HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 24, 2019

RFP CALENDAR

HMA News

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

THIS WEEK

- IN FOCUS: HMA CONFERENCE ON THE NEXT WAVE OF MEDICAID GROWTH AND OPPORTUNITY TO FEATURE INSIGHTS FROM 40+ SPEAKERS, INCLUDING HEALTH PLAN CEOS, STATE MEDICAID DIRECTORS, PROVIDERS
- IN FOCUS: CMS ANNOUNCES PRIMARY CARES INITIATIVE
- COLORADO SENATE TENTATIVELY ENDORSES STUDY OF STATE-RUN PUBLIC OPTION HEALTH PLAN
- FEDERAL JUDGE ORDERS FLORIDA TO EXPAND HEPATITIS C TREATMENT FOR INMATES
- MEDICAID EXPANSION NEWS: MONTANA, OKLAHOMA
- OREGON RECEIVES 19 APPLICATIONS FOR CCO 2.0 CONTRACTS
- TEXAS CHILDREN ARE IMPROPERLY LOSING MEDICAID COVERAGE, STATE DATA SHOW
- ANTHEM, UNITEDHEALTH ARE AMONG LEADING SUITORS TO ACQUIRE MAGELLAN HEALTH
- HMA WELCOMES: CINDY ZELDIN (ALTANTA, GA), CATHERINE GUERRERO (DENVER, CO), SCOTT HAGA (LANSING, MI), ERIC HAMMELMAN (CHICAGO, IL), DAVE SCHNEIDER (LANSING, MI), TARLTON THOMAS (COLUMBUS, OH)
- NEW THIS WEEK ON HMAIS

IN FOCUS

HMA CONFERENCE TO FEATURE INSIGHTS FROM 40+ SPEAKERS, INCLUDING HEALTH PLAN CEOS, STATE MEDICAID DIRECTORS, PROVIDERS

Pre-Conference Workshop: September 8, 2019
Conference: September 9-10, 2019
Location: Chicago Marriott Downtown Magnificent Mile

Health Management Associates is proud to announce its fourth annual conference on trends in publicly sponsored health care: *The Next Wave of Medicaid Growth and Opportunity: How Payers, Providers, and States Are Positioning Themselves for Success*.

The HMA conference has emerged as a premier informational and networking event, attracting more than 450 executives and policy experts. Speakers this year include state Medicaid directors and leaders from Medicaid managed care, hospitals, clinics, community-based organizations, and other providers.

"This is our strongest agenda to date, said Carl Mercurio, Principal, HMA Information Services. The conference will address a broad array of opportunities and challenges involving Medicaid managed care, state innovation, opioids, work requirements, social determinants of health, foster care, behavioral health, dual eligibles, Medicare Advantage, pharmacy costs, and provider-led managed care.

Early Bird registration is now open. Visit the conference website for complete details: https://conference.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available. The conference agenda appears below.

<table>
<tr><td colspan="2">The Next Wave of Medicaid Growth and Opportunity:
How Payers, Providers, and States Are Positioning Themselves for Success</td></tr>
<tr><td colspan="2">Pre-Conference Workshop: Sunday, September 8</td></tr>
<tr><td>1:00 - 5:00 pm</td><td>Inner Workings of Medicaid: State-by-State Program Basics and Key Variations</td></tr>
<tr><td colspan="2">Conference Day One: Monday, September 9</td></tr>
<tr><td>7:00 - 8:00 am</td><td>Registration</td></tr>
<tr><td>8:00 - 8:45 am</td><td><u>Regulatory Keynote Address</u>
The Next Wave of Medicaid Growth and Opportunity
Does Medicaid represent the future of healthcare in America? The truth is that no other program is seeing more experimentation or garnering more populist attention. Efforts include voter-driven demands for Medicaid expansion; calls for Medicaid buy-ins; and integrated initiatives to serve high-cost aged, disabled, and chronically ill populations. There have also been a wide variety of efforts to test concepts involving community engagement, work requirements, value-based payments, delivery system redesign, substance-abuse treatment, healthy behaviors, community-based care, social determinants health, and other important components of coverage and care delivery. During this keynote address, a leading healthcare expert will discuss the growing and changing role of Medicaid and how it is likely to impact the broader direction of healthcare in America for years to come.

<u>Speaker</u>
To be announced

<u>Moderator</u>
Gaylee Morgan, Vice President, HMA</td></tr>
<tr><td>8:45 - 10:00 am</td><td><u>State Medicaid Director Q&A Keynote Session</u>
Opportunities and Pitfalls of Medicaid Innovation at the State Level
The past few years have been marked by a flurry of expected – and unforeseen – alterations,</td></tr>
</table>

	innovations, and experiments among state Medicaid programs. Given the growing emphasis on member accountability, it's obvious states would explore initiatives like work requirements, premiums, and health savings accounts. But there has also been an uptick in the number of Medicaid expansion states, heightened interest in Medicaid buy-ins, and growing use of state waivers to test innovative new care delivery and coverage models. Meanwhile, states continue to gravitate toward Medicaid managed care, which has consistently gained market share versus fee-for-service. During this keynote session, leading Medicaid directors will outline opportunities and pitfalls of these efforts, as well as provide a roadmap for the likely direction of Medicaid innovation at the state level. *Speakers* ***Mari Cantwell***, *Chief Deputy Director, Health Care Programs, California Department of Health Care Services* ***Mandy Cohen***, *MD, Secretary, North Carolina Department of Health and Human Services* ***Doug Elwell***, *Medicaid Director, Illinois Department of Healthcare and Family Services* ***Jami Snyder***, *Director, Arizona Health Care Cost Containment System* ***Carol Steckel***, *Commissioner, Kentucky Division of Medicaid Services* *Moderator* ***Kathleen Nolan***, Vice President, HMA
10:00 - 10:30 am	Break
10:30 - 11:15 am	**Managed Care Keynote Address** **The Growing Role of Medicaid Managed Care in Serving the Nation's Most Vulnerable** Medicaid managed care plans are playing a growing role in the lives of the nation's most vulnerable citizens – not just administering healthcare, but also attempting to become a force for good in the communities they serve. Increasingly, this means helping to address hunger, homelessness, job training, education and other social determinants that impact a person's health and well-being. During this keynote address, Paul Tufano, chairman and CEO of AmeriHealth Caritas, will discuss his organization's investments in whole-person care, wellness centers, and other pathways to prosperity and independence for members. Tufano will also outline how health plans, providers, and local governments can best work together to address the needs of families and individuals enrolled in Medicaid. *Speaker* ***Paul Tufano***, *Chairman, CEO, AmeriHealth Caritas* *Moderator* ***Jay Rosen***, *President, HMA*
11:15 - 12:30	**Medicaid Managed Care Keynote Q&A Session** **Delivering on the Promise of Medicaid Managed Care** Managed care continues to take center stage in efforts by states to improve the quality and efficiency of their Medicaid programs. That's good news for managed care plans, which continue to enjoy growing market share in a wide variety of Medicaid programs. But Medicaid plans also face significant challenges, including the adequacy of capitated payment rates, increased demands to ensure quality while simultaneously controlling costs, and the ability to adjust to the type of change and uncertainty inherent in state Medicaid programs. During this session, leading Medicaid managed care executives will address some of the most pressing challenges facing health plans as they participate in government-sponsored healthcare programs and strive to meet the needs of vulnerable member populations. *Speakers* ***Heidi Garwood***, *President, Medicaid, Health Care Service Corp.* ***Janet Grant***, *Regional Vice President, Great Plains Region, Aetna Medicaid* ***Joanne McFall***, *Market President, Keystone First Health Plan*

	***Dennis Mouras**, CEO, UnitedHealthcare Community Plan of Michigan* ***Patrick Sturdivant**, President, Virginia Medicaid Health Plan, Anthem, Inc.* *Moderator* ***Donna Checkett**, Vice President, HMA*
12:30 - 2:00 pm	**Luncheon Speaker** **Substance Abuse Treatment and the Opioid Crisis: A New Way Forward** As the federal government prepares to spend billions of dollars battling opioids, it's important to recognize that the opioid epidemic is part of a broader pattern of substance abuse in America. Effectively treating opioids means addressing the historical structure of the nation's approach to addiction treatment and identifying pathways at the state, provider, and health plan level for fostering an effective addiction treatment eco-system. During this session, leading addiction experts will discuss existing barriers to successful opioid addiction treatment as well as outline a new way forward for addressing both the opioid epidemic and substance abuse overall. *Speakers* ***Carole Johnson**, Commissioner, New Jersey Department of Human Services* ***Corey Waller**, MD, Principal, HMA*
2:00 - 3:30 pm	Concurrent Breakout Session **Medicaid Expansion and Other Efforts to Expand Healthcare Coverage** The number of states that have expanded Medicaid since 2016 has risen to 37, with several others considering expansion options. There have also been efforts at the state and local level to increase healthcare coverage for underserved populations through Medicaid universal care initiatives, and the growing use of state waivers. During this breakout session, state and local leaders will discuss some of the most interesting and innovative coverage expansion options as well as which states are most likely to pursue expansion and why. Panelists will also discuss the use of 1332 waivers to broaden healthcare coverage through the Affordable Care Act Exchanges. *Speakers* ***Dennis Smith**, Senior Advisor, Medicaid and Health Care Reform, Arkansas Department of Human Services* ***Fred Cerise**, MD, President, CEO, Parkland Health & Hospital System* *Other speakers to be announced.* *Moderator* ***Matt Powers**, Principal, HMA*
	Concurrent Breakout Session **Innovations in Managing Drug Spending – Value-Based Purchasing** State Medicaid programs are engaging in some outside-the-box thinking on the best way to manage drug costs and utilization, including concepts of value-based purchasing and adapting to drug spending in a managed care environment. During this breakout session, experts from state government, health plans, and pharmacy organizations will discuss some of the most innovative concepts and initiatives in the intersection of value-based purchasing and drug spending. *Speakers* ***Terry Cothran**, Director, Pharmacy Management Consultants, University of Oklahoma College of Pharmacy* ***Josh Fredell**, Senior Director, Specialty Product Development, CVSHealth* ***Darren Moore**, Senior Director, Value and Market Access, Melinta Therapeutics* ***Michael Todaro,** Vice President, Pharmacy Operations, Centene/Magnolia Health* *Moderator* ***Anne Winter**, Principal, HMA*

	Concurrent Breakout Session **Breakthroughs in Addressing Social Determinants of Health** State Medicaid programs, health plans, and providers are beginning to implement a series of concrete strategies to address social determinants of health (SDOH), including poverty, homelessness, food insecurity, and education. These include standardized SDOH screenings, community engagement, payer-provider partnerships, and payment strategies that incentivize the delivery of SDOH services to members. During this session, industry leaders from states, health plans, and providers will outline some of the recent breakthroughs and strategic developments that have led to measurable improvement in member health through services aimed at addressing SDOH. *Speakers* ***Brad Lucas**, MD, Senior Medical Director, Buckeye Health Plan* ***Kevin Moore**, VP, Policy - Health & Human Services, UnitedHealthcare Community & State* ***Sharon Raggio**, President, CEO, Mind Springs Health* ***Betsey Tilson**, MD, State Health Director, Chief Medical Officer, North Carolina Department of Health and Human Services* *Moderator* ***Heidi Arthur**, Principal, HMA*
3:30 - 4:00 pm	Break
4:00 - 5:30 pm	Concurrent Breakout Session **Lessons of Medicaid Work Requirements, Premiums, and Other Forms of Community Engagement** It's been over a year since states like Indiana, Arkansas, and New Hampshire began to implement Medicaid work requirements. Meanwhile, several other states have applied for approval of work requirements, premiums, health savings accounts, and other forms of community engagement and member accountability. During this session, representative from state Medicaid programs, health plans, providers, and advocates will discuss some of the lessons learned from these early community engagement initiatives and whether they are successfully helping members achieve self-sufficiency. *Speakers* ***Natalie Angel**, Healthy Indiana Plan Director, Indiana Office of Medicaid Policy and Planning* ***Jean Caster,** HIP Program Director, Anthem Indiana Medicaid* ***Ray Hanley**, President and CEO, AFMC* *Other speakers to be announced.* *Moderator* ***Kaitlyn Feiock**, Senior Consultant, HMA MMS*
	Concurrent Breakout Session **What's Next for Foster Care: Preparing for Dramatic Changes** State foster care is expected to undergo dramatic change following the enactment of new federal regulations aimed at keeping children in family settings instead of in group homes. The rules emphasize substance abuse prevention, mental healthcare, parenting advice, and other services to help keep families together. During this webinar, foster care experts will discuss how states are preparing to implement these monumental changes and what this means for foster care programs going forward. *Speakers* ***Rebecca Jones-Gaston**, Executive Director, Social Services Administration, Maryland Department of Human Services* ***Tracy Wareing Evans**, Executive Director, American Public Human Services Association* *Other speakers to be announced.*

<table>
<tr><td></td><td><u>Moderator</u>
Uma Ahluwalia, Principal, HMA</td></tr>
<tr><td></td><td><u>Concurrent Breakout Session</u>
Successful Models and Variations in Behavioral Health Integration
Payers and providers are making great strides forward in the successful integration of medical and behavioral healthcare, while also attending to social determinants of health. No one model has emerged as preeminent. Instead, a variety of approaches, variations and unique solutions are serving to empower patients and caregivers in understanding the complex interplay of depression, substance use disorder, and other mental health conditions with a person's overall health status. During this session, leading medical and behavioral health experts will highlight some of the most innovative approaches to behavioral health integration, including a look at the foundational components of successful integration efforts. They will share important lessons learned along the way in terms of successes and pitfalls.

<u>Speakers</u>
Deepu George, Assistant Professor of Family Medicine, Division Chief - Behavioral Medicine, Department of Family & Preventive Medicine, UTHealth
Elise Pomerance, MD, Senior Medical Director, Practice Transformation, Inland Empire Health Plan
Walter Rosenberg, Director, Social Work and Community Health, Rush University Medical Center
Deborah Weidner, MD, Vice President, Safety and Quality, Behavioral Health Network, Hartford HealthCare

<u>Moderators</u>
Emily Brandenfels, Principal, HMA
Jeff Ring, Principal, HMA</td></tr>
<tr><td>5:30 - 7:00 pm</td><td>Reception</td></tr>
<tr><td colspan="2">Conference Day Two: Tuesday, September 10</td></tr>
<tr><td>7:00 - 8:00 am</td><td>Breakfast</td></tr>
<tr><td>8:00 - 8:45 am</td><td>The Growing Role of Medicare Advantage and the Future of Medicare
With more than 21 million enrollees, Medicare Advantage plans manage care for more than a third of all Medicare beneficiaries, and that percentage is rapidly growing. Coupled with gains in other government programs, the growth in Medicare Advantage puts health insurers in the driving role to shape the future of publicly sponsored healthcare. During this session, policy and industry experts will assess the future of both Medicare Advantage and the Medicare program in general, with a special emphasis on how changes in Medicare will impact the overall market for healthcare services in America, including state Medicaid programs.

<u>Speakers</u>
Jonathan Blum, Managing Principal, HMA; former CMS Deputy Administrator for Medicare
Other speakers to be announced.</td></tr>
<tr><td>8:45 - 10:00 am</td><td>Managed Care Models for Dual Eligible Medicaid-Medicare Beneficiaries
States are increasingly turning to managed care to serve high-cost, dual eligible Medicaid-Medicare beneficiaries. Yet no single managed care model has emerged as preeminent – whether it involves Capitated Financial Alignment Demonstrations, Dual Eligible Special Needs Plans (D-SNPs), Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), or provider-led initiatives. Furthermore, state and federal policies are evolving in ways that will dramatically impact the roles and responsibilities of participating plans. During this session, industry experts will provide an overview of the complex landscape for integrated Medicare-Medicaid managed care. Speakers will also discuss how health plans and</td></tr>
</table>

	providers can best develop integrated models that effectively serve members and successfully compete regardless of which models emerge. *Speakers* ***Karen Kimsey**, Chief Deputy, Virginia Department of Medical Assistance Services* ***Lois Simon**, EVP, Policy and Programs, Seniorlink* *Other speakers to be announced.* *Moderators* ***Sarah Barth**, Principal, HMA* ***Karen Brodsky**, Principal, HMA*
10:00 - 10:30 am	Break
10:30 - 11:30 am	**Health System Keynote Address** **What's Next for Provider-Led Medicaid Managed Care?** Providers have played a growing role in Medicaid managed care efforts through various accountable care organizations, risk-sharing arrangements, and Delivery System Reform Incentive Payment programs. With several years of experience under their belts, states and providers can begin to evaluate the success of these efforts and decide upon next steps. During this session, leading providers will address the future of provider-led Medicaid managed care, with an emphasis on the lessons learned from existing programs and the likelihood that these types of initiatives will continue to gain momentum. *Speakers* ***Mitchell Katz**, MD, President and CEO, NYC Health + Hospitals* *Moderator* ***Pat Terrell**, Vice President, HMA*
11:30 am - 12:30 pm	**Innovative Care Delivery Models for High-Cost, High-Acuity Patients** Some of the most innovate care delivery initiates involve new models to treat high-cost, high-acuity patients in integrated local settings. These providers employ models that include patient-centered medical homes, primary care, wrap-around services, and high-touch community-based care for the highest risk patients. During this session, some of the most innovative organizations discuss their approaches to care and results to date. Speakers will also provide insights on how care models for the nation's sickest and most vulnerable individuals will likely evolve. *Speakers* ***Alan Cohn**, CEO, President, AbsoluteCARE Inc.* ***Rebecca Kavoussi,** President, West, Landmark Health* ***Sarita Mohanty**, MD, VP, Care Coordination, Kaiser Permanente* ***René Santiago**, Deputy County Executive, County of Santa Clara, CA* *Moderator* ***Betsy Jones**, Managing Principal, HMA*
12:30 pm	Adjourn

CMS Announces Primary Cares Initiative

On April 22, 2019, the Centers for Medicare & Medicaid Services (CMS) Innovation Center announced the Primary Cares Initiative (PCI), which will present eligible providers and other entities with the opportunity to engage in value-based payment and direct contracting payment models for primary care beginning in January 2020. CMS designed PCI to reduce expenditures and preserve or enhance quality of care for beneficiaries in Medicare fee-for-service (FFS). PCI is comprised of two tracks, Primary Care First (PCF) and Direct Contracting (DC). The PCF track, which builds on the Comprehensive Primary Care Plus (CPC+) initiative, is intended for individual primary care practices and seeks to reward providers for reductions in hospital utilization and total cost of care through performance-based payment adjustments. Also, under the PCF track, practices that specialize in serving high-need and/or seriously ill populations will receive adjusted payments to account for the populations served. Providers that participate in these models will qualify as participating in an Advanced Alternative Payment Model and be eligible to receive full bonus payments under CMS's Medicare Incentive Payment System (MIPS).

The DC track is intended for a broader set of stakeholders with experience accepting financial risk and serving larger patient populations. Medicare Advantage plans can also apply for DC, although details are forthcoming. Entities interested in pursuing DC can choose from one of three models; DC Professional, DC Global; DC Geographic (see table below). The form of the capitated payment they receive will depend on the model they select. The capitated arrangements range from reimbursing for a portion of the expected primary care costs to the total cost of care. At a conference earlier this week, CMS indicated the DC payment benchmarks would be based on a prospective blend of historical spending and adjusted regional Medicare Advantage (MA) expenditures.

Both the PFC and the DC emphasize voluntary assignment of beneficiaries into provider entities, which allows for beneficiaries to select the provider with which they want to establish and maintain the primary care relationship. This differs from the mandatory assignment method common with Accountable Care Organizations (ACO), which typically "attributes" beneficiaries to an ACO based on the primary care provider from which the beneficiary receives a "majority" of care. The only exception to this is the DC Geographic model, which incorporates all beneficiaries in a target region. Beneficiaries would also continue to maintain their choice of provider, and they would not be limited to the PCI participant network.

CMS has not yet provided the complete details of each of the models, but the agency has indicated that additional information will be provided through a Requests for Applications (RFAs) process which will begin in Spring 2019. Model details that are currently available are summarized in the table below. CMS also issued a Request for Information (RFI) on the DC Geographic model to identify potential refinements and will likely not launch this particular model until 2021. CMS also noted that this model would use a separate benchmarking methodology, based on a one-year historical fee-for-service spend for the region, but this would be finalized based on responses to the RFI. RFI Responses are due no later than May 23, 2019.

Pathway	Model	Eligible Participant(s)	Model Description
Primary Care First (PCF)	PCF General	Primary care practitioners certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine in 26 designated regions, in addition to other criteria	Monthly population- based payment and flat primary care visit fee as well as performance-based adjustment providing upside up to 50% revenue/downside up to 10% revenue
	PCF High Needs	Same as above	Similar to above. Payment amounts will be set to reflect the high need, high risk nature of the population as well as include an increase or decrease in payment based on quality
Direct Contracting (DC)	DC Professional	Health care providers operating under a common governance structure with attention given to advancing primary care, Medicare ACOs, Medicaid MCOs that serve dual eligible beneficiaries	Primary Care Capitation: Risk adjusted monthly payment equal to seven percent of total cost of care for enhanced primary care services; 50% shared savings/losses
	DC Global	Same as above	Primary Care Capitation (see above); **or** Total Cost of Care Capitation: risk adjusted monthly payment for all services provided by participants and subcontracted providers
	DC Geographic	In addition to the above, health plans, health care technology companies and "other entities"	Total Cost of Care Capitation (see above) for beneficiaries in a target region

Following a series of CPC+ and Medicare Shared Savings Program (MSSP) ACO evaluation reports finding that upside-only arrangements do not generate across-the-board savings, CMS now encourages providers and other entities to transition to payment and care delivery models with downside risk. The new models also provide alternatives to Medicare Advantage (MA) contracting for those that are not included in MA networks or pursue value-based payment opportunities outside of the MA program. CMS has indicated that they expect one in four primary care providers to participate. However, the level of participation will be influenced by additional details regarding eligibility and selection criteria, payment benchmarking and risk adjustment, and other information that will likely be addressed in the RFAs or subsequent guidance.

HMA will continue to monitor developments regarding the PCI. For more information or questions about the PCI or HMA's Medicare capabilities, please contact Mary Hsieh or Jon Blum.

HMA Medicaid Roundup

Colorado

Senate Tentatively Endorses Study of State-Run Public Option Health Plan. *Modern Healthcare/Associated Press* reported on April 17, 2019, that the Colorado Senate has tentatively endorsed a bill to study the creation of state-run public option health insurance plan. The legislation, which has already passed the House, would require another Senate vote before being sent to the Governor's desk. Under the legislation, the state Department of Health Care Policy and Financing and the Department of Regulatory Agencies would recommend a public plan that competes with Exchange plans and other private insurance options. The bill is sponsored by Senator Kerry Donovan (D-Vail), Representatives Dylan Roberts (D-Avon), and Marc Catlin (R-Montrose). Read More

Florida

House Proposes Cuts to Medicaid Hospital Rates for Fiscal 2020. *The Orlando Sentinel/News Service of Florida* reported on April 22, 2019, that the Florida House has recommended cuts to fiscal 2020 Medicaid rates for hospital inpatient and outpatient services. Meanwhile, the Senate did not recommend cuts, but instead suggested redistributing $318 million allotted for hospitals treating Medicaid and charity-care patients to meet overall hospital funding needs. The proposals are part of the state's broader budget negotiations. Read More

Federal Judge Orders Florida to Expand Hepatitis C Treatment for Inmates. *Health News Florida* reported on April 22, 2019, that a federal judge ordered Florida to expand treatment to inmates in the early stages of hepatitis C. The order, which could impact 20,000 to 40,000 inmates, comes after allegations that the Department of Corrections was indifferent to providing care for infected inmates. Read More

Illinois

Nursing Homes Close Amid Medicaid Funding Shortfall. *The Chicago Sun Times* reported on April 19, 2019, that 22 Illinois skilled-care nursing homes have closed since March 2014 because of a state Medicaid funding shortfall. Nursing homes lose $41 dollars per day for each Medicaid patient, or a total of $649 million annually, according to a study commissioned by the Health Care Council. The council proposed a $100 million increase in state funding for nursing homes. Read More

Maine

Lawmakers Consider Bills to Reform Child Protective Services, Care for Individuals With Disabilities. *U.S. News* reported on April 23, 2019, the Maine lawmakers are considering bills to reform the state's child protective services system and initiate a pilot to provide housing to adults with intellectual disabilities. The state legislature's Health and Human Services Committee will hold hearings on the bills next Tuesday. Read More

Lawmaker Sponsors Bill to Add Dental Coverage to Medicaid. *Press Herald* reported on April 17, 2019, Maine House Rep. Drew Gattine (D-Westbrook) sponsored a bill that would provide a comprehensive dental benefit to 100,000 adult Medicaid recipients. No cost estimate has yet been attached to the bill; however, the federal government would pay between 67 and 90 percent of the cost of the new benefit. Maine would join 33 other states with Medicaid dental benefits. Read More

Missouri

Social Services Director to Step Down. *SF Gate* reported on April 18, 2019, that Steve Corsi will step down as director of the Missouri Department of Social Services, effective June 3. Previously, Corsi headed the Wyoming Department of Family Services. Read More

Montana

Legislature Approves Bill to Continue Medicaid Expansion. *NBC Montana* reported on April 18, 2019, that the Montana legislature has passed a bill to continue the state's Medicaid expansion program, with added work requirements and a six-year expiration date. The bill is now headed to the governor's desk for signature. Expansion in Montana covers nearly 96,000 adults. Read More

New Hampshire

Senate Advances Bill to Expand Medicaid Dental Benefits For Adults. *Seacoastonline.com* reported on April 18, 2019, that the New Hampshire Senate advanced a bill to expand Medicaid dental benefits to adults. The bill would also establish a working group to assess implementation of the benefit. The bill now heads to the Senate Finance Committee for review before final vote. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

UHF Reports Examine New York's Remaining Uninsured, Patient Centered Medical Homes. The United Hospital Fund has released two reports. The first, *Reaching the Five Percent: A Profile of Western and Central New Yorkers Without Health Coverage*, looks at who remains uninsured despite the coverage expansion that occurred under the affordable care act. The report finds that many currently uninsured individuals appear to be eligible for financial help

for coverage. Barriers to obtaining coverage include complexities in the health system, lack of knowledge about the availability of free enrollment assistance from trained counselors, and some lingering stigma about public programs. For those seeking Qualified Health Plans from the Marketplace, even with tax credits and cost-sharing reductions, premiums were unaffordable for many, and deductibles unacceptable.

The second report, *Patient-Centered Medical Homes in New York, 2018 Update: Drivers of Growth and Challenges for the Future*, describes recent developments in the adoption of the patient-centered medical home model. New York State continues to lead the nation in the adoption of the medical home model, accounting for 15 percent of the nation's NCQA-recognized PCMH clinicians. The number of primary care providers in New York State adopting the PCMH model rose by more than 35 percent between May 2017 and May 2018, a dramatic increase in the rate of growth over prior years. The recent growth coincides with the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP provided incentives for health systems to help practices adopt the National Committee for Quality Assurance's PCMH model, in which all or most of a patient's health care needs are coordinated through a primary care physician. However, the report notes that uptake of the PCMH model continues to be uneven across the state. Over the past five years, growth has consistently been slower in New York City compared with the rest of the state.

Planning for the Future of Integrated Care for Dual-Eligible Enrollees. The New York dual integration demonstration, Fully Integrated Duals Advantage (FIDA), ends at the end of the year. As the state plans for the transition of FIDA members into other forms of coverage, they have convened a stakeholder process to inform their planning. The second stakeholder session was held on February 28. The state described their current thinking, which is to move all FIDA enrollees into that plan's Medicaid Advantage Plus plan. The Centers for Medicare & Medicaid Services (CMS) is currently reviewing those plans as to their benefits, networks and costs. The state is also considering enhancing the Medicaid Advantage Plus (MAP) program so that it more closely resembles FIDA. They are considering changes in three areas: adopting FIDA's integrated grievance and appeals process, allowing MAP plans to use integrated marketing materials, and aligning enrollment so that members only have to complete a single enrollment rather than enrolling separately in a Medicaid and a Medicare plan. Finally, the state is exploring whether it can establish a "default enrollment" process when Medicaid beneficiaries become Medicare-eligible, which would allow them to transition seamlessly from a plan's Medicaid product into its Medicare product. Read More

New York Updates its Prevention Agenda. New York State's Prevention Agenda, which began in 2008, has started its third implementation cycle for the period 2019 to 2024. Partnerships between local health departments, health care providers, and community-based organizations are now occurring in every county. Each partnership is addressing health issues selected from the five statewide priority areas:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases Read More

New York Foundation Opens Grant Application Process. New York's Mother Cabrini Health Foundation, established as a result of the acquisition of Fidelis Care by Centene Corporation last year, has opened its on-line grant application portal for its 2019 round of grants. The foundation will be granting up to $150 million in 2019. It is using a two-step process, requiring a Letter of Intent, and then inviting select applicants to submit a full proposal. The LOI submission window opened on April 18, 2019; LOIs are due on May 9, 2019. The foundation will notify all LOI applicants by June 2019 as to whether they are invited to submit a full proposal. Applicants whose projects are identified by Cabrini Foundation as potentially strong fits for its 2019 priorities will be invited to submit full proposals and will have approximately four weeks to submit their full proposals. The Cabrini Foundation plans to notify selected applicants and issue award letters by the end of 2019. Read More

Ohio

Hospital Patient Deaths May Result In Increased Hospital Oversight. *The Columbus Dispatch* reported on April 17, 2019, that Ohio may increase hospital oversight after the deaths of patients at Mount Carmel hospital. Ohio is the only state that doesn't license its hospitals, and while some lawmakers call for increased regulation, others say that increasing oversight will take away from patient care. The Ohio Nurses Association stands in support of more regulation. However, other groups, like the Ohio Hospital Association, say that regulations already in place are overwhelming, and that desired outcomes of further regulations must be examined. Read More

Attorney General Recommends Pharmacy Benefit Overhaul. *The Dayton Daily News* reported on April 23, 2019, that Ohio Attorney General Dave Yost announced a four-step plan for the state to make major changes to how its pharmacy benefits are managed. Pharmaceutical Care Management Association, a trade group that represents pharmacy benefit managers (PBMs) said that they are reviewing Yost's proposal, and that they "applaud the Ohio Attorney General for examining prescription drug prices". Yost's proposal includes a master PBM contract, unrestricted authority for the Ohio Auditor of State to review PBM drug contracts, a regulation that requires PBMs to be fiduciaries, and that nondisclosure agreements on drug pricing with the state be prohibited. Read More

Oklahoma

Residents File Petition for Medicaid Expansion Ballot Initiative. *NonDoc* reported on April 19, 2019, that attorneys for two Oklahoma residents filed a petition for a ballot initiative that would expand Medicaid to low-income adults with incomes up to 138 percent of the federal poverty level. The initiative requires 177,958 signatures to make the ballot. Read More

Oregon

Oregon Receives 19 Applications for CCO 2.0 Contracts. The Oregon Health Authority announced on April 23, 2019, that it received 19 applications for coordinated care organization (CCO) contracts for the period from 2020-24. Applications were due April 22, 2019, and awards are expected to be announced in July 2019. The Oregon Health Plan currently serves nearly 1 million members. Based on the service areas stated in the applications, all counties will be served by at least one CCO. Additionally, the Oregon Health Authority reported that four organizations made changes to their submitted letters of intent. Providence Health Assurance revoked its intent to apply, Trillium (Centene) and Umpqua Health Alliance removed regions from their service areas, and PrimaryHealth made changes to its organizational chart. Read more.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Skilled Nursing Facilities Lose $631 Million Annually on Medicaid, Analysis Finds. *Skilled Nursing News* reported on April 17, 2019, that skilled nursing facilities in Pennsylvania lose about $631 million annually serving Medicaid patients, according to an analysis prepared by RKL and LeadingAge PA. The state's 221 not-for-profit facilities account for about 60 percent of the losses. The analysis is based on data from 534 nursing facilities in the state from 2017 and 2018. Read More

Tennessee

House Seeks Katie Beckett Waiver. *The Tennessean* reported on April 23, 2019, that Tennessee House lawmakers say they are willing to fight for a bill that would require the state to apply for a Katie Beckett waiver covering children with severe illnesses or disabilities who are not on Medicaid. The state Senate hasn't committed to supporting the waiver, which requires federal approval. Read More

TennCare Adds 24,000 Children in February, March. *Tennessean* reported on April 18, 2019, that TennCare added more than 24,000 children in the past two months. The enrollment data comes after reports that 128,000 children had been cut from TennCare and CoverKids over the past two years. TennCare officials blamed a rudimentary system used to process applications and renewals. Read More

Texas

Texas Children Are Improperly Losing Medicaid Coverage, State Data Show. *The Texas Tribune* reported on April 22, 2019, that use by Texas of an automated Medicaid eligibility system to check household income several times per year has resulted in thousands of children improperly losing coverage, according to the state Health and Human Services Commission. State Representative Philip Cortez (D-San Antonio) filed a bill in November to ensure continuous Medicaid coverage for children with no interim income checks and to avoid children improperly losing coverage. Read More

National

CMS Recommends Three Integrated Care Models for Dual Eligibles. On April 24, 2019, the Centers for Medicare & Medicaid Services (CMS) sent a letter to state Medicaid directors encouraging partnerships to address the needs of 12 million dual-eligible Medicare-Medicaid beneficiaries. CMS Administrator Seema Verma suggested three integrated care models to help lower cost and improve health outcomes of duals: 1. A capitated financial alignment model to provide Medicare and Medicaid services for a set amount; 2. A managed fee-for-service model; 3. A state-specific model. Read More

CMS Proposes 2.5 Percent Increase in Skilled Nursing Facility Payments for Fiscal 2020. *Modern Healthcare* reported on April 19, 2019, that the Centers for Medicare & Medicaid Services (CMS) has proposed a 2.5 percent increase in skilled nursing facility (SNF) payments in fiscal 2020 with an emphasis on value-based care. Last year, CMS finalized a new case-mix model, the Patient Driven Payment Model (PDPM), which will go into effect on October 1, 2019. Unlike the current Resource Utilization Groups (RUGs) system, PDPM will reimburse SNFs based on patient's conditions and care rather than the volume of therapy provided. CMS also proposes to revise the definition of group therapy as including two to six patients to align with the definition for inpatient rehabilitation facilities (IRFs). The proposed rule also includes two new quality measures to assess transfer of patient health information from a SNF to different provider as well as to the patient. Read More

Medicaid Enrollment Declines Most in States With Tough New Renewal Processes, Report Says. ***Modern*** *Healthcare* reported on April 19, 2019, that Medicaid enrollment fell by 1.8 million in 2018, with the sharpest declines in states that have tightened eligibility redetermination processes, according to a report from advocacy group Families USA. Enrollment fell 9.7 percent in Tennessee, 7.3 percent in Arkansas, and 7.2 percent in Missouri – all states that have established new processes. Read More

Concern Over Hospital Financials May Pose Obstacle to Medicare-for-All. *The New York Times* reported on April 21, 2019, that concerns over financial losses at hospitals may pose the biggest obstacle for advocates of Medicare-for-All. Assuming hospital rates are reduced to Medicare levels, hospitals could face significant restructuring, including closures and layoffs. Read More

NIH to Fund Research on How Integrated Prevention, Treatment, and Recovery Can Reduce Opioid Deaths. *The New York Times/Reuters* reported on April 18, 2019, that the National Institutes of Health will award $350 million in research grants to Kentucky, Massachusetts, New York, and Ohio to study how integrating prevention, treatment, and recovery can reduce opioid overdose deaths. Researchers will target at least 15 communities, with the goal of reducing overdose deaths by 40 percent over three years. Read More

OIG Investigates Medicaid Managed Care Denials. *The Gazette* reported on April 17, 2019, that the U.S. Office of Inspector General (OIG) has launched an investigation into coverage denials by Medicaid managed care organizations (MCOs). The review "will determine whether Medicaid MCOs complied with federal requirements when denying access to requested medical and dental services and drug prescriptions that required prior authorization," the agency's website states. Read More

CMS Proposes 2.3 Percent Hike For Inpatient Rehab Facility Payments in Fiscal 2020. *Modern Healthcare* reported on April 17, 2019, that the Centers for Medicare & Medicaid Services (CMS) has proposed a 2.3 percent increase in inpatient rehabilitation facility (IRF) payments per discharge in fiscal 2020. The proposal would also increase payment rates in rural areas by 4.3 percent and urban areas by 2.2 percent. CMS is seeking comments. Read More

CMS Proposes Increased Medicare Payments For Rural Hospitals. *Modern Healthcare* reported on April 23, 2019, that the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Inpatient Prospective Payment System, with the goal of increasing payments to rural hospitals. Urban hospitals would be negatively impacted by the change. Under the proposal, which would be in effect for four years beginning fiscal 2020, hospitals with a wage index below the 25th percentile would see an increase, while hospitals with a wage index above the 75th percentile would see a decrease, capped at 5% for fiscal year 2020. Other proposed changes include increasing technology add-on payments and modernizing payment policies for medical devices. Read More

Medicare Hospital Fund To Be Depleted By 2026, Says Trustee Report. *The New York Times/Reuters* reported on April 22, 2019, that the Medicare hospital insurance trust fund is still projected to be depleted by 2026, according to a report from the Social Security and Medicare boards of trustees. The report also projects that Medicare Part B and D drug costs associated with the Medicare Supplementary Medical Insurance trust fund will grow from 2.1 percent of gross domestic product in 2018 to 3.7 percent by 2038. Read More

CMS to Launch New Medicare Primary Care Payment Model. *Modern Healthcare* reported on April 22, 2019, that the Centers for Medicare & Medicaid Services (CMS) will launch a two-track voluntary program for Medicare primary care providers to shift from fee-for-service (FFS) to a direct-contracting payment model with varying degrees of risk starting 2020. The first track targets small primary care practices and will offer providers a flat monthly fee per patient. The second track, aimed at larger practices and hospital systems, offers comprehensive options with 50 percent to 100 percent risk. At least a quarter of traditional Medicare beneficiaries are expected to be served under the new model. Read More

Medicaid Innovation Accelerator Program to Host National Learning Webinar: Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness: Additional Data Sources. On May 16, 2019, from 2:00 pm-3:30 pm ET, the Medicaid Innovation Accelerator Program (IAP) will provide Medicaid agencies with an overview of a new technical resource, "Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness: Additional Data Sources." This Technical Resource describes approaches to combining Medicaid data with additional data sources that can assist state Medicaid agencies with developing data analytics to better understand their population with serious mental illness. Data analyses related to housing, corrections/justice involvement and food insecurity are highlighted as examples of the approaches described in the resource. The webinar will feature an overview of the technical resource, example analyses, and a discussion with state Medicaid leaders from Arizona and Minnesota who will share insights based on their experience conducting similar analyses. This resource builds on the Medicaid claims and encounters data analytics described in the IAP resource Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness.

HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates. To participate in this webinar, register here.

INDUSTRY NEWS

Anthem, UnitedHealth Are Among Leading Suitors to Acquire Magellan Health. *MedCity News* reported on April 19, 2019, that the bidding process for Magellan Health has advanced to the second round, with Anthem Inc., UnitedHealth Group, and the Carlyle Group among the potential acquirers. Activist investor Starboard Value LP owns around 9.8 percent of the company. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
April 29, 2019	Louisiana	Proposals Due	1,500,000
May 17, 2019	Minnesota MA Families and Children; MinnesotaCare	Proposals Due	679,000
May 17, 2019	Minnesota Senior Health Options; Senior Care Plus	Proposals Due	55,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
June 28, 2019	Louisiana	Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
July 1, 2019	Washington Integrated Managed Care - North Sound (Island, San Juan, Skagit, Snohomish, and Whatcom Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
July 9, 2019	Oregon CCO 2.0	Awards	840,000
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
January 1, 2020	Washington Integrated Managed Care - Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum Counties); Salish (Clallam, Jefferson, and Kitsap Counties); Thurston-Mason (Mason and Thurston Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	315,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	960,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	148,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	265,500
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

Company Announcements

ODG by MCG Announces John Nelson as New Director of Sales

HMA Welcomes

Cindy Zeldin – Senior Consultant

Cindy Zeldin is an innovative and experienced health policy professional with expertise in policy analysis, stakeholder and community engagement, and strategic planning. She joins HMA with more than 15 years' experience in Medicaid, Children's Health Insurance Program and Affordable Care Act implementation, as well as work in insurance regulation, behavioral health and social determinants of health.

Prior to joining HMA, Cindy served as the executive director of Georgians for a Healthy Future (GHF), a statewide consumer health advocacy organization. As the organization's first executive director, Cindy carved out a niche for GHF as a critical bridge between healthcare consumers and health and insurance-focused policymakers.

Under her leadership, GHF built partnerships and coalitions around a variety of health policy issues including coverage expansions, health insurance outreach and enrollment, social determinants of health and preventing youth substance use disorders. She oversaw the development of publications including the annual *Getting Georgia Covered* report, which synthesized information about consumer experiences enrolling in, and using, health insurance marketplace coverage.

During her time at GHF, Cindy was regularly sought-after to provide the consumer perspective on healthcare policy issues, trends and legislation. She was appointed to and served on the governor's Health Insurance Exchange Advisory Committee, the Senate Study Committee on the Provider and Consumer Protection Act and as a consumer representative to the National Association of Insurance Commissioners.

Cindy earned her Master of Public Health in health policy and management from the Rollins School of Public Health at Emory University, has a master's degree from The George Washington University, and a bachelor's degree in political science from Emory University.

Catherine Guerrero – Principal

An accomplished leader with experience spearheading public health and social change initiatives to combat physical and psychological violence, Catherine Guerrero has dedicated her career to advancing health equity.

She has worked in various capacities to build strong networks and improve individual and community well-being during her career. Catherine possesses a deep understanding of non-profit leadership, developing community-rooted strategies to increase health and well-being and the prevention of violence.

Before joining HMA, Catherine served as the associate director and chief strategy officer of the North Carolina Coalition Against Domestic Violence. In that role, she oversaw programs focused on children's health, shelter and housing efforts, violence prevention, economic justice, rural initiatives, healthcare, health equity and anti-oppression as well as improving non-profit

capacity. Catherine was also responsible for facilitating organizational strategic planning processes and evaluation programming.

Her career has also included program and evaluation management with other social services organizations working to build strong community support systems and healthcare intersections of social determinates of health. She held leadership roles with the Colorado Department of Public Health and Environment and the North Carolina Division of Public Health.

Catherine earned a Master of Public Administration and a graduate certificate in women's studies from the University of Colorado Denver and a bachelor's degree from George Mason University.

Scott Haga – Senior Consultant

Scott Haga is a passionate patient advocate with a focus on motivational training, evidence-based treatment, collaboration and tackling the national opioid crisis head-on.

He is an experienced medical provider who co-founded and co-led an interdisciplinary complex care intervention for high frequency emergency department utilizers. This innovative, fully integrated medical and behavioral health clinic provides care for individuals with complex biopsychosocial needs including addiction medicine services to pregnant women using controlled substances.

He has been recognized as a subject matter expert on addiction, medication assisted treatment for substance use disorders, and building well-functioning interdisciplinary treatment teams.

Before joining HMA, Scott worked as a physician assistant with Spectrum Health Medical Group Center for Integrative Medicine where he provided expert consultation to social worker case review. He also developed pathways with insurance payers to identify and refer appropriate patients with the highest utilization to appropriate programs and treatment teams.

He also served as lead physician assistant, providing primary care and psychiatric services for 10 years in Federally Qualified Health Centers in rural Washington. This experience provided a deep knowledge base of how addiction medicine services fit within the larger healthcare system, in which he is now a provider and trainer. He oversaw physician assistant students, served as a member of peer review committees, and was the co-clinical lead for implementing electronic health records helping medical providers with the transition.

Scott earned a Master of Physician Assistant Studies from Grand Valley State University and a bachelor's degree from Calvin College in social work.

Eric Hammelman - Principal

Eric Hammelman is a data-driven analyst who has spent his career overseeing healthcare data, risk adjustment and data analytics teams and projects. His experience includes serving as staff vice president with Anthem and vice president with Avalere Health. A leader in translating complex data analytics into actionable business strategies for healthcare entities, Eric has directed teams to conduct data-driven analyses of the impact of payment policies on healthcare patterns, including the effects of emerging payment and delivery models on providers, manufacturers and health plans.

Most recently, Eric led a risk adjustment analytics team for Medicare, Medicaid and Affordable Care Act business lines. During his tenure, the team identified and implemented several new processes to expand the risk adjustment operations by more efficiently engaging members and physicians. He also spearheaded efforts to combine claims, clinical and other non-traditional data to create a comprehensive risk profile of enrollees and providers.

Eric has experience analyzing large data sets including Medicare, Medicaid and private payer claims to identify trends and patterns – and then forecasting those trends to estimate future impact. He has also developed user-friendly models in Excel to estimate premiums, medical cost and coverage implications for a variety of state and federal proposals. Earlier in his career, he provided investment advice to institutional investors about companies in the healthcare services sector.

Eric earned a Master of Business Administration from the University of Southern California, Marshall School of Business, a Master of Music Performance from Mannes College of Music, and a bachelor's degree from the University of Illinois at Urbana-Champaign. He is a Chartered Financial Analyst (CFA) Charterholder.

Dave Schneider – Principal

Dave Schneider is an experienced public administrator with more than 30 years' experience dedicated to improving specialty healthcare. Through cross-county and cross-organizational collaborations, he helped develop innovative solutions built upon a foundation of public administration education and experience, community service and servant-leadership excellence.

Prior to joining HMA, Dave served as a behavioral health specialist for the Michigan Department of Health and Human Services where he led development of metrics projects, implemented federal regulations and facilitated coordination of programs to improve health and well-being of those with co-morbid physical and behavioral health conditions.

He is a proven strategic planner and leader with a passion for behavioral and integrated healthcare. He has guided the development and operations of information systems, quality management, regulatory compliance, client access and eligibility and contract management as the lead administrator of a Prepaid Inpatient Health Plan (PIHP).

Dave previously served as chief executive officer of a start-up regional health entity serving a PIHP and clients in 21 counties. He worked with national consultants to implement a behavioral health home pilot, forging relationships with Medicaid health plans and assuming responsibility for management of public funding for substance use disorder services in the region.

He earned a Master of Public Administration and bachelor's degrees from Western Michigan University.

Tarlton Thomas - Principal

A proven leader with excellent communication and problem-solving skills, Tarlton Thomas is a healthcare financial professional with expertise in healthcare quality and leadership development.

He joins HMA with more than 25 years of financial and operational leadership in healthcare and business services and has a deep understanding of publicly funded health programs. An intellectually curious problem solver, he knows how to strengthen an organization financially and operationally.

Tarlton was most recently at CareSource, a Medicaid managed care plan based in Ohio where he served as chief operating officer (COO) and chief financial officer. During his tenure, he oversaw growth in financial functions while managing tremendous enrollment, product, and revenue growth, including accounting, financial planning, financial analysis, treasury, actuarial, procurement, enrollment, health care quality, and facilities. He was also instrumental in setting up, and managing, multiple captive insurance entities to managed stop loss insurance as well as a unique risk sharing arrangement with a large, publicly traded health plan.

As COO, Tarlton was tasked with maturing operational functions including claims, configuration, provider credentialing, provider contract configuration, provider administration and process improvement. During his tenure, strategic improvements were made in all areas with operational metrics published near real time for increased visibility to view and monitor progress.

In addition, his work experience also includes financial management and oversight, process improvement, including earning a Six Sigma Green Belt, and corporate restructuring.

Tarlton earned accounting and finance degrees from Wright State University and passed the Certified Public Accountant exam in 2000.

HMA NEWS

New blog posts:

HMA Opioid Experts Are in Demand

Managing Principal Jonathon Blum Breaks Down Trump Administration's Agenda for Pharmacy Rebates

HMA MACPAC Report Published

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- MLRs at Hawaii Medicaid MCOs Average 91.8%, 2018 Data
- MLRs at Iowa Medicaid MCOs Average 95.0%, 2018 Data
- MLRs at Kentucky Medicaid MCOs Average 89.3%, 2018 Data
- MLRs at Louisiana Medicaid MCOs Average 84.8%, 2018 Data
- MLRs at Nevada Medicaid MCOs Average 82.8%, 2018 Data
- MLRs at Ohio Medicaid MCOs Average 83.9%, 2018 Data
- MLRs Average 74.5% at DC Medicaid MCOs, 2018 Data
- MLRs Average 82.8% at Georgia Medicaid MCOs, 2018 Data
- MLRs Average 85% at Michigan Medicaid MCOs, 2018 Data
- MLRs Average 85.4% Among Maryland Medicaid MCOs, 2018 Data
- MLRs Average 86.7% Among Nebraska Medicaid MCOs, 2018 Data
- MLRs Average 88.0% at Florida MMA MCOs, 2018 Data
- MLRs Average 88.0% at Indiana Medicaid MCOs, 2018 Data
- MLRs Average 92.7% at Illinois Medicaid MCOs, 2018 Data
- Alabama Medicaid Spending is Up 2.5% to $6.5 Billion, 2017 Data
- Florida Medicaid Managed Care Enrollment is Down 1.7%, Mar-19 Data
- Mississippi Medicaid Managed Care Enrollment is Flat, Apr-19 Data
- Oklahoma Medicaid Expenditures Approach $5.2 Billion, 2018 Data
- Oregon Medicaid Managed Care Enrollment is Up 1.2%, Mar-19 Data
- South Dakota Medicaid Spending Nearly $871 Million, 2018 Data
- Virginia Medicaid MLTSS Enrollment is Over 241,000, Apr-19 Data
- Wyoming Medicaid Spending Up 2.2% to $567 Million, 2018 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alaska Medical Claims Cost Avoidance and Post Payment Recovery Services RFP, Apr-19
- Arkansas Medicaid Dental Contracts 2017-19
- California Medi-Cal External Quality Review Organization (EQRO) Mental Health Services RFP and Award, Mar-19
- Hawaii Kupuna Care Case Management Services RFP, Apr-19
- Oklahoma SoonerCare Consulting Services RFP, Apr-19
- Oregon Final CCO 2.0 RFA, Attachments, and Applicant List, Apr-19
- Utah Medicaid Auditing and Accounting RFP and Award, Apr-19

Medicaid Program Reports, Data and Updates:

- Colorado Medicaid Quality Technical Reports, 2014-18
- Florida Medicaid Eligibility by County, Age, Sex, Mar-19 Data

- Indiana CHIP Annual Evaluation Report, CY 2018
- Massachusetts One Care Procurement Databooks, Apr-19
- Nebraska Annual External Quality Review Technical Reports, 2017-18
- Oklahoma Medicaid Enrollment by Age, Race, and County, Mar-19 Data
- Vermont Department of Health Hospital Utilization Reports, 2014-17
- Vermont EQRO Annual Technical Reports, 2015-18

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

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

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

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

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