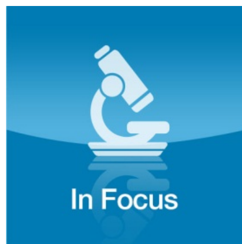
HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 9, 2019



RFP CALENDAR
HMA News

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THIS WEEK

- IN FOCUS: HMA EXPERTS CONTRIBUTE TO REPORT ON HEALTH DISPARITIES IN MINNESOTA'S MEDICAID POPULATION
- AZ, FL, NM NAME MEDICAID DIRECTORS
- CALIFORNIA GOVERNOR ORDERS TRANSITION OF MEDICAID PHARMACY BENEFIT FROM MANAGED CARE TO FFS
- FLORIDA REJECTS REBID OF MEDICAID MANAGED CARE CONTRACT AWARD FOR HIV/AIDS
- VIRGINIA MEDICAID DIRECTOR CALLS FOR OVERHAUL OF FORECASTING, RATE-SETTING PROCESSES
- CMS NAMES CHRIS TRAYLOR ACTING DIRECTOR OF CENTER FOR MEDICAID AND CHIP SERVICES
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- TA ASSOCIATES COMPLETES INVESTMENT IN BEHAVIORAL HEALTH WORKS
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IN FOCUS

HMA EXPERTS CONTRIBUTE TO REPORT ON HEALTH DISPARITIES IN MINNESOTA'S MEDICAID POPULATION

This week, our *In Focus* section reviews a report recently submitted to the Minnesota Legislature, *Accounting for Social Risk Factors in Minnesota Health Care Program Payments*. The report delivers Minnesota Department of Human Services (DHS) recommendations to reduce health disparities among Medicaid and other DHS program participants. Under the direction of Dr. Justine Nelson, PhD, of DHS, the research team included Ellen Breslin, MPP and Dr.

Anissa Lambertino, PhD from Health Management Associates (HMA), partner colleague Dennis Heaphy, MPH, of the Disability Policy Consortium, and consultant Tony Dreyfus, MCP. Dr. Lori Raney and Dr. Greg Vachon of HMA and Dr. Suzanne Mitchell, formerly of HMA, also provided clinical input.

DHS hired HMA to identify Medicaid populations who experience the greatest health disparities and their related health care costs to the Medicaid program. The team conducted a ground-breaking, comprehensive, quantitative analysis of the relationship between Medicaid enrollees' social risk factors and health outcomes. Extensive data and analytic work was conducted by the HMA team and by Minnesota DHS, using used enrollment and medical claims data, as well as other data from DHS. The analysis includes a review of Medicaid enrollees' mortality, the prevalence of physical chronic conditions (e.g. diabetes), the prevalence of behavioral health conditions (e.g., post-traumatic stress disorder), and whether enrollees received recommended preventive healthcare over the course of a year. To measure health disparities, the team developed a conceptual framework shaped by several sources, including literature, provider input, and the work of nationally recognized organizations.

Key Findings

HMA found that the following groups had significantly worse health outcomes than their fellow enrollees, even when controlling for patient demographics, geography and other social risk factors. A brief summary of the findings that are included in the report to the Minnesota Legislature are provided here. Please refer to the report for a more comprehensive set of findings.

Substance Use Disorder (SUD)

Adults with a recently-diagnosed SUD had higher rates of every chronic condition measured than those without SUD. They are four and a half times as likely to have post- traumatic stress disorder (PTSD), five times as likely to have depression, and twice as likely to have physical conditions such as hypertension, and heart conditions such as a heart attack or heart disease which require hospitalization. Adults with SUD had dramatically higher health care costs than other adults on Medicaid and three times the usual rate of preventable hospitalizations.

Serious and Persistent Mental Illness (SPMI)

Adults with SPMI were 50 percent more likely to have asthma and diabetes and 20 percent more likely to have hypertension or chronic obstructive pulmonary disease (COPD), compared to adults without SPMI. Fifty percent of people with an SPMI also have an SUD. Adults with SPMI had the highest medical costs of any group that was examined.

Deep Poverty (At or Below 50 Percent of Federal Poverty Level (FPL))

Medicaid adults in deep poverty had higher rates of every chronic condition measured in the study. They had a mortality rate two times higher than adults who were not poor and had more preventable Emergency Department (ED) visits and hospitalizations. Medicaid children in deep poverty also had a mortality rate two times higher than those who are not poor.

Homelessness

While adults who are homeless are 5 percent less expensive to Medicaid than those who are not homeless, their health outcomes were worse for asthma, HIV/Hep-C, hypertension, COPD, depression, PTSD, and SUD, with higher rates of preventable ED visits and hospitalizations.

Previous Incarceration

Medicaid adults who were previously incarcerated were more likely to have health conditions such as COPD, depression, PTSD, and SUD than those not previously incarcerated.

Child Protection Involvement

Child protection involvement was the strongest predictor of poor health outcomes among children. Children were more likely to have ADHD, asthma, PTSD, and to develop SUD as a teenager.

Native American Heritage

In addition, HMA reviewed the health outcomes of different racial/ethnic groups. Native Americas had dramatically worse mortality rates, a much higher rate of chronic conditions, and more high-cost potentially preventable health care than those with any other group. They are more likely to have diabetes, hypertension, heart disease, PTSD and SUD. Children are more likely to have asthma, and newborns are more likely to have conditions requiring a higher level of medical care.

Next Steps for Minnesota

Minnesota has initiated a number of projects to address health disparities. This includes the Integrated Health Partnership program that rewards providers for improving health care outcomes and controlling health care costs. Additionally, CMMI (CMS) State Innovation Model (SIM) funding was awarded to organizations that sought to reduce health care costs and improve quality through patient-centered collaborations. Through community and provider-based programs, these organizations supported individuals with social risk factors such as SUD, mental health illness, homelessness, food insecurity, poverty and/or incarceration. Meanwhile, Minnesota's research team is continuing to investigate the most promising interventions related to homelessness and SUD.

For more information, contact Ellen Breslin.

A copy of Minnesota's report can be found here. HMA's summary report can be found here. HMA can also make available a White Paper on this topic.

HMA Medicaid Roundup

Arizona

Medicaid Agency Seeks 3.6 Percent Increase in Fiscal 2020 Budget. *State of Reform* reported on December 27, 2018, that the Arizona Health Care Cost Containment System (AHCCCS) is seeking $14.32 billion in funding for fiscal 2020, up 3.6 percent. The request, which was submitted to Governor Doug Ducey's Office of Strategic Planning & Budgeting, includes $2.15 billion in appropriated funds and $12.17 billion in federal and other non-appropriated funds. AHCCCS has also asked for an increase in funding for Arizona's Long Term Care System. Separately, the Arizona Department of Health Services is asking for $474.8 million, comprised of $147.6 million in appropriated funds and $327.2 million in non-appropriated funds. Ducey's budget proposal is expected to be released in early January. Read More

Law Protecting Patients From Surprise Medical Bills Goes Into Effect. *The Arizona Capitol Times* reported on December 31, 2018, that a new Arizona state law designed to protect patients from "surprise" out-of-network medical bills went into effect on January 1, 2019. Under the new law, patients can ask the Arizona Department of Insurance to determine whether a bill is a "surprise," which would limit patient liability to their plan's copay, deductible, or cost-sharing requirement. The law requires the disputed bill to be at least $1,000 and does not apply to individuals enrolled in an HMO. Read More

Arizona Names Jami Snyder Medicaid Director. Arizona Governor Doug Ducey announced on December 31, 2018, the appointment of Jami Snyder as director of the Arizona Health Care Cost Containment System (AHCCCS). Snyder, who was formerly deputy director, will replace longtime AHCCCS head Tom Betlach, who retires on January 4. Read More

Maricopa Integrated Health System Board Names Mark Dewane Chairman. *AZ Big Media* reported on December 5, 2018, that the five-member board overseeing the Maricopa Integrated Health System (MIHS) has named Mark Dewane chairman, effective immediately. The board also named former Litchfield Park, AZ, mayor Woodfin Thomas as the newest board member. Dewane has served on the board since 2012. Read More

Arkansas

Centene to Acquire QualChoice. *The Arkansas Democrat Gazette* reported on January 4, 2019, that St. Louis-based Centene has entered into a definitive agreement to acquire QualChoice Health Insurance, an Arkansas group and individual managed care plan. The deal, which requires state regulatory approval, would bolster Centene's market share in the state. Centene is the third largest managed care plan in Arkansas, and QualChoice is fourth. Read More

California

Governor Orders Transition of Medicaid Pharmacy Benefit from Managed Care to FFS. In his first act as Governor of California on January 7, 2018, Gavin Newsom ordered the state Department of Health Care Services "to take all necessary steps to transition all pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 2021." The executive order also directs the state to "develop and implement bulk purchasing arrangements for high-priority drugs." According to the order, 25 drugs account for about half of the state's drug spending. The state will also encourage local governments to participate in the purchasing arrangement and develop a framework for private purchasers to benefit. The change could set up California to be "the nation's largest single-purchaser system for prescription drugs." Read More

California Medicaid Determines Company Improperly Denied Care. *The Los Angeles Times* reported on December 19, 2018, that California Medicaid regulators have determined that care coordination company Agilon Health improperly denied or delayed care for at least 1,400 patients. The state Department of Managed Health Care is investigating further. Agilon, which serves about 400,000 Medicaid members in the state, found after an internal investigation that some patients experienced modest delays in care but there was no evidence of "systemic denials." Read More

Colorado

Lawmakers Introduce Public Option Health Plan Legislation. *The Denver Post* reported on January 4, 2019, that Colorado lawmakers introduced two bills aimed at creating a public option health insurance plan. The Senate bill would create a public option for individuals in the high-cost western slope region starting in fall 2019. The House bill, sponsored by Rep. Dylan Roberts (D-Avon), would expand the program statewide in 2020. The public option plan would reimburse providers at rates similar to Medicare. Other bills introduced would increase hospital billing transparency, expand opioid treatment, and allow state residents to import prescription drugs from Canada. Read More

Colorado Medicaid Buy-in Option Would Be 28 Percent Less Expensive than Individual Plan Coverage, Study Says. Manatt Health released a report on December 19, 2018, projecting that a proposed Colorado Medicaid "buy-in" option would be 28 percent less expensive than buying coverage on the individual market. Read More

Florida

Florida Rejects Rebid of Medicaid Managed Care Contract Award for HIV/AIDS. *News4Jax* reported on January 4, 2019, that Florida has rejected an administrative law judge's recommendation that the state rebid its Medicaid managed care contract for HIV/AIDS services. The judge had ruled last year that the Florida Agency for Health Care Administration didn't follow its own procurement rules in awarding the contract to Simply Healthcare Plans. AIDS Healthcare Foundation/Positive Healthcare, which had protested the award, has now appealed the state's decision to the Florida 1st District Court of Appeal. Read More

Governor-Elect Names Mary Mayhew to Run Health Agency. *The Tampa Bay Times* reported on January 4, 2019, that Florida Governor-elect Ron DeSantis has named Mary Mayhew, formerly a top Medicaid official in the Trump administration, to run the state's Agency for Health Care Administration. Mayhew was most recently deputy administrator and director of the federal Center for Medicaid and CHIP Services. She also served as commissioner of the Maine Department of Health and Human Services under Governor Paul LePage. Mayhew is a staunch opponent of Medicaid expansion. Read More

Florida Faces Lawsuit Over Medicaid HCBS Waiting List for Disabled, Elderly. *WJCT* reported on January 2, 2019, that the Florida Agency for Health Care Administration is facing a lawsuit concerning wait times of more than 3 years in some cases for approval of in-home, long-term health care services. Enrollment in the long-term care program is capped, with about 50,000 individuals on the waiting list. Currently, about 22 percent of the state's Medicaid long-term care spending goes to home and community-based services, compared to the national average of 45 percent. Read More

Florida Provider System Lee Health Launches Medicaid Plan in Southwest Region. *The Fort Myers News-Press* reported on December 31, 2018, that Florida health care system Lee Health launched Vivida Health, a Medicaid managed care plan targeting a share of the 200,000 eligibles in the state's southwest region. Lee, which won a state contract to offer a provider service network, already treats the majority of Medicaid members in the local area. Read More

Georgia

Lawmakers Propose Legislation to Alter State's Certificate of Need Law. *The Atlanta Journal-Constitution* reported on January 9, 2019, that efforts to alter Georgia's provider certificate of need laws have gained momentum in the state legislature. Senator Ben Watson (R-Savannah) has drafted legislation, while Georgia House Speaker David Ralston (R-Blue Ridge) has appointed a committee to craft a bill. Committees in both chambers have studied the issues in recent months. The House Rural Development Council, led by Rep. Terry England (R-Auburn) and the chair of the chamber's Appropriations Committee, has recommended lifting CON laws in Atlanta and relaxing them throughout the rest of the state. Read More

Idaho

Governor-Elect Commits to Implementing Voter-Approved Medicaid Expansion. *The News Tribune/Associated Press* reported on January 3, 2019, that Idaho Governor-elect Brad Little has committed to implementing the state's voter-approved Medicaid expansion, while expressing concerns over logistics and funding. Some state lawmakers suggest the possibility of implementing expansion with a work or training requirement. An estimated 60,000 low-income adults would be eligible for Medicaid under the expansion. Read More

Iowa

UnitedHealthcare Community Plan of Iowa Names Alissa Weber CEO. *The Gazette* reported on January 3, 2019, that UnitedHealthcare Community Plan of Iowa has named Alissa Weber as chief executive, effective January 15. Most recently, Weber served as the chief financial officer for the Iowa plan. UnitedHealthcare covers more than 420,000 Medicaid members in the state. Read More

Kansas

Kansas Wins CMS Waiver Renewal of Medicaid Managed Care Program. *The Hays Post* reported on December 19, 2018, that the Centers for Medicare & Medicaid Services (CMS) has approved Kansas' 1115 waiver extension application to continue operating the state's Medicaid managed care program, KanCare. The application includes approval of a supported employment pilot for individuals with disabilities, a waiver of the 15-day monthly maximum for Substance Use Disorder Institute for Mental Disease (IMD) utilization for individuals ages 21 to 64 years, and extension of the Delivery System Reform Incentive Payment program. The original waiver application included Medicaid work requirements. However, they will not be enforced because of budgetary provisions the legislature recently added. Read More

Kansas Is Site of New Aetna Model for Members With IDD. Aetna announced on December 20, 2018, that it will be launching an outcomes-based model for individuals with intellectual and development disabilities (IDD) on January 1, 2019, in Kansas. The new model will allow Aetna Medicaid beneficiaries with IDD to work with service coordinators to connect to community resources, quality support practices, and technology. The model will be based on the Charting the LifeCourse framework developed by the University of Missouri-Kansas City (UMKC) Institute for Human Development, Missouri's University Center for Excellence in Developmental Disabilities Education, Research and Services. Read More

Kentucky

Kentucky Again Launches Medicaid Copays. *WPSD Local 6* reported on January 2, 2019, that Kentucky has again launched copays for Medicaid members effective January 1, 2019, after abruptly cancelling a similar policy enacted last year. Copays are $3 for physician office visits, $50 for inpatient services, $4 for outpatient hospital services, and $8 for emergency room visits for a non-emergency service. Generic prescription medication will carry a $1 copay, while brand drugs will carry a $4 copay. Exemptions include pregnant women, children, and individuals under 100 percent of the federal poverty level. Read More

Medicaid Plan to Receive $24 Million In Federal Tax Credits for New Headquarters. *Insider Louisville* reported on December 20, 2018, that not-for-profit Passport Health Plan will receive $24.4 million in federal tax credits toward construction of the Passport Health and Well-Being Campus. The company will move its headquarters to the new location in 2020. Read More

Maine

Governor Janet Mills Signs Executive Order to Implement Medicaid Expansion. *The Portland Press Herald* reported on January 3, 2019, that newly elected Maine Governor Janet Mills has signed an executive order to implement the state's voter-approved Medicaid expansion. More than 70,000 individuals earning up to 138 percent of the federal poverty level would become eligible for Medicaid under the expansion. Mills authorized coverage retroactively for about 4,500 individuals who applied for coverage but were denied in 2018. Read More

Maine Receives CMS Approval for Medicaid Work Requirements. *Modern Healthcare* reported on December 21, 2018, that the Centers for Medicare & Medicaid Services (CMS) has approved Maine's Medicaid work requirements waiver. All traditional Medicaid beneficiaries in the state will be required to work, train or participate in community engagement activities for at least 20 hours per week and will have to pay monthly premiums to maintain coverage. CMS has approved similar requirements in Michigan, Wisconsin, Arkansas, Indiana, Kentucky, and New Hampshire. Read More

Massachusetts

Massachusetts Releases One Care Databook. MassHealth released on December 24, 2018, the One Care Databook and Eligibility and Enrollment File. The file contains summarized demographic and cost data related to eligible populations and covered services for One Care, the state's dual eligible demonstration. Additional Medicare data is expected in 2019. HMA has prepared a 22-page high-level summary for interested parties. Please contact Ellen Breslin at ebreslin@healthmanagement.com. In 2017, HMA estimates that there were 127,000 persons eligible for the One Care program. That number is based on the total number of reported member months. The total population in 2017 includes 17,300 One Care enrollees and 109,400 persons who were not enrolled. The One Care Databook also includes 2017 financial experience data reported by current One Care plans. The data show plans spent an estimated $546.9 million on Medicaid and Medicare services for One Care enrollees. A One Care RFP is expected to be released in 2019.

Michigan

Michigan Wins CMS Approval for Medicaid Work Requirements. *The Detroit News* reported on December 21, 2018, that the Centers for Medicare & Medicaid Services (CMS) approved Michigan's Medicaid work requirements waiver. Medicaid expansion beneficiaries in the state ages 19 to 62 must report a minimum of 80 hours of work, training, or volunteer activities. Michigan's newly elected Governor Gretchen Whitmer opposes the work requirements, which could apply to 540,000 able-bodied adults enrolled. Read More

Minnesota

Lawmakers Eye Alternatives to Provider Tax. *The Pioneer Press/Associated Press* reported on January 1, 2018, that Minnesota lawmakers are eyeing alternatives to the state's two percent provider tax, which helps fund the state's Medicaid and MinnesotaCare programs. The tax is set to expire in 2020, leaving a $700 million annual hole in the state budget. Among the possibilities are a renewal of the existing tax or a new two percent fee on claims processed by health insurers and administrators of self-insured medical benefits. Read More

Mississippi

GOP Governor Considers Medicaid Expansion. *Politico* reported on December 22, 2018, that Mississippi Republican Governor Phil Bryant, who is in his final term, has been in talks to expand Medicaid. The move comes as Mississippi Attorney General Jim Hood, a Democrat, has decided to make Medicaid expansion a central issue in the 2019 gubernatorial race. Approximately 200,000 low-income adults would be eligible for health coverage if Mississippi expands Medicaid. Read More

Montana

Lawmakers Likely to Renew Medicaid Expansion, But Disagree on Work Requirements. *The Flathead Beacon/Associated Press* reported on January 7, 2019, that Montana lawmakers are likely to renew the state's Medicaid expansion; however, Republicans and Democrats disagree over work requirements and other potential changes. Senate President Scott Sales (R-Bozeman) is calling for work requirements and means and asset testing. Democrats favor a voluntary work force training program already in place. Read More

Nebraska

Nebraska Launches Website For Medicaid Expansion Updates. *Live Well Nebraska* reported on December 20, 2018, that Nebraska launched a website aimed at regularly updating residents on progress in the state's Medicaid expansion program. The expansion measure, which was approved by voters in November, became law last week. An estimated 90,000 individuals will be eligible for Medicaid coverage. Read More

New Jersey

New Jersey Caregiver Task Force Legislation Signed. On December 28, 2018, New Jersey Acting Governor Sheila Oliver signed legislation (S959) to create the New Jersey Caregiver Task Force. The Caregiver Task Force will assess support services available to caregivers and recommend improvements and expansion of these services. It will issue a report within the next year. The Murphy Administration has expressed its commitment to supporting caregivers and related programs.

New Jersey Seeks State Plan Amendment to Add Autism Services to EPSDT. *NJBiz* reported on December 20, 2018, that the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) in conjunction with the Department of Children and Families, Children's System of Care (DCF/CSOC) is seeking a state plan amendment (SPA) from the Centers for Medicare & Medicaid Services (CMS) to include Autism Spectrum Disorder (ASD) related services for Medicaid enrollees who qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Youth with ASD will have access to an individualized and coordinated and multidisciplinary set of services. DMAHS estimates that autism-related services will total $25.5 million between fiscal years 2019 and 2020. There will be an Autism Public Forum on January 9, 2019 from 9 am to noon for public input on the proposed SPA at the New Jersey State Police Headquarters Complex, 3 Schwarzkopf Drive in Ewing. Read More

New Jersey Medicaid will Seek Federal Approval to Allow Office-Based Addiction Treatment (OBAT). The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued a public notice on December 20, 2018, of plans to seek approval from the Centers for Medicare & Medicaid Services (CMS) to amend the State Plan and the Alternative Business Plan to allow three tiers of treatment for addiction: 1) primary care services, 2) FQHC and clinic-based Opioid Treatment Providers, and 3) educational centers as a resource for treatment, training and mentoring. OBATs must include care coordination services. A copy of the notice can be found here.

2019 Marketplace Enrollments Decrease. *NJ.com* reported on December 20, 2018, that close to 20,000 fewer New Jersey residents were enrolled in the Affordable Care Act (ACA) marketplace plans during the 2019 open enrollment period. In 2018, there were about 275,000 individuals enrolled and in 2019 there will be about 257,000 enrollees. While New Jersey policymakers attribute the decline to the federal decision to shorten the 2019 enrollment period from three months last year to six weeks and reduced advertising funds, the New Jersey Policy Perspective expects that some residents may have signed up for plans without using the healthcare.gov website. At the same time policy leaders expect that some individuals in the Latino community may have declined coverage in response to national anti-immigrant concerns. The Center for Medicare & Medicaid Services (CMS) will provide final enrollment numbers in March 2019. Read More

New Jersey Releases 2018 Medicaid Scorecard on Payment Reform 2.0. The New Jersey Health Care Quality Institute (NJHCQI) published a baseline payment reform scorecard for the State's Medicaid program which was developed by Catalyst for Payment Reform (CPR) using 2016 data. CPR's scorecard methodology was piloted in New Jersey, as well as Colorado and Virginia. CPR collected data from four Medicaid MCOs representing 1.6 million enrollees on base payment methods and value-oriented payments to providers meeting quality and efficiency standards. According to the New Jersey 2018 Medicaid Payment Reform baseline scorecard:

- Fee-for-service is the dominant base method for paying providers under Medicaid value-based arrangements. This experience is comparable to commercial payment reform in the State.
- Just 1 percent of New Jersey Medicaid value-based payments put providers at downside financial risk while 5.5 percent of the State's commercial payments are at risk.
- About 11 percent of Medicaid payments in New Jersey are value-based – linked to performance or to reducing preventable utilization, compared with 52 percent of commercial payments:
  - 6.1 percent of Medicaid payments were under shared savings arrangements (compared with 37.9 percent commercial);
  - 4.5 percent of Medicaid payments were pay-for-performance (compared with 11.2 percent commercial)
  - 0.1 percent of Medicaid payments were bundled (the only at-risk payment category, and compared with 0.6 percent commercial)
- 56 percent of health plan members were associated with providers under payment reform contracts.

The complete scorecard and methodology can be found here.

Medical Assistance Advisory Council (MAAC) Releases 2019 Meeting Dates. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services published the public meeting dates for 2019. All MAAC meetings will be held from 10 am to 1 pm at the New Jersey State Police Headquarters Complex, in the PHEAL building at 3 Schwarzkopf Drive in Ewing, New Jersey.

- January 16, 2019
- April 25, 2019
- July 25, 2019
- October 24, 2019

New Mexico

New Mexico Names Nicole Comeaux Medicaid Director. On January 4, 2019, New Mexico Governor Michelle Lujan Grisham announced that Nicole Comeaux will be the new director of the state's Medical Assistance Division, effective January 7. Previously, Comeaux served as deputy executive director of the Kentucky Health Benefit Exchange and as a senior advisor to the Data and Systems Group of the Centers for Medicare & Medicaid Services (CMS). Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York City to Improve Access to Care, Coverage for Uninsured, Undocumented Residents. *The New York Times* reported on January 8, 2019, that New York City Mayor Bill de Blasio has announced NYC Care, an effort to enhance existing low-income health insurance coverage and spend $100 million to directly support access to care for some 600,000 uninsured city residents, including 300,000 undocumented individuals. The program is expected to be launched in the Bronx in the summer of 2019, and roll out citywide over two years. The insurance component of NYC Care will focus on improving coverage already provided to 516,000 individuals through MetroPlus, which is owned by city hospitals, and trying to reach additional young and uninsured eligibles. The direct spending component will include efforts to connect people with primary care providers before they need more expensive emergency room care. Read More

Mental Health and Substance Use Disorder Parity Report Act Signed Into Law. On December 21, 2018, New York Governor Cuomo signed the Mental Health and Substance Use Disorder Parity Report Act into law. The law requires insurers, health plans, and behavioral health management companies to submit key data and information to the New York Department of Financial Services for analysis and evaluation of compliance with federal and state mental health/substance use disorder parity laws culminating in the publication of a report on the Department's website. The Act is meant to provide additional accountability and transparency. Read More

Governor Announces Capital Funding for Addiction Treatment Services. On January 8, 2019, New York Governor Andrew Cuomo announced up to $10 million in capital funding is available to expand addiction treatment services. The funding, through the New York State Office of Alcoholism and Substance Abuse Services, will support the development of up to 40 new withdrawal and stabilization (short-term) or residential treatment (longer-term) beds across the state. Priority for funding through this Request for Applications (RFA) will be given to providers in areas where these services are not currently available. Responses are due by February 19, 2019. Read More

Independence Care System to Close MLTC Plan, Transition to Health Home. Independence Care System (ICS) announced it will be closing its Medicaid managed long-term care plan on March 31, 2019. The plan has suffered financial challenges largely because of its commitment to keep individuals with serious disabilities at home and in the community. The 5,825 ICS members will be transferred to another MLTC, VNSNY CHOICE, which currently serves 13,000 Medicaid enrollees. Members who are enrolled with ICS and who transition to VNSNY CHOICE will be guaranteed a minimum of one year of the same level of care they have now; members who select another plan will be guaranteed continuity of care for 120 days. ICS will transition into becoming a health home, providing care management with a continued focus on serving people with physical disabilities to help them live independently, in their communities. The ICS Health Home will help its members to coordinate their health care and gain access to community resources they need. In addition, ICS will contract with VNSNY CHOICE to provide care management services for their current qualifying members with physical disabilities.

Citizens Budget Commission Presents Options for Health System Transformation. On December 17, 2018, at a forum on economic and fiscal issues facing New York, Citizens Budget Commission (CBC) President Andrew Rein presented an analysis of options for the state in the next stage of health system transformation. Rein explored options addressing insurance and access, including an individual insurance mandate, and establishing a public plan, as well as delivery system reform, including reference pricing, bundled payment, social determinant interventions, behavioral health integration administrative simplification. Each option was evaluated in terms of cost, access, outcomes and feasibility. This package of targeted improvements was considered more feasible than a single payer approach, although Rein acknowledged that single payer would likely improve access and outcomes. Three respondents – Beatrice Grause, President, Healthcare Association of New York State; Karen M. Ignagni, President & Chief Executive Officer, EmblemHealth; and Helen Schaub, Vice President & New York State Director of Legislative Affairs and Policy, 1199SEIU United Health Care Workers East – provided additional insight into what health policy issues to expect in the new legislative session, which begins January 9, 2019. A recording of the presentation, along with written materials, is available on the CBC website. Read More

New York Announces Health Insurance Gains. On January 4, 2019, the New York State of Health, New York's official health plan marketplace, announced that as of January 1, 2019, more than 254,000 New Yorkers have enrolled in a Qualified Health Plan (QHP). With less than one month to go in the state's 2019 Open Enrollment Period, the number of QHP enrollees has already exceeded QHP enrollment at the end of the 2018 Open Enrollment Period. Among the QHP enrollees, 22 percent are new customers and 78 percent are returning customers. Read More

Coalition Forms in Opposition to Single Payer Proposal. Both houses of the New York legislature have indicated that they plan to pass legislation that would establish a single payer system in the state. A coalition of 40 organizations has formed in response, opposing the legislation. The coalition is made up of chambers of commerce, business groups and health care providers from across the state. While the group supports the concept of universal coverage, they oppose a single payer approach as being overly disruptive to the health care system, as well as being prohibitively expensive. The New York Health Act, which would establish a single payer system, is likely to be introduced early in the legislative session, which begins on January 9, 2019. Both houses of the legislature have solid majorities who have co-sponsored, voted for, or campaigned supporting the act. Governor Cuomo has indicated that he supports the concept of single payer but is not convinced of its feasibility at the state level. Read More

Department of Financial Services Announces New Superintendent; Commissioner for Office for People with Developmental Disabilities. The Superintendent of the Department of Financial Services, Maria Vullo, announced her resignation earlier this month. On January 4, 2019, Governor Cuomo announced that he was naming Linda Lovewell as her replacement. Vullo has led the Department, which oversees health insurance in addition to other financial services including banking and other insurance markets, for the last three years. Lacewell currently serves as Chief of Staff and Counselor to Governor Cuomo. Lacewell began working for Cuomo in 2007, when he was Attorney General.

Governor Cuomo also announced he is nominating Theodore Kastner to be Commissioner of the New York State Office for People with Developmental Disabilities. Dr. Kastner previously served as the founder and President of Developmental Disabilities Health Alliance, Inc., an integrated primary care mental health practice for persons with intellectual and developmental disabilities in New Jersey. He is replacing Kerry Delaney, who served as acting Commissioner since 2014. Delaney recently left the agency to become CEO of Partners Health Plan, a Medicaid managed care plan serving individuals with developmental/intellectual disabilities. Read More

New York Provides Updated Timeline on Transition to Managed Care for Children's HCBS Services. Just two weeks before the long-planned roll-out of the Children's Medicaid System Transformation, New York announced on December 21, 2018, delays in the implementation timeline at a meeting of the New York Children's Medicaid Redesign Team (MRT) subcommittee. Among the timeline changes, the transition of the billing for current home and community-based (HCBS) children to managed care is delayed until further notice. Additionally, providers now have until January 31, 2019 to document medical necessity and update the Plan of Care for Children and Family Treatment and Support Services (CFTSS).

The transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new HCBS services to the Medicaid benefit. Children currently enrolled in the state's 1915(c) waiver are being transitioned to a Health Home Care Management or Independent Entity plan.

The transition, which began on January 1, 2019, moves six HCBS waivers into one, including waivers for the Office of Mental Health Serious Emotional Disturbance, Department of Health Care at Home I/II waiver, Office for People with Developmental Disabilities Care at Home waiver, Office of Children and Families Bridges to Health SED waiver, B2H Developmental Disability waiver, and B2H Medically Fragile waiver. The single waiver is expected to streamline eligibility processing and provide a single HCBS benefit package for children. Read More

Ohio

Medicaid Delays Plans to Implement Unified Preferred Drug List. *The Columbus Dispatch* reported on December 24, 2018, that the Ohio Department of Medicaid announced plans to delay indefinitely a move to a unified preferred drug list. Implementation had been planned for January 1, 2019, and was projected to save $42 million according to the administration's 2018-19 budget proposal. Ohio Medicaid is moving forward with a new pass-through reimbursement model for drugs starting on January 1, which eliminates spread pricing by pharmacy benefit managers. Read More

Department of Developmental Disabilities Director to Retire. *The Columbus Dispatch* reported on December 31, 2018, that John Martin will retire as the director of the Ohio Department of Developmental Disabilities in January. Martin has served as director for 12 years, serving under both Democratic and Republican governors. Under Martin's tenure, fewer people live in state-run developmental centers and private residential centers, and more people have Medicaid waivers and community jobs. Read More

Department of Developmental Disabilities Technology First Council Proposes Benchmarks. *The Gongwer News* reported on December 31, 2018, that the Ohio Department of Development Disabilities Technology First Council's forthcoming report lays out a framework for expanding the use of technology. Benchmarks include increasing the number of certified technology vendors from six to ten and expanding capacity for delivering remote supports with paid back-up. Additionally, benchmarks include measures to increase awareness of technology that aids people with developmental disabilities. Read More

Managed Long Term Care Services Study Committee Releases Report. *The Gongwer News* reported on January 2, 2019, that the Ohio Patient-Centered Medicaid Managed Care Long-Term Services and Supports (MLTSS) Study Committee released its report. The legislative study committee was tasked with examining a move to statewide MLTSS proposed in the last budget. The report does not make any specific policy recommendations. Instead, it includes a compilation of testimony by stakeholders including provider groups, consumer advocates, and managed care plans. The report is intended to be used as a primer and guidance if the issues re-emerges in the next budget. Read More

Governor's Veto of Medicaid Expansion Freeze to Stand. *Cleveland.com* reported on December 27, 2018, that Ohio Governor John Kasich's 18-month-old veto of a bill that would have frozen Medicaid expansion enrollment will stand. A spokesperson for House Speaker Ryan Smith (R-Bidwell) said the veto will not come up for an override vote. Read More

Oklahoma

Medicaid Work Requirements Waiver Application Open for Public Comment. *News 9/The Associated Press* reported on December 24, 2018, that the Centers for Medicare & Medicaid Services (CMS) is seeking input on Oklahoma's new Medicaid work requirements proposal. The public comment period is open until January 20, 2019. The state's work requirements would require Medicaid beneficiaries between the ages 19 and 50 to work or be looking for employment for at least 80 hours a month. The Oklahoma Health Care Authority estimates the work requirements would impact about 6,000 individuals. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Congressmen Request CMS Guidance Regarding UPMC-Highmark Agreement Expiration. *The Pittsburgh Post-Gazette* reported on December 26, 2018, that Pennsylvania senators and representatives have asked for guidance from the Centers for Medicare & Medicaid Services (CMS) to give more information to patients who will be affected in six months by a split between Pittsburgh-based Highmark and UPMC. Starting July 1, 2019, approximately 175,000 Highmark Medicare Advantage plan members in western Pennsylvania will lose in-network access to 11 UPMC hospitals and other UPMC doctors. Sens. Bob Casey and Pat Toomey, plus U.S. Reps. Mike Doyle, Mike Kelly, and Conor Lamb wrote to CMS Administrator Seema Verma describing "significant confusion among beneficiaries" during the latest Medicare open enrollment period. In their letter, the lawmakers did not ask Verma or CMS to take any specific action but did ask Verma to "provide information on what CMS may be able to do or has done to ensure that both parties have provided beneficiaries in Western Pennsylvania with the information necessary to appropriately plan for their care for the entirety of plan year 2019. Read More

Puerto Rico

Puerto Rico Medicaid Stops Covering Hepatitis C Drugs. *Kaiser Health News* reported on January 4, 2018, that the Puerto Rico Medicaid program no longer covers hepatitis C drugs, after a pilot program to pay for the medications ran out of funding. According to the Center for Health Law and Policy Innovation of Harvard Law School, more than 11,000 hepatitis C cases where reported to the Puerto Rico Department of Health from 2010 through September 2016. Read More

Virginia

Medicaid Director Calls for Overhaul of Forecasting, Rate-Setting Processes. *The Richmond Times-Dispatch* reported on January 7, 2019, that the Virginia Department of Medical Assistance Services (DMAS) is seeking a comprehensive overhaul of the agency's forecasting and rate-setting processes for Medicaid managed care. DMAS director Jennifer Lee requested the overhaul after the state identified a $462.5 million Medicaid budget gap, largely from the state's Commonwealth Coordinated Care Plus program, which serves 230,000 complex long-term care members. The agency will hire an outside consultant to review its process and has moved its rate setting deadline from January 1 to June 30 to ensure increased oversight. Read More

Virginia Medicaid Expansion Enrollment Surpasses 180,000. *The Richmond Times-Dispatch* reported on December 19, 2018, that more than 180,000 Virginians have enrolled in the state's Medicaid expansion program, with coverage effective January 1, 2019. Virginia expects to enroll 360,000 individuals by the end of 2019 and is on track to enroll 375,000 individuals by mid-2020. Read More

Washington

Integrated Managed Care Expands to Four More Regions. On January 1, 2019, Washington's Medicaid program, Apple Health, expanded Integrated Managed Care (IMC) to four new regions: Greater Columbia region (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties), King region, Pierce region, and Spokane region (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties). Additionally, Okanogan County will join the North Central region, and Klickitat County will join the Southwest Washington region, already implemented. By 2020, Washington intends to implement IMC statewide. The program coordinates physical health, mental health, and substance use disorder treatment services under one health plan. Read More

Governor Proposes Public Option Exchange Plan. *The Seattle Times* reported on January 8, 2019, that Washington Governor Jay Inslee has proposed legislation aimed at creating a public option health insurance Exchange plan called Cascade Care. The proposed plan, which would be available statewide, would require Washington to contract with at least one health insurer to offer coverage. Currently, 14 Washington counties only have one Exchange plan option. Senator David Frockt (D-Seattle) and Rep. Eileen Cody (D-Seattle) plan to introduce the bill during the 2019 legislative session. Read More

Wisconsin

Governor Signs Medicaid Expansion Order. *The Wisconsin State Journal* reported on January 9, 2019, that Wisconsin Governor Tony Evers signed an executive order directing the state Department of Health Services to develop a plan for Medicaid expansion. However, expansion would still require approval by the state's Republican-controlled legislature. A second order signed by Evers directs the state to make recommendations and implement efforts to ensure people with pre-existing conditions can obtain health insurance. Evers also plans to withdraw Wisconsin from a federal lawsuit filed by states seeking to overturn the federal Affordable Care Act. Read More

GOP Senate Leader Isn't Ruling Out Full Medicaid Expansion. *The Cap Times* reported on December 20, 2018, that Wisconsin Senate Majority Leader Scott Fitzgerald (R-Juneau) isn't ruling out a full Medicaid expansion in the state, but adds that there currently isn't enough support in the Republican-led legislature. Full expansion is supported by newly elected Democratic Governor Tony Evers. Wisconsin partially expanded Medicaid in 2013. Read More

National

CMS Names Chris Traylor Acting Director of Center for Medicaid and CHIP Services. *The Texas Tribune* reported on January 8, 2019, that former Texas Health and Human Services executive commissioner Chris Traylor has been named acting director of the Center for Medicaid and Children's Health Insurance Program (CHIP) Services. Traylor will replace Mary Mayhew, who resigned after only three months in the job. Traylor has also served as the commissioner of the Texas Department of Aging and Disability Services. Read More

Medicaid Members Take Advantage of Health Plan GED Test Benefit. *Kaiser Health News* reported on January 7, 2019, that Medicaid members are working to earn a high school General Educational Development (GED) diploma, with their health plan picking up the cost of the exam. Philadelphia-based insurer AmeriHealth Caritas helps connect members with test prep classes, offers coaching, and pays test fees. Sixty-two individuals have earned a GED since AmeriHealth Caritas began the program in 2013, and 1,000 started training. WellCare began a similar program in 2012, with 226 having taken the GED exam. Read More

CMS Releases Medicare Advantage Advance Notice. On December 20, 2018, the Centers for Medicare & Medicaid Services (CMS) released Part I of the 2020 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part D Payment Policies, which contains information about proposed updates to the Medicare Part C risk adjustment model and the use of encounter data. The 2020 Advance Notice is being published in two parts due to provisions of the 21st Century Cures Act that require a 60-day comment period for certain changes to the Medicare Part C risk adjustment model. Part II of the 2020 Advance Notice will be released in January 2019. Payment policies for the 2020 contract year will be finalized in the annual Rate Announcement, which will be published by April 1, 2019.

CMS is proposing to adjust the Part C risk adjustment model to consider the number of conditions an individual beneficiary may have, in addition to the additive factors in the existing model. CMS is also presenting an alternate Payment Condition Count model that includes additional condition categories for pressure ulcers and dementia, and is soliciting comments on which version of the model to implement beginning in 2020 using a blended methodology to phase in the new model.

With respect to encounter data, CMS proposes to build upon recent updates to risk score calculations by adding 50% of the risk score calculated using diagnoses from encounter data (vs 25% in 2019), CMS Risk Adjustment Processing System (RAPS) inpatient diagnoses, and fee-for-service (FFS) Medicare diagnoses with 50% of the risk score calculated with diagnoses from RAPS and FFS diagnoses. CMS proposes to phase in the new risk adjustment model by calculating the encounter data-based risk scores exclusively with the new risk adjustment model, while continuing to use the existing risk adjustment model using RAPS data.

Comments on the proposals included in Part I of the Advance Notice must be submitted to CMS by February 19, 2019. Read More

Democratic Attorneys General Appeal Federal Court Ruling that Seeks to Invalidate ACA. *Modern Healthcare* reported on January 3, 3019, that a group of Democratic attorneys general have appealed a ruling by a federal judge in Texas invalidating the Affordable Care Act (ACA). The appeal, led by California Attorney General Xavier Becerra, calls the ruling "flimsy" and "legally flawed." Last month, U.S. District Judge Reed O'Connor ruled that the ACA cannot stand without an individual mandate penalty. The appeal would be heard by the 5th U.S. Circuit Court of Appeals in Louisiana. Read More

U.S. House to Vote Next Week to Intervene in ACA Lawsuit. *The Hill* reported on January 2, 2019, that the Democratic-controlled House will vote next week to intervene in a Republican-led lawsuit seeking to overturn the Affordable Care Act (ACA). House Democrats will seek the vote after a federal judge in Texas ruled that the ACA was invalid. The vote is expected to highlight protections for individuals with pre-existing conditions. Read More

Health Plans Vie for Lead Role in CMS Housing, Transportation Pilots. *Modern Healthcare* reported on December 15, 2018, that Medicaid managed care plans are vying for a lead role in pilot programs authorized by the Centers for Medicare & Medicaid Services (CMS) involving services like housing, food, and transportation. Last month, U.S. Health and Human Services Secretary Alex Azar said that the agency is developing pilots in which federal funds would be available to health plans for social determinants of health. Some health plans, including CalOptima, have already invested millions to provide housing and support services to Medicaid members. Read More

GOP Senator Blocks Democrats Efforts to Intervene in ACA Lawsuit. *The Hill* reported on December 19, 2018, that the Senator John Barrasso (R-WY) blocked a vote to authorize Senate legal counsel to defend the Affordable Care Act (ACA). Senate Democrats sought the vote after a federal judge in Texas ruled that the ACA was invalid after Congress eliminated the individual mandate penalty for not having health insurance. The Trump administration has argued that patient protections like guaranteed issue will be unconstitutional after January 1, 2019, when the individual mandate penalty is lifted. Read More

CMS Proposal to Require Drug Price Transparency Has Providers, Insurers Calling For Strong Enforcement. *Modern Healthcare* reported on December 19, 2018, that health plans and providers are calling for strong enforcement of a proposed federal rule that would require pharmaceutical manufacturers to post wholesale drug acquisition costs in direct-to-consumer television commercials. Among the public comments submitted on the proposal rule, Kaiser Permanente suggested a fine equal to one percent of Medicare and Medicaid payments on violators. However, UnitedHealth Group and UnityPoint Health opposed the proposal, arguing that direct-to-consumer drug advertising might lead consumers to make medical decisions based on misleading price information. Read More

ACA Sign-Ups Fall 4 Percent in 2018, Preliminary Data Show. *The Associated Press* reported on December 19, 2018, that health insurance Exchange enrollment is down 4 percent to 8.5 million for 2019, with a dozen states, including California and New York, still to report. Despite the decline, the numbers were ahead of expectations driven by a late surge in sign-ups. Affordability, repeal of the individual mandate, and the Trump administration's efforts to scale back advertising may have impacted enrollment. Read More

Industry News

Cressey & Co. Completes Investment in HHAeXchange. Private investment firm Cressey & Co. announced on January 8, 2019, that it had completed an investment in HHAeXchange, which provides home care management software. Financial terms were not disclosed. Read More

TA Associates Completes Investment in Behavioral Health Works. Private equity firm TA Associates announced on January 4, 2019, that it has completed an investment in Behavioral Health Works (BHW), which provides Applied Behavioral Analysis for children with autism spectrum disorder. BHW currently serves more than 1,800 patients in 11 states. Financial terms were not disclosed. Read More

AccentCare Completes Acquisition of Steward Home Care and Hospice. AccentCare, Inc. announced on January 3, 2019, that it has completed the acquisition of Steward Home Care and Hospice, effective December 31, 2018. The acquisition expands AccentCare's post-acute care services to 16 states. Financial terms were not disclosed. Read More

Western Dental Completes Acquisition of Dental Services Organization from Guardian. Premier Dental Holdings, Inc., parent of Western Dental Services, announced on January 2, 2019, that it has completed the acquisition of a dental services organization from the Guardian Life Insurance Company of America. The transaction, which closed December 31, 2018, adds 63 supported offices in Texas, California, and Alabama. Premier's Western Dental and its affiliates now support 312 offices in five states. Read More

Conduent Completes Acquisition of Health Solutions Plus. Conduent Inc. announced on January 3, 2019, that it has completed its acquisition of Health Solutions Plus, which provides software for health care payer administration. Financial terms were not disclosed. Read More

Community Health Systems Completes Planned Divestiture of Mary Black Health System. Community Health Systems announced on December 31, 2018, that it has completed the divestiture of 207-bed Mary Black Health System in Spartanburg, SC, and 125-bed Mary Black Health System in Gaffney, SC, to Spartanburg Regional Healthcare System. The effective date of the transaction is January 1, 2019. Read More

Psychiatric Medical Care to Expand Following Recapitalization. Private equity fund Consonance Capital Partners announced on December 21, 2018, that it has completed the recapitalization of Psychiatric Medical Care (PMC), a transaction that will allow the behavioral health company to expand more rapidly. Financial terms were not disclosed. Read More

InTandem Capital Invests in Pediatric Home Service Partners. Pediatric Home Service Partners (PHSP) announced on December 18, 2018, that it has selected private equity firm InTandem Capital as its investment partner, with the goals of expanding services and accelerating local and national growth. PHSP, which operates in Minnesota and Wisconsin, is a home care company that serves children with complex medical needs.Read More

Cigna, Express Scripts To Close $67 Billion Merger After Winning NJ State Approval. *Modern Healthcare* reported on December 19, 2018, that Cigna Corp. and Express Scripts expect to close their $67 billion merger on December 20, after receiving all state regulatory approvals required to move forward. New Jersey was among the last states to sign off, nearly nine months after the companies agreed to merge. The companies had combined 2017 revenues of $141.7 billion. The U.S. Department of Justice approved the deal in September. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	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
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
April 1, 2019	Idaho Medicaid Plus (Dual) - Bonneville, Bingham, Bannock Counties	Implementation	3,329
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 WELCOMES

Uma Ahluwalia – Washington D.C.

Uma S. Ahluwalia is a respected healthcare and human services professional with extensive experience leading key growth initiatives in demanding political and legislative environments.

She is an expert in delivering innovative, reliable, cost-effective solutions and public policy strategies that improve operations and productivity.

Prior to joining HMA, she served as director of the Montgomery County Department of Health and Human Services in Maryland. During her 12-year tenure she led implementation of the Affordable Care Act, oversaw the move to a more integrated and interoperable health and human services enterprise, and managed public-private partnerships and programs.

Uma's work experience also includes leadership as the interim director in the Child and Family Services Agency in Washington, DC and assistant secretary of the Department of Social and Health Services in the State of Washington.

She has a master's degree in social work from the University of Delhi in India and a specialist, post-master's in health services administration from George Washington University. Over her 28-year career in human services, she has progressively moved from case-carrying social work to executive leadership at the state and local levels.

HMA NEWS

HMA Conducts Multi-Layered Study to Address Alarming Youth Suicide Trends Across Colorado. On January 3, 2019, Colorado Attorney General Cynthia H. Coffman released the study, *Community Conversations to Inform Youth Suicide Prevention*. The multi-layered study, conducted by HMA, analyzes and characterizes the trends and patterns in the fatal and non-fatal suicidal behaviors among young people in the four Colorado counties with the highest rates of youth suicide: El Paso, La Plata, Mesa, and Pueblo. The purpose of the study was to determine the best strategies for addressing and preventing youth suicide in Colorado and to see where the state's efforts and dollars can be used most effectively. Read more

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Arizona Medicaid Managed Care Enrollment is Down 1.9%, Dec-18 Data
- California Dual Demo Enrollment is Down 3.7%, 2018 Data
- California Medicaid Managed Care Enrollment is Down 2.4%, 2018 Data
- Georgia Medicaid Management Care Enrollment is Up 1.1%, Jan-19
- Hawaii Medicaid Managed Care Enrollment is Down 3.2%, Sep-18 Data
- Kentucky Medicaid Managed Care Enrollment is Down 2.1%, 2018 Data
- Michigan Dual Demo Enrollment is Down 10%, 2018 Data
- Michigan Medicaid Managed Care Enrollment is Down 1.8%, 2018 Data
- New Mexico Medicaid Managed Care Enrollment is Down 0.7%, 2018 Data
- Ohio Dual Demo Enrollment is Up 3.0%, Dec-18 Data
- Oregon Medicaid Managed Care Enrollment is Up 1.1%, Nov-18 Data
- Rhode Island Dual Demo Enrollment is 15,554, Dec-18 Data
- South Carolina Dual Demo Enrollment is Up 7.0%, Nov-18 Data
- South Carolina Medicaid Managed Care Enrollment is Up 1.4%, 2018 Data
- Texas Dual Demo Enrollment is 37,675, Dec-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 5.0%, Dec-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 1.1%, Jan-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arizona Fee-For-Service Pharmacy Benefit Management Services RFP, Contract Award, and Related Documents 2018
- Colorado NEMT RFP, Jan-19
- Colorado Enrollment Broker Services RFP, Feb-18
- Connecticut Medicaid Enterprise Technology System Organizational Change Management RFP, Dec-18
- Florida Integration Services and Integration Platform ITN, Jan-19
- Illinois IV&V Medicaid Management System (MMIS) RFP, Jan-19
- Indiana Opioid Treatment Programs RFI, Dec-18
- Indiana Pharmacy Benefit Management Services Proposals, Contract and Amendments, 2011-17
- Massachusetts One Care RFP Announcement, Data Book, Eligibility and Enrollment Description, Dec-18

- Michigan Independent Validation & Verification Services RFP and Contract, 2017
- Ohio Medicaid Managed Care RFP and Related Documents, 2012
- Oregon Draft CCO 2.0 RFA, Jan-19
- Pennsylvania Medicaid Medical Assistance (MA) Technical Assistance & Consultant Services RFP, Dec-18
- Pennsylvania Medical Assistance Transportation Program Full Risk Broker Services RFA, Dec-18
- Texas External Quality Review Organization RFP, Dec-18
- Virginia Medallion 4.0 Contract, 2019
- Wisconsin Managed Care Organization for the Delivery of Managed Long-Term Care in Selected Service Areas in GSR 7 and 8 RFP, Apr-18

Medicaid Program Reports, Data and Updates:

- Arizona AHCCCS Annual Audited Financial Reports, FY 2008-17
- Arizona AHCCCS Appropriation Status Reports FY 2019, Nov-18
- Arizona AHCCCS Budget Request FY 2020
- California Medi-Cal Managed Care Performance Dashboard, Dec-18
- CMS Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare, Dec-18
- Colorado Children's Health Plan Plus Caseload by County, 2014-17, Nov-18
- Colorado Department of Health Care Policy & Financing Annual Reports, 2015-18
- Delaware Primary Care Physicians Survey, 2018
- Florida Healthy Kids Corporation Board of Directors Meeting Materials, Jan-19
- Florida Medicaid Eligibility by County, Age, Sex, Nov-18 Data
- ID Medicaid Plus 1915(b) Waiver, Nov-18
- Iowa DHS Annual Progress and Services Report, Jun-17
- Iowa Managed Care Annual Performance Reports, 2016-18
- Iowa Medicaid MCO Quarterly Performance Reports, 2016-1Q19
- Idaho Dual Eligibles Stakeholder Presentations, Dec-18
- Illinois MCO Priority Measure Rates, 2018
- Kentucky Medicaid Managed Care Rate Certifications, FY 2015-18
- Kentucky Section 1115 Demonstration Revised Waiver Application, CMS Approval, State Acceptance Letter, and Related Documents, 2016-18
- Massachusetts Managed Care HEDIS Reports, 2013-17
- Maryland Medicaid Total Cost of Care Savings Report, Dec-18
- Maine 1115 MaineCare Medicaid Waiver Application and Approval, 2018
- Michigan 1115 Demonstration Waiver Application and Approval, Healthy Michigan Plan, 2018
- Missouri LTC Levels of Care Transformation Project Presentations, Nov-18
- North Carolina Medicaid Annual Reports, SFY 2015-18
- Nebraska Long Term Care Redesign Committee Minutes, Nov-18
- New Hampshire Granite Advantage Health Care Program 1115 Waiver Demonstration, 2018
- New Hampshire MCM Network and Access Monitoring Report- Adult & Child CAHPS, Aug-18
- New Hampshire Medicaid Care Management Network & Access Monitoring Presentation, Jul-18

- New Hampshire Medicaid SUD Treatment and Recovery Access 1115 Waiver, 2018
- New Jersey HMO, PPO Performance Reports, 2015-17
- Oklahoma Medicaid Enrollment by Age, Race, and County, Nov-18 Data
- Oklahoma Provider Fast Facts by County, Nov-18
- Oregon Medicaid Dental Health Service Delivery by Plan and by County, Eligibility Group, and Age Group, Nov-18
- Oregon Medicaid Mental Health Service Delivery by Gender, Race, and Plan, 2017, Nov-18
- Oregon Medicaid Mental Health Service Delivery by Plan and by County, Eligibility Group, and Age Group, Nov-18
- Oregon Medicaid Physical Health Service Delivery by Plan and by County, Eligibility Group, and Age Group, Nov-18
- Pennsylvania Community HealthChoices (CHC) Design Components and Lessons Learned Presentation, May-18
- PWSMI Activity Map and Flowchart, Jul-18 Data
- South Carolina Medicaid Enrollment by County and Plan, Nov-18
- Tennessee Designing and Implementing Integrated MLTSS Programs Presentation, May-18
- Tennessee Medicaid Quality Assessment and Performance Improvement Strategy Reports, 2013-18
- Texas HHS Medicaid & CHIP Reference Guide, 2018
- Texas Medicaid and CHIP Quick Facts, Dec-18
- Texas Medicaid Managed Care Provider Network Adequacy Report, Dec-18
- Washington Medicaid Managed Care Capitation Rate Development, CY 2015-18

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