beneficiaries (1.7 percent), an issue which DMAHS has since remedied.

- *The audit also determined that close to one third of individuals who had been enrolled in MLTSS with outdated clinical assessment determinations did not receive timely MCO clinical assessments or plans of care within the required 45 days of enrollment.*

The State's Office of Community Choice Options is hiring additional nurses to address the timeliness of clinical eligibility assessment determinations. DMAHS is working with its External Quality Review Organization contractor to monitor MCO assessment and plan of care timeliness.

A copy of the full report can be found here.

New Jersey Moves Fee-for-Service Personal Care Assistance Authorizations to DMAHS. The New Jersey Department of Human Services has changed the Division from which providers must request authorization to deliver personal care assistance (PCA) services to individuals covered by Medicaid fee-for-service (FFS). The Division of Disability Services (DDS) historically managed authorizations of PCA services for FFS enrollees. Effective November 1, 2018, this responsibility shifted to the Division of Medical Assistance and Health Services (DMAHS) Medical Assistance Customer Centers (MACC) that cover the enrollee's county.

New Jersey DMAHS Submits Executive Summary of DSRIP through Managed Care. On September 28, 2018, the New Jersey Division of Medical Assistance and Health Services (DMAHS) submitted an Executive Summary of the DSRIP Sustain and Transform program to the Centers for Medicare & Medicaid Services (CMS). It includes a timeline of actions that would support the implementation of a new approach to improve hospital performance that will require changes to the Medicaid managed care organization (MCO) contracts. Under this new arrangement, DMAHS intends for contracted MCOs to distribute funding to network hospitals on a performance basis. DMAHS is currently soliciting members for a Quality and Measures committee to assist in the development of the measure specifications.

New Jersey DSRIP Transition Plan Timeline And Steps

DATE	DSRIP TRANSITION PLAN STEP
September 30, 2018	Submit final DSRIP Transition Plan to CMS for approval
November 15, 2018	Appoint Quality Measure Committee
December 30, 2018	Submit pre-print to CMS for approval
May 30, 2019	Release detailed program strategies, activities and payment mechanisms
June 30, 2019	Submit performance measurement framework to CMS
September 30, 2019	Submit sample amended Managed Care Contract to CMS
December 31, 2019	CMS approval of Managed Care Contract amendment
January 15, 2020	Release program application to hospitals
April 1, 2020	MCOs sign amended Managed Care Contract (effective July 1, 2020)
April 15, 2020	Lead entity applications due
June 15, 2020	Application approvals announced
July 1, 2020	NJ Sustain and Transform Program implementation begins

Division of Aging Services Provides Medicaid MLTSS Update. The New Jersey Division of Aging Services reported that as of June 2018 there were 56,228 Medicaid long-term care recipients, of which 44,703 (or 79.5 percent) were enrolled in Managed Long-Term Services and Supports (MLTSS). Within the MLTSS group, 61 percent live in home- and community-based settings (HCBS). In addition, 1,055 of Medicaid beneficiaries receiving long term care are enrolled in a PACE program. The state continues to see a rising trend in the proportion of individuals receiving LTSS through HCBS; the number rose from 46.1 percent in June, 2017, to 50.2 percent in June 2018.

FamilyCare Plans Comprehensive Benefit Package for Children with Autism. Michele Schwartz, from the New Jersey Department of Children and Families, Children's System of Care, gave an update to the New Jersey Medical Assistance Advisory Council (MAAC) on its work to provide covered services for youth with autism beyond the Autism Spectrum Disorder (ASD) pilot. CMS guidance on EPSDT would add medically necessary ASD services (in-home, out of home and clinical services) without limitations to New Jersey's Medicaid State Plan under the renewal of the 1115 waiver for individuals under age 21. An additional $17 million was included in Governor Murphy's fiscal year 2019 budget to expand and improve access to services for youth with autism.

An Autism Executive Planning Committee has been working to develop the comprehensive benefit package and to inform the elements of a State Plan Amendment (SPA) with a target effective date of January 2019.

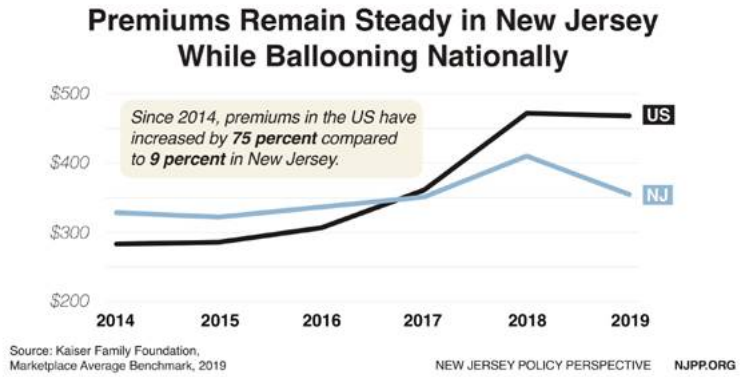
Department of Human Services Proposes Medication Assisted Treatment Concept. Roxanne Kennedy, Director of Behavioral Health Management with the New Jersey Division of Medical Assistance and Health Services (DMAHS), presented to the New Jersey Medical Assistance Advisory Council (MAAC) on its proposed concept for Medication Assisted Treatment (MAT) and Office Based Addictions Treatment (OBAT) to be a Medicaid reimbursable service within a MATrx system. The proposed MATrx model would consist of three different types of providers with various specialties to treat substance abuse disorders, and in particular, opioid use disorders (OUD). Each provider type would offer MAT and refer and/or consult, depending on the severity of individuals seeking treatment. Providers could be categorized as:

- **Centers of Excellence (COE)**. A comprehensive center and community resource with the capacity to function as an integrated care and addictions treatment hub able to manage complex cases.
- **Premier Providers.** CCBHCs, FQHCs, Opioid Treatment Providers (OTP) or independent clinics that meet certification for integrated care or coordinated care.
- **Office Based Addiction Treatment Providers.** Primary care physicians with a Data 2000 Waiver who meet standards for excellence and affiliate with Premier Providers/COE to integrate care.

DMAHS is working on a payment structure for each provider type. A provider stakeholder group convened to obtain model concept input. DMAHS is planning to implement MATrx in three phases.

MATrx PROGRAM PROPOSED TIMELINE		
PHASE 1	**PHASE 2:**	**PHASE 3**
Sept. – Dec. 2018	**Jan. – Mar. 2019**	**Apr. – Jul. 2019**
Determine OBAT requirements	OBAT billing begins Jan 1, 2019	Premier Provider billing begins
Establish reimbursements for OBATs	Determine requirements for Premier Providers	Peer Support and Case Management Services covered by Medicaid beginning July 1, 2019
Identify OBAT providers	Evaluation and reporting requirements	
Determine criteria for COE; initiate MOA/MOU		
Identify COEs		
Announce DMAHS trainings for Data 2000 prescribers		

New Jersey ACA Exchange Premiums Among the Lowest in the Nation. According to a report released by the New Jersey Policy Perspective (NJPP) in November 2018, New Jersey's individual insurance market premiums for the Silver plan in 2019 ranked 47th among states during the open enrollment season for the coming benefit year. This represents a large improvement compared to New Jersey's position in 2014, when the state was the ninth highest in Exchange premium costs.



In addition to lower prices many people will qualify for premium subsidies. According to NJPP, the lower premiums did not reflect reduced plan benefit offerings. Rather, they attribute premium savings to several state actions:

- Adoption of an individual mandate, which introduced a level of market stability that was less prevalent in neighboring states.
- Establishing a reinsurance program to help protect insurers from exposure to unusually high medical costs.

- Department of Banking and Insurance encouraged insurers to offer less expensive Silver plans.
- The launch of Get Covered New Jersey, a state outreach campaign that is expected to attract a healthier pool of insureds.

While New Jersey marketplace plan premiums decreased on average by 9 percent, the premiums are between 38 percent to 94 percent lower than in Delaware, New York, and Pennsylvania. There are currently 140,000 State residents enrolled in a New Jersey marketplace plan. Read More

New Mexico

Judge Rejects Medicaid Contract Award Challenge by Molina. *The Santa Fe New Mexican* reported on November 21, 2018, that a New Mexico judge rejected Molina Healthcare's challenge to the state's Medicaid managed care contract award. Molina, which lost its bid to retain the business, claimed that the state made a number of scoring and bid-evaluation errors in awarding contracts to Western Sky Community Care, Blue Cross Blue Shield of New Mexico, and Presbyterian Health Plan. Approximately 206,000 Medicaid recipients, now served by Molina, will need to switch to another plan on January 1, 2019. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Long-Term Care Plans Impose an Enrollment Lock-In. Beginning December 1, 2018, enrollment in New York Managed Long-Term Care (MLTC) Partial Capitation plans will be subject to a lock-in period. The lock-in applies to new enrollments and plan-to-plan transfer effective December 1, 2018, or later; it will not apply to current enrollees unless they transfer plans. Beneficiaries will have a 90-day grace period to transfer to a different plan and will then experience a lock-in period of nine months. After the initial 90-day grace period, enrollees can only disenroll or transfer to a different plan for good cause. Examples of good cause include: the enrollee is moving from the plan's service area, the plan fails to furnish services, or it is determined the enrollment was non-consensual. After the completion of the lock-in period, an enrollee may transfer without cause, but is subject to a grace period and subsequent lock-in as of the first day of enrollment with the new MLTC partial capitation plan. Read More

Community-based Providers Seek Financial Support for Workforce Retention. *Crain's New York* reported on November 9, 2018, that a broad coalition of community-based providers, including health centers, behavioral health nonprofits and home care agencies, are calling on New York to set aside some of the proceeds it received from the sale of Fidelis Care to Centene to invest in its workforce. They are asking for a one-time infusion of $169 million for retention of the community-based provider workforce, arguing that the proceeds of the sale of Fidelis Care to Centene provides an unprecedented opportunity to support community-based providers' efforts to recruit and retain quality staff. The request comes on the heels of a Medicaid rate increase for hospitals and nursing homes that Governor Cuomo's administration enacted effective November 1, 2018, using $675 million from the money the state received as part of the $3.75 billion sale of Fidelis to Centene. That rate increase is ear-marked to increase employee pay and benefits, largely benefiting workers who are members of 1199 SEIU, the politically powerful health care union. The community providers argue that since state policy is focused on moving health care out of institutional settings and into community-based settings, its financial commitments should reflect those priorities. Read More

New York Approves CVS Acquisition Of Aetna. The New York Department of Financial Services announced on November 26, 2018, that it has approved CVS Health's acquisition of Aetna Insurance Company of New York. The approval includes a number of conditions, including enhanced consumer and health insurance rate protections, privacy controls, cybersecurity compliance, and a $40 million commitment to support health insurance education and enrollment and other consumer health protections. DFS held a public hearing on the proposed acquisition in October 2018, and heard testimony regarding vertical and horizontal competitive issues, pharmacy benefit management practices, the lack of articulated business plans by CVS Health or Aetna Inc. sufficient to demonstrate that any promised benefits would materialize, and concerns for data privacy and security. The overwhelming majority of both oral and written testimony expressed concerns with the transaction. As part of DFS's approval, CVS has agreed to specific conditions intended to protect New York consumers, including:

- Increased health insurance rates cannot be sought in New York to pay for the cost of the acquisition and premiums and cost-sharing owed by policyholders cannot increase
- Dividends cannot be paid by Aetna without the express prior approval of the Superintendent for a period of three years
- Current products throughout the Aetna New York service area must be maintained for three years following the approval
- One or more new products must be made available by Aetna to the small and large group markets within two years from the approval through an existing or new New York-domiciled insurer
- $40 million to New York State, over a three-year period, to support health insurance education and enrollment activities and strengthen New York health care transformation activities, which may include payments to the New York State Health Care Transformation Fund

- Ensuring that participating provider networks for insured products maintain access to non-chain New York pharmacies for three years from the approval

Read More

New York Begins Taxing Drug Makers, Distributors to Offset Costs of Opioid Crisis. *The Wall Street Journal* reported on November 19, 2018, that New York has begun taxing drug companies and distributors under a new law aimed at raising money to help fight the opioid epidemic. The New York State Department of Health has sent bills to 75 companies under the Opioid Stewardship Act, a tax based on the volume and potency of opioids sold or distributed in the state. Companies impacted by the law, which hopes to raise $600 million over six years retroactive to 2017, argue that the tax penalizes them unfairly. Read More

Ohio

Ohio Reviews New IMD Waiver Opportunities as SUD Waiver Public Comment Period Closes. *Gongwer* reported on November 23, 2018, that Ohio is reviewing the opportunity announced by the Centers for Medicare & Medicaid Services (CMS) to design waivers that would allow states to cover services at an institution for mental disease (IMD) for adults with serious mental illness and children with serious emotional disturbance. Ohio recently submitted an application for a similar waiver to allow for treatment of substance use disorder (SUD) in IMDs, which was open for public comment until November 25, 2018. The newly announced waiver opportunity could allow Ohio to increase access to inpatient and residential care for mental health.Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Expands Prescription Assistance. The Pennsylvania General Assembly approved, and Governor Tom Wolf signed into law, House Bill 270, which raises the maximum income limits of the Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET) program. This is the first increase in income limits for the PACENET program in 15 years. The program is administered by Pennsylvania's Department of Aging. Individuals 65 and older with annual incomes up to $27,500 and couples up to $35,500 now qualify for the program, increasing the number of individuals that qualify for PACENET's low-cost prescription program by 17,000.

Pennsylvania Announces New Audit of Nursing Home Oversight. *Pennsylvania Real-Time News* reported on November 15, 2018, that Pennsylvania's Auditor General, Eugene DePasquale, will be conducting a new audit of the Department of Health's (DOH) oversight of nursing homes. This review will be a follow up to a 2016 audit, which found issues with staffing levels, substandard facilities, and improper handling of complaints. DePasquale indicated that the review's intent is to measure how much progress DOH has made. Read More

South Carolina

South Carolina Medicaid Reimbursement Rates for Autism Treatment Are Still Too Low, Advocates Claim. *The Greenville News* reported on November 27, 2018, that autism advocates in South Carolina assert that Medicaid reimbursement rates for applied behavior analysis (ABA), the most effective treatment for autism, remain too low and continue to limit children's access to required treatment. According to a survey of 33 states conducted by Autism Speaks, South Carolina paid the lowest ABA rate at $17 per hour. While that rate was recently increased to $31, it still trails payment rates in nearby states such as North Carolina and Georgia. The state's Medicaid agency approved 751 children for autism treatment between April 1 and November 2, of which it estimates half are receiving ABA treatment. Read More

Tennessee

Families Struggle with Medical Costs for Children with Severe Disabilities Who Do Not Qualify for Medicaid Program. *The Tennessean* reported on November 26, 2018, that in Tennessee, children with severe disabilities from middle-and-high income families do not qualify for the state's Medicaid program, leaving parents to pay large medical bills. According to Sarah Sampson, the deputy director of the Tennessee Disability Coalition, there is no program designed as a "pathway to the Medicaid program for children with long-term disabilities or complex medical needs." In 2016, the state closed enrollment to three Home and Community-Based Services waivers which allowed children to qualify for Medicaid without counting parents' income. TennCare's Essential Family Supports, a benefit group within it's Employment and Community First CHOICES program, is limited to 3,000 children with an intellectual or developmental disability. Read More

Virginia

Virginia Submits Work Requirement Application; Considers Reimbursement Increase to Attract Providers. *NBC 12* reported on November 27, 2018, that the Virginia Department of Medical Assistance Services (DMAS) has submitted its work requirement application to the Centers for Medicare & Medicaid Services (CMS). State Republicans had delayed submission, wanting more time to review the application, particularly the requirement exemptions. In addition, according to the *Richmond Times-Dispatch*, the state is considering a proposal to increase reimbursement rates for doctors to encourage them to provide care to Medicaid patients. DMAS asked Governor Ralph Northam to include $19.1 million in his two-year budget proposal to help alleviate the health-professional shortage that some parts of the state are experiencing. Dr. Jennifer Lee, the DMAS director, estimates that 63 percent of physicians participate in Medicaid and 71 percent of those are taking new patients. DMAS expects that raising physican rates to 80 percent of the Medicare rate would cost $40 million for the existing Medicaid population and about $25 million for the expansion population. About 400,000 people are expected to enroll in Medicaid under the expansion. Read More

Wisconsin

Governor-elect May Seek to Stop Medicaid Work Requirements from Being Implemented. *The Associated Press* reported on November 21, 2018, that Wisconsin Governor-elect Tony Evers may seek to stop Medicaid work requirements from being implemented in the state. Federal officials approved the state's work requirements waiver in October; however, the state isn't expected to roll out the program for a year. Evers told reporters he is concerned about requirements that reduce access to healthcare and it is possible he will try to withdraw the waiver prior to implementation. Read More

National

Trump Administration Considers Relaxing Ban on Health Care Kickbacks. *The New York Times* reported on November 24, 2018, that the Trump administration has asked the health care industry for recommendations on relaxing anti-kickback rules, which were implemented to prevent remuneration in exchange for referrals of Medicare and Medicaid patients. While health care providers say the ban is an obstacle to coordinated care, others argue it's a check against fraud. Read More

Drug Company Raised Price of Opioid Treatment to Capitalize on Epidemic, Subcommittee Report Says. *Cleveland.com* reported on November 18, 2018, that pharmaceutical company Kaleo raised the price of its naloxone drug Evizo by more than 600 percent to $4,100 per unit in 2016 in order to capitalize on the opioid epidemic, according to a report from the Permanent Subcommittee on Investigations, chaired by Senator Rob Portman (R-Ohio). The report also says the Kaleo sales team focused on making sure doctors signed necessary paperwork indicating that Evizio was medically necessary. Read More

Medicaid Spending Rises 7.3 Percent in Fiscal 2018, NASBO Says. *Reuters* reported on November 15, 2018, that Medicaid spending rose 7.3 percent in the fiscal year ending June 30, 2018, compared to a 4.4 percent increase in fiscal 2017, according to National Association of State Budget Officers' (NASBO) annual state expenditure report. The figures include both state and federal funding for Medicaid, but excludes spending on the Children's Health Insurance Program, care for the mentally ill or developmentally disabled, and child welfare programs. Federal funds accounted for about 61 percent of Medicaid spending, while state funds accounted for the remainder. Read More

ACA Exchange Plan Sign-ups Are Down In Early Days of Open Enrollment. *The Hill* reported on November 14, 2018, that an estimated 1.2 million individuals enrolled in Affordable Care Act (ACA) Exchange plans in the first ten days of open enrollment, which is about 300,000 less than the same period last year. The data from the Centers for Medicare & Medicaid Services (CMS) also indicated that the number of new customers enrolling is also down compared to last year. Open enrollment ends on December 15. Read More

Industry News

CVS Health, Aetna Close $69 Billion Merger. *Modern Healthcare* reported on November 28, 2018, that CVS Health and Aetna have closed their $69 billion merger, nearly one year after agreeing to merge. The merger received all state regulatory approvals earlier this week. The companies expect to yield $750 million in savings by year two of the merger. Read More

Quality of Patient Care at Nursing Home Chain Deteriorated Prior to Bankruptcy. *The Washington Post* reported on November 25, 2018, that the HCR ManorCare nursing home chain exposed 25,000 patients to health risks and health code violations before filing for bankruptcy in March. Violations at HCR ManorCare properties rose 26 percent from 2013 to 2017, according to a *Washington Post* tally. The Carlyle Group, which owns HCR ManorCare, attributed the chain's troubles to reduced Medicare reimbursement rates. Read More

Community Medical Services Acquires Two Opioid Abuse Treatment Providers. Clearview Capital announced on November 20, 2018, that its portfolio company Community Medical Services (CMS) acquired two providers of medication-assisted treatment for patients suffering with opioid use disorder. With the acquisitions of Premier Care and Maintenance and Recovery Services, effective November 1, CMS provides treatment to more than 9,300 patients across 28 clinics daily. Read More

Audax, LLR Partners Complete Sale Of Numotion. Audax Private Equity and LLR Partners announced on November 15, 2018 that they have completed the sale of Tennessee-based Numotion to AEA Investors LP. Numotion provides wheelchairs specifically configured for individuals with disabilities. Read More

Community Health Systems to Sell Four SC Hospitals. Community Health Systems, Inc. announced on November 19, 2018, that its subsidiaries have signed a definitive agreement to sell four hospitals in South Carolina to the Medical University Hospital Authority in Charleston. The agreement includes the 82-bed Chester Regional Medical Center, 225-bed Springs Memorial Hospital in Lancaster, 396-bed Carolinas Hospital System in Florence, and the 124-bed Carolinas Hospital System in Mullins. The transaction, which is part of planned divestiture already announced by the company, is expected to close in the first quarter of 2019. Read More

BayMark Health Services Acquires UT Opioid Treatment Program. BayMark Health Services announced on November 15, 2018, that it has acquired Metamorphosis, which provides medication-assisted treatment for opioid addiction in Salt Lake City and Ogden, Utah. The Metamorphosis programs in both locations will become BAART Programs, a BayMark Health Services company that provides outpatient medication-assisted treatment and rehabilitation for patients with opioid addiction. Read More

LifePoint Health Completes Merger with RCCH HealthCare Partners. LifePoint Health announced on November 16, 2018, that it had completed its merger with RCCH HealthCare Partners, which is owned by funds managed by affiliates of Apollo Global Management, LLC. The combined organization will provide community-based healthcare in more than 85 non-urban communities. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
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

COMPANY ANNOUNCEMENTS

ConcertoHealth to Provide Specialized Primary Care for Regence BlueShield Medicare Advantage Patients in Western Washington

HMA WELCOMES

Jose Robles – Principal (Chicago)

Jose Robles brings more than 24 years of experience in serving healthcare systems and multi-discipline organizations to HMA. He has worked extensively in the area of revenue integrity and understands the complexities surrounding his clients' reimbursement and regulatory environments.

Jose is a trusted advisor who has helped many clients optimize reimbursements from governmental entities to traditional managed care payors. He also understands the need to mitigate risk and adhere to the regulations and rules governing the healthcare industry.

Prior to joining HMA, he was a director in the Health Industries Advisory practice at PricewaterhouseCoopers LLP where he served a wide client base. His work has included evaluation, analysis and policy development for Medicare, Medicaid and Blue Cross as well as other managed care contracts. He has also worked with clients on due diligence and accounts receivable-related matters.

He has a bachelor's degree in accountancy from the University of Illinois and is a Certified Public Accountant (inactive), member of the Healthcare Financial Management Association and the Association of Latino Professionals in Finance and Accounting.

Michael Stiffler – Senior Consultant (Costa Mesa)

Michael Stiffler is a healthcare analyst and medical financial expert who meets clients' needs by applying rigor and discipline to the transformation of all types of healthcare data into meaningful reporting and analysis for decision making purposes.

Before joining HMA, he was director of healthcare analysis at Molina Healthcare of California where he developed and managed a team of analysts conducting medical economic analysis and reporting as well as operational analysis and reporting for the Medicaid, Medicare, Dual-Eligible, Medicare-Medicaid Plan and Marketplace lines-of-business.

Prior to working at Molina, Michael held various leadership positions with large national payors such as Amerigroup Corporation and United Healthcare. He also spent more than five years working for a large national home health/home medical equipment provider in a senior leadership role.

Throughout his career, Michael has been responsible for all types of data driven profitability, trend, pricing, contracting, and operational analysis that was used to drive major organizational changes.

Michael earned his undergraduate degree in Spanish at Emory University and has a Master of Business Administration with a concentration in finance from Saint Louis University.

HMA News

HMA Awarded California Perinatal MAT Expansion Project. HMA is proud to have received the official notice of award for the California Perinatal MAT Expansion Project through the Substance Use Disorder Compliance Division of the California Department of Health Care Services (DHCS). Read more

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Arizona Medicaid Managed Care Enrollment is Down 2.1%, Nov-18 Data
- Colorado RAE Enrollment is 1.2 Million, Oct-18 Data
- Georgia Medicaid Management Care Enrollment is Down 1.6% Nov-18
- Iowa Medicaid Managed Care Enrollment is Up 4.9%, Oct-18 Data
- Illinois Dual Demo Enrollment is Up 1.8%, Oct-18 Data
- Illinois Medicaid Managed Care Enrollment is Up 18.1%, Oct-18 Data
- Indiana Medicaid Managed Care Enrollment is Down 3.6%, Oct-18 Data
- Kentucky Medicaid Managed Care Enrollment is Down 1.6%, Sep-18 Data
- Louisiana Medicaid Managed Care Enrollment is Up 0.5%, Oct-18 Data
- Mississippi Medicaid Managed Care Enrollment is Down 8.8%, Nov-18 Data
- Nebraska Medicaid Managed Care Enrollment Rises 1.3%, Oct-18 Data
- New York Dual Demo Enrollment is Down 15.4%, Oct-18 Data
- New York Medicaid Managed Care Enrollment is Flat, Oct-18 Data
- Ohio Dual Demo Enrollment is Up 6.1%, Nov-18 Data
- Rhode Island Dual Demo Enrollment is 15,530, Nov-18 Data
- South Carolina Dual Demo Enrollment is Down 2.3%, Oct-18 Data
- South Carolina Medicaid Managed Care Enrollment is Flat, Nov-18 Data
- Texas Dual Demo Enrollment is 38,572, Nov-18 Data
- Utah Medicaid Managed Care Enrollment is Down 4.1%, Nov-18 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.7%, Oct-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- California Medi-Cal Nonmedical Transportation RFI, Nov-18
- Colorado Medicaid Utilization Management Contract, 2015
- Massachusetts HIX And Miscellaneous Notices Business Process Operations Services RFR, Nov-18
- Michigan Medicaid Eligibility Quality Control (MEQC) Review Pilot Consultant RFP, Nov-18
- New Jersey MMIS RFP, Proposal, BAFO, 2013-14
- Nevada Medicaid Managed Care RFP, Scoring, Proposals, and Contracts, 2016
- Oregon Coordinated Care Organization Model Contract, 2018
- Tennessee Medicaid Managed Care Contract, 2018
- Tennessee Pharmacy Benefits Management RFP, Nov-18
- Utah Medicaid ACO Contracts, 2017-18
- Vermont Disproportionate Share Hospital (DSH) Audit RFP, Nov-18

Medicaid Program Reports, Data and Updates:

- CMS Annual Reporting on the Quality of Care for Adults in Medicaid, 2018
- NASBO State Expenditure Report, FYs 2016-18
- GAO Medicaid Managed Care Report to Congressional Requesters – Additional CMS Actions Needed to Help Ensure Data Reliability, Oct-18
- Alaska DHSS Annual Medicaid Reform Report, FY 2018
- Arizona Medicaid Advisory Committee Meeting Materials, Oct-18
- Colorado Children's Health Plan Plus Caseload by County, 2014-17, Oct-18
- DC Medical Care Advisory Committee Meeting Materials, Oct-18
- Florida Medicaid Eligibility by County, Age, Sex, Oct-18 Data
- Indiana Medicaid Advisory Committee Meeting Materials, Aug-18
- KY Medicaid Managed Care Financial Report, 2017
- Maryland Medicaid Treatment and Service Fees for Substance Use Disorders Chartbook, CY 2012–16
- Maryland Physician Medicaid Fees to Medicare Fees Chartbook, FY 2018
- Mississippi Medicaid Managed Care Actuarial Rate Certifications, 2017-18
- North Carolina Approved Medicaid Reform Section 1115 Demonstration Waiver Documents, Nov-18
- North Dakota Healthy Steps CHIP Quality Strategy Plan Draft, Nov-18
- North Dakota Home and Community-Based Services Waivers, 2018-19
- North Dakota Revised Statewide Transition Plan For HCBS Settings, Nov-18
- Nevada Medicaid Managed Care Actuarial Rate Certifications, CY 2016-18
- Oklahoma Medicaid Enrollment by Age, Race, and County, Oct-18 Data
- Oklahoma Medical Advisory Meeting Materials, Sep-18
- Oklahoma Provider Fast Facts by County, Oct-18
- Oregon CCO 2.0 Report and Update Materials, Nov-18
- Oregon Revised Statewide Transition Plan For HCBS Settings, Nov-18
- South Carolina Medical Care Advisory Committee Meeting Materials, Nov-18
- South Dakota Department of Social Services Medicaid Annual Reports, 2012-18
- South Dakota Medicaid Advisory Committee Meeting Materials, Nov-18
- Texas HHS Procurement and Contracting Improvement Plan, Nov-18
- Utah ACO Actuarial Rate Certifications, CY 2015-18
- Virginia A Commonwealth Coordinated Care Plus Data Books and Capitation Rates, 2016-18
- Virginia Medallion 3.0 Data Book and Capitation Rates, FY 2016-18
- Vermont Medicaid Program Enrollment and Expenditures Report, Q4 SFY 2018
- Vermont Medication Assisted Treatment for Opioid Use Disorder Inventory and Benefit-Cost Analysis, 2017
- Washington Health Home MFFS Dual Demonstration Years 2-3 Report, Nov-18

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- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

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