HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*December 5, 2018*






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## THIS WEEK



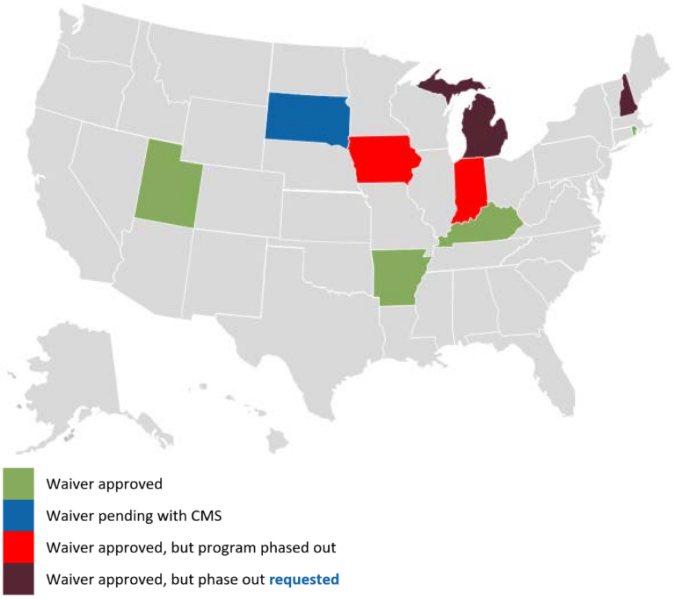
## IN FOCUS

### PREMIUM ASSISTANCE PROGRAMS FOR THE WORKING ADULT POPULATION IN MEDICAID EXPANSION STATES

This week, our *In Focus* section comes to us from HMA Senior Consultant Erin Mathies (Indianapolis), who reviews the premium assistance programs for the working adult population in Medicaid expansion states. Medicaid programs that pay for premiums in commercial insurance for individuals eligible for

Medicaid have been part of state Medicaid programs since the 1990s. Under a premium assistance program, the employer or individual market coverage is the primary plan and Medicaid supports the cost of the premium, pays for cost sharing, and provides any wrapped benefits. These programs can save money for state Medicaid agencies by leveraging the employer contribution towards premiums and holding expenditures per member to the annual out of pocket maximum amounts. Existing Health Insurance Premium Payment (HIPP) programs traditionally cover children and populations with disabilities. Individuals eligible under Medicaid expansion programs may be more likely to have access to employer sponsored-insurance (ESI) and leveraging premium assistance options for these populations represents an unrealized opportunity for many state Medicaid agencies.

The map below shows the states using 1115 waivers to incorporate premium assistance programs through employer and/or individual Marketplace coverage.




In addition to the extension of adult coverage at higher income levels, recent federal regulatory developments provide the ability to use tax advantaged employer Health Reimbursement Arrangement (HRA) contributions to purchase coverage on the individual market. This may increase the viability of premium assistance for the working Medicaid population by making individual coverage options more attractive.

## Premium Assistance Program Requirements and Operational Needs

States designing premium assistance programs must demonstrate cost effectiveness and must have wrap-around and cost sharing provisions in place to ensure that benefits are equivalent to, and out of pocket expenses are no greater, for enrollees than they would have been under traditional Medicaid.

### 1. Cost Effectiveness and Plan Review

To implement a premium assistance program, the state must develop a methodology to assure that premium assistance costs no more than enrollment in Medicaid. When premium assistance operates under an 1115 waiver, budget neutrality must also be assured.

Cost effectiveness determinations may be made on an aggregate program basis or an individual basis. Methods for determining cost effectiveness include determining if the commercial plan (employer sponsored or individual coverage) cost is less than the capitation payment for a beneficiary enrolled in a Medicaid MCO or alternatively analyzing the individual claims history and projecting the cost of covering the individual on a private plan. In addition, the benefits in the plan are reviewed to ensure the commercial plan offers comprehensive coverage. This review also supports the cost effectiveness determination that the out of pocket costs are reasonable as compared to the costs of providing Medicaid coverage. Tools can be developed to streamline plan review and the cost effectiveness determination process. Advance determinations that certain plans are cost effective and comprehensive can streamline premium assistance operations.

**2. Wrapped Benefits**

Premium assistance programs require that Medicaid provide wrap-around benefits for the individual in addition to what is provided on the commercial insurance coverage. This applies to both benefits that may not be covered by the commercial coverage and are covered by Medicaid and those benefits that may be covered, but have lower annual limits than Medicaid coverage. The complexity of wrapping benefits can increase when different Medicaid populations have benefits that vary from state plan Medicaid services, such as when a Medicaid expansion population receives benefits via an Alternative Benefit Plan which differs from the Medicaid state plan (https://www.healthmanagement.com/wp-content/uploads/061318-HMA-Roundup.pdf). Under premium assistance Medicaid remains the payer of last resort and claims payment for individuals enrolled in premium assistance requires the coordination of benefits between the primary payer (commercial insurance) and Medicaid.

An example of benefits wrapped to an Alternative Benefits Plan (ABP) is provided below.

| ESI Coverage | ABP/Medicaid Coverage |
|---|---|
| • Physical Therapy – 20 visits per year | • Physical Therapy – 30 visits per year |

Member receives 21st physical therapy visit.
ESI denies coverage. The state wraps services to the ABP. Medicaid covers the service up to 30 visits.

**3. Cost Sharing and Premiums**

Premium assistance programs require that Medicaid eligible individuals enrolled in premium assistance have cost sharing no higher than present in Medicaid. Members must be reimbursed for the premium cost of enrollment, or a method to coordinate with the employer or health plan must be put in place to assure that the premiums are no higher for premium assistance than for Medicaid enrollment. Comparably, where the private plan includes copayments, co-insurance, or deductibles, Medicaid must cover any of these costs under premium assistance that are more than the Medicaid allowable cost sharing amounts.

## Design Considerations for Premium Assistance Programs

Expanding the footprint of existing HIPP programs and implementing new Medicaid premium assistance programs offer opportunities for developing unique program designs.

- **Required vs. Voluntary Participation**

Member participation in employer sponsored or Marketplace plan coverage for Medicaid beneficiaries may be mandatory, requiring participation where cost effective commercial plans are available, or voluntary, allowing the beneficiary to elect the coverage. Requirements on the members can by extension become requirements on employers, since if Medicaid beneficiaries must enroll in the employer coverage then employers may be required to engage with the members and Medicaid agency to support that enrollment.

- **Family Coverage**

Commercial plans typically offer family coverage with the same coverage type and networks to their employees. Medicaid enrollment typically looks at each individual singularly. For premium assistance programs, leveraging the ability to enroll entire families into commercial plans may support cost effectiveness. Considering options on how to model family coverage under Medicaid when designing premium assistance programs can maximize the effectiveness of these programs.

- **Employer and Member Roles and Renewal Timing**

When premium assistance is primarily administered through employer plans, the responsibilities and roles of the employers and employees (Medicaid beneficiaries) become important points in program design.

The following table describes some of the possible employer vs. employee roles.

| PREMIUM ASSISTANCE PROGRAM ROLES | |
|---|---|
| **Employer Active Role** | **Employee/Member Active Role** |
| • State outreach to the employer community to provide information for all the ESI plans offered by the employer, including dental and vision. | • The employee or member will need to provide to the state their ESI plan information.<br>o The plan information may include the Summary of Benefits and Coverage or Summary Plan Description which may not be easy for the member to find. |
| • State request for employer to verify employment and other confirmations as requested for eligible members. | • Member to verify employment and other plan enrollment details as requested by the state.<br>o Some states may request a paystub or other documentation from the member enrolled in the program to provide proof of employment in the absence of an employer role. |

In addition, renewal timing is another consideration for premium assistance programs. Renewal timing and 'open enrollment' for these commercial plans are typically at the end of the calendar year. The renewal period is likely different than the member's annual Medicaid recertification period. As a result, a member may renew their ESI and recertify Medicaid at different times. Aligning the Medicaid and employer renewal periods for individuals with premiums assistance can streamline operational processes and help to minimize member churn between Medicaid and commercial coverage.

## Future of Premium Assistance Programs

Premium assistance programs will continue to evolve as the Medicaid expansion population and Marketplace coverage requirements and policies change. For example, the new federal proposal to allow employer contributions to pay for non-employer based insurance could lead to new regulations that would have an impact on states' premium assistance program designs. For programs administered primarily through individuals plans, the coordination between Medicaid and the Marketplace is key to ensure eligibility and coverage requirements are met. Leveraging premium assistance programs may provide more healthcare continuity for working members as coverage from their employer plan will remain in effect even if a change in income has an impact on their Medicaid eligibility.

For more information, please contact Erin Mathies.

HMA Medicaid Roundup

## Arkansas

**Trump Administration Files Motion to Dismiss Work Requirements Lawsuit.** *The Arkansas Times* reported on December 1, 2018, that the Trump Administration has asked U.S. District Court Judge James Boasberg to dismiss a federal lawsuit aimed at stopping Arkansas from implementing Medicaid work requirements. The lawsuit, filed by nine Medicaid recipients, argues that the Trump Administration overstepped its authority in approving work requirements. More than 12,000 Arkansans have lost Medicaid coverage since work requirements were implemented. Read More

## Florida

**Florida Wins Approval to Shorten Retroactive Medicaid Eligibility.** *The Ocala Star Banner/News Service of Florida* reported on December 3, 2018, that the Centers for Medicare & Medicaid Services (CMS) has approved Florida's request to reduce Medicaid retroactive eligibility from 90 to 30 days, excluding pregnant women and children. CMS said the new policy "will help ensure that eligible individuals apply for and receive Medicaid coverage in a timely manner." Florida Medicaid officials estimate the change will save the state nearly $100 million and impact about 39,000 people. Read More

**Florida Begins Roll Out of Medicaid Managed Care Plans for Foster Care, Early Childhood Intervention.** *Health News Florida* reported on December 3, 2018, that Florida has begun rolling out Medicaid managed care plans for the medical component of foster care and early childhood intervention, the first time the state has contracted with health plans to cover these eligibility categories. Roll-out will begin in Miami-Dade, Broward, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties. Children up to three years old with developmental issues are eligible for early intervention services. Read More

## Kansas

**Kansas GOP Lawmakers Elect Medicaid Expansion Opponent as House Majority Leader.** *The Wichita Eagle* reported on December 3, 2018, that Kansas House Republicans have elected Representative Dan Hawkins (R-Wichita), a staunch opponent of Medicaid expansion, as Majority Leader. Democrats chose Representative Tom Sawyer (D-Wichita) to serve as Minority Leader. Democratic governor-elect Laura Kelly supports Medicaid expansion in the state. Read More

## Massachusetts

**Massachusetts Receives CMS Approval for Flexible Services Program.** **M**assachusetts announced on December 3, 2018, that the Centers for Medicare & Medicaid Services (CMS) approved a $149 million Flexible Services Program for the state's MassHealth Medicaid program, allowing Accountable Care Organizations (ACOs) to pay for health-related nutrition and housing supports for certain eligible members. The Flexible Services Program aims to address the health-related social needs of members. Implementation is expected to begin January 2020. Read More

**Massachusetts Approves Beth Israel-Lahey Health Merger With 7-Year Cap on Price Increases.** *Modern Healthcare* reported on November 29, 2018, that Massachusetts Attorney General Maura Healey has approved the merger of Beth Israel Deaconess Medical Center and Lahey Health, following a settlement in which the newly formed system will cap price increases at 3.1 percent annually for seven years and participate in Medicaid and the Children's Health Insurance Program (CHIP). The combined system also committed to spending $71.6 million to improve access to health care for low income communities. The merger is expected to close in the first quarter of 2019. Beth Israel Lahey Health will include 10 hospitals, three affiliated hospitals, and more than 4,000 physicians. Read More

## Mississippi

**Medicaid To Cover 16 Physician Office Visits in 2019.** *US News Today/Associated Press* reported on December 5, 2018, that Mississippi Medicaid will cover 16 physician office visits annually, up from 12, effective January 1, 2019. Lawmakers hope the change will increase use of preventive care and decrease emergency room visits. The state's Medicaid program provides coverage for nearly 675,000 individuals. Read More

## Montana

**Montana Is Projected to Have Enough Funds to Continue Medicaid Expansion.** *The Missoulian/Associated Press* reported on December 3, 2018, that Montana is expected to raise enough revenues to fund its Medicaid expansion program in fiscal 2020 and 2021 despite an increase in cost, according to a report from the state Legislative Fiscal Division. The net cost of the program, which covers 95,000 adults, is expected to increase by $59 million for the two fiscal years combined, an amount exceeded by incremental tax revenue growth. Voters rejected a ballot measure last month to add a $2 per-pack tax increase on tobacco to help fund the program. Read More

## Nevada

**Nevada Medicaid Announces 6-Month Hold on Signing Up Certain Behavioral Health Providers.** *The Pahrump Valley Times* reported on November 30, 2018, that Nevada Medicaid will place a six-month hold on signing up additional behavioral health aides and qualified mental health associates. The moratorium comes amid concerns over inappropriate billing practices and the lack of proper provider qualifications. "We clearly need to increase the quality and oversight," Nevada Medicaid acting Administrator Cody Phinney stated. Until the moratorium is lifted, providers will be allowed to re-enroll only if they have current registrations with the state. Read More

## New Hampshire

**New Hampshire Receives Federal Approval of Medicaid Expansion Work Requirements.** *The Concord Monitor* reported on December 1, 2018, that New Hampshire has won federal approval to implement Medicaid work requirements for its expansion population as part of a five-year reauthorization of the program. Medicaid expansion recipients will need to report 100 hours per month of work or community engagement activities to maintain coverage. Approximately 50,000 Medicaid expansion recipients will be impacted. The work requirement is set to begin as early as April 2019. Read More

## New York

HMA Roundup – Denise Soffel (Email Denise)

**Delivery System Reform Incentive Payment Program Update.** The New York Department of Health convened a meeting of the Project Approval and Oversight Panel (PAOP) to present information on the performance of the 25 Participating Provider Systems (PPSs) participating in the states Delivery System Reform Incentive Payment program (DSRIP). As part of the DSRIP program requirements outlined by CMS, NYS was required to convene a stakeholder panel to review DSRIP applications; the state subsequently extended the work of the panel to serve as an independent oversight body. The presentation included an update on overall DSRIP performance and spending. A representative from the Independent Assessor, PCG, noted that three million Medicaid beneficiaries have been "touched" by a DSRIP project with one of the 25 Performing Provider Systems that are participating in DSRIP. The PPS's have earned 86 percent of potentially available funds, a total of $3.9 billion, for having achieved project-specific milestones and metrics. One of the goals of DSRIP was to increase the number of primary care providers that meet NCQA Level 3 recognition, and over the last two years 7,500 providers have achieved that recognition, 2,500 of which were new Patient Centered Medical Home (PCMH) providers. Distribution of funds to partners outside the PPS has improved, but it continues to be a challenge, as 44 percent of dollars went to hospitals and PPS project management functions. In contrast, 6.6 percent of funds flow went to primary care providers, 3.3 percent went to mental health and 1.2 percent to substance abuse providers. Although PPS's are allowed to share up to five percent of their funds with non-safety net providers including community-based organizations, only 3.2 percent of funds went to community-based organizations.

The PAOP meeting included a presentation on PPS-specific performance, including follow-up after hospitalization for mental illness, prevention quality indicators for asthma, antidepressant medication management, alcohol and drug dependence treatment, and access to preventive care. Finally, the Department of Health provided information on the results of a PPS sustainability survey that they have conducted. They said that they are involved in active internal conversations about applying for an extension of the waiver, although they have not yet opened that conversation with CMS. They noted the challenge that faces the PPS's as the pivot from the DSRIP performance payments to value-based payment with managed care contracts that can support population health, noting it was not clear that VBP contracts would happen quickly enough to sustain DSRIP activities. PPSs have been working to identify what type of successor organization can maintain the data infrastructure that has been built to facilitate the team-based approach that DSRIP encouraged, whether it be an ACO, IPA or MSO.

Information about the meeting, including the presentations and a recording of the session, can be found on the Department of Health website. Read More

**New York South Nassau Joins Mount Sinai Health System.** New York-based South Nassau Communities Hospital and the Mount Sinai Health System have finalized a partnership, making South Nassau Communities Hospital part of the Mount Sinai Health System, one of the largest academic health systems in the nation. As part of the relationship, Mount Sinai will provide $120 million to help expand South Nassau's campus and services, including plans for a new four-story addition in Oceanside with an expanded Emergency Department and new intensive care beds and surgical suites. South Nassau's Board of Directors announced its plans with Mount Sinai in January 2018, after having signed a nonbinding letter of intent in May of 2017. South Nassau's Board of Directors will be retained and direct the day-to-day operations of the Oceanside campus. The South Nassau and Mount Sinai boards will share representation on each other's boards. South Nassau was one of the few remaining independently controlled hospitals on Long Island. The Mount Sinai Health System is New York City's largest integrated delivery system encompassing (with the addition of South Nassau Communities Hospital) eight hospital campuses, a medical school, and a large network of ambulatory practices throughout the greater New York region. Read More

## *Oregon*

**CCOs To Establish Service Areas by County For 2020-2024 Contracts.** The Oregon Health Authority announced on November 28, 2018, that all coordinated care organizations (CCO) will have to match their service areas to county lines for the new 2020-24 contract period. Currently 15 CCOs operate in service areas defined by the state's 2012 RFA, while nine of those do not follow county lines. CCO applicants will be able to seek exceptions to county-wide coverage with justification. Read More

# Pennsylvania

HMA Roundup – Julie George (Email Julie)

**Pennsylvania Receives $10 Million Grant from Bloomberg Philanthropies to Address Opioid Epidemic.** Pennsylvania has been selected as the first state to participate in a three-year initiative with Bloomberg Philanthropies designed to strengthen state and local opioid prevention and treatment efforts. Targeted funding areas for the $10 million grant will include staffing, technical assistance, and data collection over the next three-year period. Read More

**Pennsylvania Home Health Care Companies Involved in Medicaid Fraud Scheme.** *The Associated Press* reported on November 28, 2018, that three home health companies have been implicated in a multi-million dollar Medicaid fraud scheme. According to charges unsealed Tuesday, Moriarty Consultants, Activity Daily Living Services, and Everyday People Staffing received more than $87 million in Medicaid payments for services that were not performed. The alleged fraudulent acts also included creating fake employees, falsifying documents, and submitting claims for consumers who were in jail or dead. Read More

# Tennessee

**TennCare Director Accepts Health Care Post in Nashville.** *The Times Free Press* reported on December 4, 2018, that Wendy Long, M.D., will be leaving her position as director of the state's TennCare Medicaid program, having been named director of health for the Metropolitan Board of Health of Nashville and Davidson County. Long has served as director of TennCare for two and a half years. Read More

# Texas

**Texas Little River Healthcare Seeks to Liquidate Under Chapter 7 Bankruptcy.** *Modern Healthcare* reported on December 1, 2018, that Rockdale, Texas-based Little River Healthcare is seeking to liquidate under Chapter 7 bankruptcy. The company, which originally filed for Chapter 11 bankruptcy protection in July, has been unable to pay its bills or find a buyer. Little River owes more than $1 million in unpaid wages. The company operates the only rural, acute-care hospitals in Rockdale and Cameron, Texas. Read More

# Virginia

**Virginia Medicaid Expansion Enrollment Is Expected to Outpace Projections.** *The Washington Post* reported on November 29, 2018, that more than 117,000 Virginians have enrolled in the state's Medicaid expansion program since open enrollment began on November 1. Virginia is on track to enroll 375,000 individuals by July 2020, compared to a previous projection of 300,000. Coverage is effective on January 1, 2019. Read More

## Wisconsin

**Lawmakers Vote to Enact Medicaid Work Requirements.** *The Associated Press* reported on December 5, 2018, that Wisconsin's Republican-controlled legislature approved an extensive legislative package including a measure to enact Medicaid work requirements before Democratic governor-elect Tony Evers takes office. The state waiver received federal approval for work requirements in October. The bill would also limit the governor's ability to seek future health care waivers. However, the Senate rejected a guaranteed issue measure, with Democrats arguing it would not provide adequate coverage and increase premiums. Read More

## National

**Bipartisan Senate Bill Aims to Lower Drug Pricing.** *The Hill* reported on December 4, 2018, that a bipartisan bill introduced by Senators Chuck Grassley (R-IA) and Ron Wyden (D-OR) aims to lower Medicaid drug prices. The bill would allow the U.S. Department of Health and Human Services (HHS) to crack down on manufacturers intentionally misclassifying a drug in order to pay lower rebates. This bill comes as Mylan, the maker of the branded epinephrine autoinjector EpiPen, paid the government $465 million to settle the company's failure to adequately pay Medicaid rebates. Read More

**Medicaid Work Requirements May Result in Higher Beneficiary Earnings, Report Says.** *Modern Healthcare* reported on December 3, 2018, that Medicaid work requirements could result in an increase in lifetime earnings of nearly $1 million among individuals who transition off of Medicaid, according to the conservative Buckeye Institute. The Centers for Medicare & Medicaid Services (CMS) has approved work Medicaid work requirements in five states. Read More

**HHS Tells States to Scale Back Certificate of Need Rules, Touts Expanded Health Plan Options.** *Modern Healthcare* reported on December 3, 2018, that the U.S. Department of Health and Human Services (HHS) is urging states to scale back certificate of need and scope of practice regulations to help foster competition and push back against hospital consolidation. The recommendations were included in a 120-page report, which also touted the Trump administration's support of limited duration health plans and association plans. Read More

**CMS Says States Can Launch Savings Accounts for Exchange Plan Members.** *Modern Healthcare* reported on November 29, 2018, that states can provide cash contributions to a savings account for use by Exchange plan members to pay premiums and out-of-pocket health expenses, according to Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS). Authority to launch the accounts would come through the Section 1332 State Innovation Waiver process. Verma's comments, which follow the release of CMS guidance on 1332 waivers last month, outlined several other ideas including allowing states to develop new premium subsidy structures, establish rules for which health plans are eligible for state premium subsidies, and implement risk-stabilization strategies. Read More

**HHS Sets January 2019 Start Date for 340B Price Ceiling.** *Modern Healthcare* reported on November 29, 2018, that the U.S. Department of Health and Human Services (HHS) has approved a long-postponed rule that sets ceiling drug prices in the 340B drug discount program. The rule will be effective January 1, 2019. Implementation of the rule was previously expected to occur on July 1, 2019. Read More

**Congress Hits Roadblock In Passing Health Home Program For Chronically Ill Kids.** *Modern Healthcare* reported on November 28, 2018, that disagreements over how to fund the Advancing Care for Exceptional Kids (ACE Kids) Act, a bill that would set up an optional health home program for kids with complex illnesses, have obstructed its Congressional approval. Preliminary estimates by the Congressional Budget Office shows that the bill would cost $300 million. The federal government would pay for 90 percent of Medicaid costs for chronically ill children managed by a provider-coordinated health home. Approximately 300,000 to 500,000 kids could qualify. Read More

**Number of Uninsured Children Increased By 276,000 in 2017, Report Says.** *Modern Healthcare* reported on November 29, 2018, that for the first time since 2008, the number of uninsured children under the age of 19 increased in 2017 over the prior year. Specifically, the number of uninsured children rose by an estimated 276,000 to about 3.9 million in 2017, according to a report by Georgetown University's Center for Children and Families. The report suggested that the increase in uninsured children may be related to concerns around immigration status and would be expected to rise should the federal government finalize a proposed rule penalizing permanent resident applicants for using Medicaid. South Dakota, Utah, Texas, Georgia, South Carolina, and Florida saw the sharpest drops in children enrolled in coverage over the one-year period. Read More


## Industry News

**Centene Executive Cynthia Brinkley To Retire in February 2019.** Centene Corporation announced on December 4, 2018, that chief administrative and markets officer Cynthia Brinkley plans to retire effective February 15, 2019. Until then, Brinkley will continue to focus on Centene Forward, an internal initiative to standardize administrative processes and improve innovation. Following Brinkley's departure, Centene Forward will be co-led by Shannon Bagley, senior vice president of Human Resources, and Jeffrey Schwaneke, chief financial officer. Brent Layton, Executive Vice President & Chief Development Officer, will take over responsibility for the company's international operations. Read More

**Centria Healthcare Acquires Massachusetts-Based Autism Therapy Provider.** Centria Healthcare announced on December 5, 2018, the acquisition of Massachusetts-based Applied Behavioral Associates, LLC., which provides home and community-based applied behavior analysis therapy to children with autism. Financial terms were not disclosed. Read More

**The Columbus Organization Acquires Certain Assets of Progressive Comprehensive Services.** The Columbus Organization announced on December 4, 2018, that it has acquired the support coordination assets of New Jersey-based Progressive Comprehensive Services. The acquisition will allow Columbus, a provider of support coordination and other services for individuals with intellectual and developmental disabilities, to expand to six states and provide services to more than 10,000 individuals, families, and guardians. Financial terms were not disclosed. Read More

**Lyft Names Megan Callahan VP of Healthcare.** *Modern Healthcare* reported on November 29, 2018, that Lyft has selected Megan Callahan as the company's first vice president of healthcare. Callahan, who was previously chief strategy officer at Change Healthcare, will lead Lyft's development of health care transportation services and technology. Read More

# RFP CALENDAR

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| December 2018 | Massachusetts One Care (Duals Demo) | RFP Release | 150,000 |
| 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 |
| 2019 | Louisiana | RFP Release | 1,500,000 |
| 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 |
| Late Spring 2019 | Kentucky | RFP Release | 1,200,000 |
| 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 |
| July 1, 2020 | Kentucky | Implementation | 1,200,000 |
| January 1, 2020 | Louisiana | 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

## New this week on HMA Information Services (HMAIS):

**Medicaid Data and Updates:**

- California Dual Demo Enrollment is Down 3.3%, Oct-18 Data
- Delaware Medicaid Managed Care Enrollment Is 200,108, Oct-18 Data
- Georgia Medicaid Management Care Enrollment is Down 1.4% Dec-18
- Kansas Medicaid Managed Care Enrollment is Flat, Oct-18 Data
- New Mexico Medicaid Managed Care Enrollment is Down 0.8%, Nov-18 Data
- Tennessee Medicaid Managed Care Enrollment is Down 8.6%, Nov-18 Data

**Public Documents:**

*Medicaid RFPs, RFIs, and Contracts:*

- Georgia Medicaid Managed Care Model Contract, Jul-16
- Idaho Systems Integrator for Modular MMIS Reprocurement & Certification RFI, Nov-18
- Maryland Behavioral Administrative Services Organization (ASO) RFP, Nov-18
- Virginia Commonwealth Coordinated Care Plus MLTSS MCO Contracts, 2017-19

*Medicaid Program Reports, Data and Updates:*

- Alaska Medicaid 1115 Behavioral Health Demonstration Waiver Application and Approval, Nov-18
- California Financial Alignment Initiative Cal MediConnect: First Evaluation Report, Nov-18
- Colorado External Quality Technical Reports for Children's Health Plan Plus, 2016-18
- Connecticut Department of Social Services Annual Reports, 2012-17
- Delaware Fiscal Year 2020 Budget Hearing Presentation, Nov-18
- Illinois Financial Alignment Initiative Medicare-Medicaid Alignment Initiative: First Evaluation Report, Nov-18
- Louisiana LDH Advancing Medicaid Managed Care White Paper, Public Comment Summary, Sep-18
- Louisiana Medicaid Managed Care Enrollment by Plan, Region, and Subprogram, 2015-17, Oct-18
- Maryland Medicaid Advisory Committee Meeting Materials, Oct-18
- Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience Report, 2017-18
- Minnesota Medicaid Matters Annual Report, 2017
- Minnesota Medicaid Services Advisory Committee Meeting Materials, Aug-18
- Montana Medicaid Expansion Dashboard, Nov-18
- Montana Medicaid Expansion Beneficiaries Diagnosed with Diabetes, 2016-18
- North Dakota Medicaid Expansion Program Annual Technical Report, 2017
- North Dakota Medicaid Expansion Quality Strategy Plan Draft, 2018

- Nebraska DHHS Division of Behavioral Health Annual Reports, FY 2013-17
- Ohio Medicaid Enrollment by Eligibility Category, 2016-17, Oct-18
- Ohio Financial Alignment Initiative MyCare Ohio: First Evaluation Report, Nov-18
- South Carolina Work Requirement Waiver Public Notice, Dec-18
- Texas Behavioral Health Strategic Plan Progress Report, Dec-18
- Texas HHS Coordination of Medicaid Dental and Medicaid Services Report, Dec-18
- Texas HHS Evaluation of Pharmacy Service Delivery Models Report, Dec-18
- Texas HHS Quality Measures and Value-Based Payments Annual Report, Dec-18
- Vermont Executive Budget Recommendations, FY 2019
- West Virginia Medical Services Fund Advisory Council Meeting Materials, Jun-18

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