HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 29, 2019

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THIS WEEK

IN FOCUS

IT TAKES A VILLAGE: HOW TO COORDINATE AND PAY FOR A COMMUNITY RESPONSE TO HEALTH INEQUITIES

This week, our *In Focus* section reviews the Pathways HUB model, an approach designed to help coordinate outreach by specialized community health workers who are incentivized to engage high-need populations. An HMA webinar, held May 9, 2019, with Mark Redding, co-developer of the Pathways HUB model, and Heidi Arthur, HMA can be viewed here.

A range of social, economic and environmental factors drive persistent health inequities and require comprehensive attention, cross sector coordination, and community-led collective effort. Community-Based Organizations (CBOs) are important partners in advancing health equity goals. They address the social determinants of health, have direct connections to the highest need populations that healthcare systems most often wish to reach, and they can offer interventions that impact overlapping clinical and social service needs among high-risk groups.

Yet, CBOs face many challenges in delivery system engagement. From funding and operational challenges to IT and workforce limitations, the question of how to activate local systems of care and finance sustainable CBO engagement has led a number of states and communities across the country to invest in innovative new models.

One approach, the Pathways HUB model, is an evidence-based, population-focused, pay-for-performance (P4P) care coordination model that identifies and addresses the comprehensive array of interrelated risk factors experienced by targeted populations within a defined geographic area. It engages local CBOs within the healthcare delivery system via a sustainable managed care financing infrastructure to coordinate efforts and standardize metrics among local community health workers (CHWs).

The model establishes a community-owned and operated HUB able to contract with multiple payers. HUBs coordinate outreach by specialized CHWs who are incentivized to find and engage the area's highest need populations. CHWs identify and address standardized health risks via shared metrics or standardized "Pathways" that have demonstrated impact on the social determinants of health.

An early adopter managed care organization (MCO) achieved significant reduction in neonatal admissions and, for every dollar spent on Community HUB activities, realized a savings of $2.36. The model has a formal research base related to maternal and child health, but is broadly responsive to population health goals and has been utilized for an array of populations.

The model helps delivery systems and local communities effectively activate the capacity of existing CBOs and civic resources to operate as extenders to the formal delivery system under a pay for performance methodology that systematically identifies and reduces risk factors while also supporting local population health planning with multiple payers.

It specifically addresses the need for an infrastructure to support resource sharing and delivery system financing for the smallest, grassroots and locally connected CBOs that are best able to build meaningful relationships at the community level, harness formal and informal resources, and make connections to health care benefits and providers, plus human services to address the SDOH.

HUBs are able to coordinate participating CBOs to address gaps in the system of care (Pathways for which services are not available or insufficient) via the HUB's ability to braid and blend funding from health and human services contracts.

The Pathways HUB Model has been recognized by the Institute for Healthcare Improvement, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health, CMS

Innovation Center, HRSA, and National Science Foundation, and is the predominant approach adopted in Washington State's Accountable Communities of Health.

HUBs are active in Ohio, Michigan, Oregon, Texas, New Mexico, Wisconsin, Minnesota. HUBs are being planned in Pennsylvania, North Carolina, South Carolina, Connecticut, Virginia. Community coalitions in five other states are exploring the model.

The HUB represents a local "care traffic control center" for the participating network of community-based health and human services agencies. The HUB contracts with payers and funders, oversees quality, and administers data collection and billing claims on behalf of the member organizations. The HUB ensures that care coordinators and providers within the system of care routinely collaborate in their approach to identify and address risks, identify service gaps for targeted investment, and avoid service duplication.

Working with a team of social workers and medical personnel, CHWs who have strong local connections and resource knowledge are incentivized to identify, reach out, and engage the individuals and families who have the most serious risk factors and the poorest health outcomes. CHWs develop a risk reduction plan of care based on a comprehensive assessment of medical, social and behavioral health risk factors for each identified individual within a family. Each risk factor identified in the assessment is assigned a specific Pathway that is tracked in order to ensure it is appropriately addressed. There are 20 nationally standardized Pathways. These Pathways, and associated risk reduction interventions, span access to health and behavioral health care, housing, food stability, education, and employment. The model is a pay-for-performance approach in which salaried CHWs can earn incentive payments for mitigating health risks. Programs delivering nationally certified HUB model services are paid when each Pathway (risk reduction) is completed.

The HUB model advances a community response for individuals and for local systems of care. At the individual level it brings together CBOs, local service providers, funders, and community members as part of the intervention team. The Pathways HUB model does not provide direct medical or social services. Instead, the model works to identify those at risk, assess their health and social service needs, and ensure they are connected to necessary critical interventions to address those needs. At the system of care level, the HUB serves as a central organizing structure for a local network of CBOs that are most often small entities experienced in an array of different services.

The HUB is an objective, quality focused agency able to effectively represent its network of community-based agencies and the individuals it serves. Each HUB has an advisory board and uses Pathways data, plus other related community assessment approaches, to ensure that the HUB is focused on the needs of the local community and that its guidance and leadership comes from the HUB's service region. It is recommended that HUBs not be part of a national or state network of agencies that may have to abide by state or national guidance and requirements that might differ from the local needs of the community.

Ideally, a local not-for-profit is developed whose sole purpose is to serve as the HUB. The HUB also represents CBOs for contracting with a variety of different funding entities including managed care organizations, grant makers, and public health departments. Working together as an organized team of agencies, the HUB network identifies those at greatest risk and ensures they are

connected to CHWs from the community who are the frontline force for outreach and care coordination among the appropriate medical, social, and behavioral health interventions.

HUBs most often develop from a well-connected group of individuals within a community who form a network focused on outcome improvement. Often there are one or more "community change agents" or leaders who can bring the individuals, agencies, and combined interests of the community together to accomplish their goals. Technical support through the Pathways Community HUB Institute and a CBO engagement toolkit available from HMA is available to assist in this process. PCHI is responsible for the national standards and certification of HUBs and has committed to ongoing modification of the standards, based on scientific evidence.

To learn more about the Pathways HUB model and how to build CBO capacity and HUB readiness in your community, contact:

Heidi Arthur at heidiarthur@healthmanagement.com

HMA Medicaid Roundup

Arizona

Legislature Approves Budget with Funds to Eliminate KidsCare Enrollment Freeze. *The Arizona Republic* reported on May 28, 2019, that the Arizona legislature approved an $11.8 billion state budget for fiscal 2020, including $1.6 million to eliminate an enrollment freeze in the KidsCare Children's Health Insurance Program. Read More

Arkansas

Arkansas Faces Lawsuit Over Failure to Provide Appeals Hearings for HCBS Care Denials. *The Arkansas Times* reported on May 24, 2019, that the Arkansas Department of Human Services (DHS) is facing a federal lawsuit over the failure to provide appeals hearings for individuals with disabilities and seniors who are denied care in the state's home and community-based ARChoices program. The lawsuit, filed by Legal Aid of Arkansas on behalf of a Craighead County woman and others, also claims that DHS workers discouraged people from exercising their appeal rights. Read More

California

Lawmakers Disagree Over Governor's Decision to Remove MCO Tax from Budget. *The Associated Press* reported on May 24, 2019, that California lawmakers disagree with Governor Gavin Newsom's decision to remove a Medicaid managed care organization (MCO) tax from the state's fiscal 2020 state budget. The $2 billion tax, which is set to expire June 30, is favored by Senate and Assembly committees but removed by the Governor who does not believe it would receive approval from the Trump administration. Lawmakers will begin budget negotiations with the Governor shortly. Read More

California Medi-Cal Buprenorphine Treatment Use Nearly Quadruples. *California Healthline* reported on May 23, 2019, that buprenorphine use to treat opioid addiction among California Medi-Cal users has nearly quadrupled from the end of 2014 through the third quarter of 2018. Regulatory changes, physician training, and other initiatives have made the medication more accessible. The California Medication Assisted Treatment (MAT) Expansion Project trains physicians to obtain a federal waiver required to treat patients with buprenorphine. The MAT expansion initiative covers costs for Medi-Cal members, the uninsured, and individuals with private insurance that does not cover treatment. Read More

Connecticut

Governor Proposes State Insurance Subsidies for Individuals, Small Businesses. *The CT Mirror* reported on May 23, 2019, that Connecticut Governor Ned Lamont and Democratic legislators have proposed legislation that would offer state insurance subsidies to individuals who aren't eligible for federal Exchange subsidies and to small businesses. The program, called Connecticut Option, would seek bids from health plans to provide the coverage. All health plans on the state Exchange would also be required to offer Connecticut Option coverage. The bill would need to pass the House and Senate before the legislative session adjourns on June 5. Read More

Governor Appoints Deidre Gifford to Lead Social Services Department. *The CT Mirror* reported on May 24, 2019, that Connecticut Governor Ned Lamont announced the appointment of Deidre Gifford, MD, as commissioner of the state's Department of Social Services (DSS), effective June 21. Most recently, Gifford served as deputy director for Medicaid and CHIP services at the Centers for Medicare & Medicaid Services (CMS). Her appointment is pending confirmation by the General Assembly. Read More

Florida

Florida Issues Request for Information (RFI) Related to the Canadian Prescription Drug Importation Program. The Florida Legislature passed House Bill 19 (HB 19) directing the Agency for Health Care Administration to establish a Canadian Prescription Drug Importation Program and to contract with a vendor to provide services under the Program. The Agency will initiate a competitive solicitation in Fall 2019 to procure a contract with a vendor to manage the importation of safe and effective prescription drugs from Canada. The Agency is issuing this Request for Information (RFI) to ascertain an estimation of the total vendor costs for providing services under the program. Read More

Indiana

Indiana Legislative Council to Study Medicaid Reimbursements for Out of State Specialized Care. *The Chicago Tribune* reported on May 22, 2019, that the Indiana Legislative Council has assigned a group of lawmakers to study Medicaid reimbursement rates to children's hospitals in neighboring states. The group aims to find the best approach to reimburse out of state facilities who accept Indiana children seeking specialized treatment not found in the state. Read More

Kentucky

Medicaid Plan Passport Health to Be Acquired By Evolent Health. *The Courier Journal* reported on May 29, 2019, that publicly-traded Evolent Health has agreed to acquire a 70 percent stake in not-for-profit Passport Health Plan of Louisville, KY, for $70 million. Evolent national Medicaid president Scott Bowers will become chief executive of Passport beginning June 7. Passport, which has struggled financially, has 300,000 Medicaid members. Evolent had already been providing administrative services to the plan. Read More

Kentucky Schools to Use Medicaid Dollars For Physical, Behavioral Health. *The Richmond Register* reported on May 24, 2019, that the Kentucky Cabinet for Health and Family Services (CHFS) will allow schools to use Medicaid funds to cover physical and behavioral health services. Kristi Putnam, deputy secretary of the CHFS, said that an amendment to the state Medicaid plan and analysis required to gain access to the funds were submitted May 1 with a planned August 1 start date. Kentucky is one of 14 states hoping to allow schools access to additional Medicaid funding. Read More

Louisiana

Senate Panel Shelves Proposal to Use Tax Data to Check Medicaid Eligibility. *The Shreveport Times* reported on May 27, 2019, that the Louisiana Senate Revenue and Fiscal Affairs Committee voted 5-3 against giving the state's legislative auditor access to income tax data to assist in the review of Medicaid eligibility. Opponents cited privacy concerns and an improved income verification system to check eligibility. The proposal was spearheaded by Representative Tony Bacala (R-Prairieville) and had already been approved by the House. Read More

Louisiana Medicaid Eligibility System May Remove Additional 17,000 Beneficiaries. *The Advocate* reported on May 22, 2019, that Louisiana is asking 17,000 additional Medicaid beneficiaries to prove their eligibility by June 30 or risk losing coverage. Under the state's new Medicaid eligibility system, 40,000 letters were sent out to individuals in February and over 30,000 lost coverage in March as a result. Most of the individuals were covered under the Medicaid expansion program. Read More

Massachusetts

Massachusetts Extends Deadline to Submit Proposals for One Care Procurement. On May 22, 2019, the Massachusetts Executive Office of Health and Human Services (EOHHS) issued an amended and restated request for responses (RFR) for One Care Plans. The new RFR extends the deadline for responses from May 24 to June 7. Plans that already submitted a response may submit an updated response by the new date. Implementation is still set to begin January 1, 2021. One Care is the state's dual demonstration program.

Nebraska

Senate Approves Bill to Delay Transition of Long-Term Care, HCBS Beneficiaries to Managed Care. *Unicameral Update* reported on May 24, 2019, that the Nebraska Senate approved a bill that delays the transition to Medicaid managed care of beneficiaries in nursing homes, assisted living facilities, and home and community-based settings until July 1, 2021. The bill, sponsored by Senator Lynne Walz (D-Fremont), also requires a hearing of the Banking, Commerce, and Insurance Committee if the state submits a 1332 innovation waiver to the federal government. Read More

New Hampshire

New Hampshire to Delay Start Date for New Medicaid Managed Care Contracts Until September 1. New Hampshire announced on April 17, 2019, that it will delay the contract start dates for the state's recently reprocured Medicaid managed care program from July 1 to September 1, 2019. The announcement, made during a Governor and Executive Council Meeting, said the state needed more time to effectively implement the reprocured program, which is known as New Hampshire Medicaid Care Management. The total cost for the nine months from September I, 2019, through June 30, 2020, will be $797.8 million. Current state fiscal 2019 contracts will be effective until August 31, 2019. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Begins Electronic Visit Verification Implementation. The New York State Department of Health has launched a webpage dedicated to sharing information on the state's implementation of an Electronic Visit Verification (EVV) system, as required by federal law under the 21st Century Cures Act. In addition, regional listening sessions have been scheduled to provide stakeholders an opportunity to have input in New York's EVV design and implementation. The webpage includes program information, stakeholder information, frequently asked questions, and a calendar that includes information on how to register for the regional listening sessions. Read More

New York Plans Change in Nursing Home Case Mix Methodology. *LeadingAge New York* reported that New York's fiscal 2019-20 budget authorized a change in the nursing home case mix methodology, which is expected to generate savings of $123 million (state share) in nursing home reimbursement. The budget authorized a workgroup to make recommendations on the methodology utilized to calculate case-mix adjustments to nursing home rates. The workgroup, chaired by Medicaid Chief Financial Officer Michael Ogborn, met on May 22 in Albany. The Department of Health (DoH) announced that a change in the rate-setting methodology will be reflected in the July 2019 rates. The change allows DoH to use an average case mix index for each facility resident over an 8-month period, rather than a single point in time as is the current system. The focus of the workgroup is on how to improve the accuracy of the case-mix determination process, and to reduce or eliminate abusive practices, for future rate periods. Workgroup

members raised concerns about the negative financial impact that this cut will have on many facilities. Read More

New York Legislature Holds Hearing on Single Payer Bill. *Crain's HealthPulse* reported on May 28, 2019, that the New York State Assembly and the State Senate held a joint hearing on the New York Health Act, a single-payer proposal for the state. The hearing, which lasted over 14 hours, highlighted how contentious the issue remains. While most speakers lauded the intent of a single payer bill, many questioned whether a redesign of the entire state health care insurance structure was necessary to provide coverage to the 5 percent of New Yorkers, estimated at about 1 million people, who do not currently have insurance. Dr. Mitchell Katz, President and CEO of the NYC Health +Hospitals, spoke in favor of the proposal, although groups representing the broader hospital industry expressed concern that lower reimbursement rates could further destabilize financially vulnerable hospitals and prompt further closures. The New York Health Plan Association representing New York's insurers remains opposed to the plan. Unions in the state remain divided over the plan, with both the New York Nurses Association and 1199SEIU, representing health care workers, supporting the bill; unions representing public sector workers oppose the plan as it might erode current health benefits their members receive. A recording of the hearing can be found at here. Read More

North Carolina

Judge Hears Arguments from 3 Health Plans Protesting Medicaid Managed Care Contracts. *The North Carolina Health News* reported on May 28, 2019, that three health plans appeared before a North Carolina administrative judge to argue for a second chance at winning Medicaid managed care contracts as well as a temporary halt to the state's planned transition to Medicaid managed care. Lawsuits filed by Aetna, Optima, and My Health by Health Providers, which failed to win contract awards, called the state's procurement process "flawed and unfair." The plans are seeking temporary injunctions to block the state from moving forward, which could impact the November start date for Phase 1 of the transition, which includes Region 2 and 4 of the state. Award winners included AmeriHealth Caritas, BCBS of NC, United, and WellCare. Read More

Medicaid Managed Care Redesign to Impact LME-MCO Enrollment. *DailyAdvance.com* reported on May 23, 2019, that Trillium Health Resources, one of seven North Carolina managed care organizations (MCOs) that oversee mental and behavioral health services, is set to lose most, if not all, of its 54,000 members because of the "sweeping" Medicaid reforms that have been taking place. The state's Department of Health and Human Services (DHHS) awarded contracts to companies to begin to offer comprehensive services through pre-paid standard health plans. Almost 70 percent of the patients now served through Trillium will go to standard plans covered by other organizations. Trillium has submitted a proposal to continue to oversee patients with severe behavioral or intellectual needs in tailored-plans which are set to be implemented in July 2021. Read More

Oklahoma

Oklahoma Goes to Trial Against Johnson & Johnson Over Opioid Crisis. *The New York Times/Associated Press* reported on May 27, 2019, that Oklahoma is the first state to go to trial against a pharmaceutical company over the opioid crisis. Oklahoma filed a lawsuit alleging that Johnson & Johnson helped create an opioid crisis by marketing the drugs and underplaying the risk of addiction. Several other states have reached settlements with drug makers Purdue Pharma and Teva Pharmaceuticals. Read More

Pennsylvania

Medical Assistance Advisory Committee Meeting Held May 23. At the Pennsylvania Medical Assistance Advisory Committee (MAAC) meeting held on May 23, 2019, the Pennsylvania Department of Human Services (DHS) provided status updates on multiple procurements. DHS is still evaluating options and does not have an anticipated release date for the HealthChoices Physical Health request for proposals (RFP). DHS is currently evaluating the responses to the Medical Assistance Transportation Program RFP. An RFI, released in early March, for the managed long-term services and supports Independent Enrollment Broker (IEB) received close to 500 comments from 38 entities. A draft IEB request for application (RFA) will be released in mid-June and a final RFA is expected in late summer/early fall. Additionally, a final Preferred Drug List is with the Secretary's Office for approval and the full file is expected to be delivered to MCOs after June 1.

Puerto Rico

Expiration of Temporary Medicaid Assistance Could Cause Funding Shortfall in PR, Study Finds. The Kaiser Family Foundation published a brief on May 21, 2019, analyzing the implications for Puerto Rico and the U.S. Virgin Islands if temporary federal Medicaid funds were to expire in September 2019. The report found that without additional funds, Puerto Rico would see a significant budget shortfall that could adversely impact Medicaid enrollment, Medicaid spending, and the number of uninsured lives. Specifically, expiration of the funds and a return to capped federal funding at a 55 percent federal medical assistance percentage (FMAP) would result in a shortfall of $1 billion in FY 2020 and $1.5 billion in FY 2021 in Puerto Rico. Read More

Texas

Lawmakers Pass 3 Patient Protection Bills Aimed at Medicaid Managed Care. *The Dallas Morning News* reported on May 27, 2019, that the Texas legislature passed three patient protection bills aimed at Medicaid managed care. The bills include creation of an "external medical reviewer" to review coverage denials by Medicaid plans as well as additional transparency and oversight measures. The bills now head to the Governor's desk for signature. Read More

National

CMS Finalizes Rule to Update, Modernize PACE. The Centers for Medicare & Medicaid Services (CMS) announced on May 28, 2019, that it has finalized a rule aimed at updating and modernizing the Programs of All-Inclusive Care for the Elderly (PACE), which provides comprehensive medical and social services to the frail elderly. The rule allows for increased flexibility in creating interdisciplinary teams, targets redundancies and administrative burdens, and adds patient protections. Read More

Trump to Seek Repayment of Medicaid Costs from Sponsors of Legal Immigrants. *The Wall Street Journal* reported on May 23, 2019, that the Trump administration will seek repayment for the cost of Medicaid and other public services from sponsors of legal immigrants who access the services in cases where the sponsor had promised to support the immigrant if necessary. According to the Trump administration, such provisions already exist in immigration and welfare laws but are not "adequately enforced." The new rule would also apply to food stamps and Temporary Assistance for Needy Families (TANF) payments. Read More

Trump Reportedly to Release Executive Order on Health Care Price Transparency. *The Wall Street Journal* reported on May 24, 2019, that the Trump Administration is expected to release an executive order on health care price transparency, according to an unnamed source. The order would mandate the disclosure of prices under the 21st Century Cures Act, the Affordable Care Act, Health Insurance Portability and Accountability Act, and Employee Retirement Income Security Act. The order may also involve the Justice Department to address hospital and managed care organization monopolies. Read More

Senators Draft Legislation Targeting Health Care Costs for Individuals. *The Hill* reported on May 23, 2019, that Senate Health Committee Chairman Lamar Alexander (R-TN) and Senator Patty Murray (D-WA) have proposed a health care package consisting of nearly three dozen provisions aimed at reducing health care costs for individuals. The package addresses surprise medical bills, drug price transparency, and pharmacy benefit management. Alexander and Murray hope to bring the package to the Senate for a July vote. Read More

Industry News

No news to report.

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
June 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
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 5, 2019	Kentucky	Proposals Due	1,200,000
July 8, 2019	Louisiana	Awards	1,500,000
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
September 1, 2019	New Hampshire	Implementation	181,380
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

Evidence-Based Interventions for Social Determinants of Health. Read More

HMA News

Upcoming Webinars:
Advancing and Codifying Health Equity and Wellness for Medicaid Populations - June 4, 2019, 1-2 pm EDT

Creating Effective Health and Law Enforcement Partnerships to Combat the Opioid Epidemic - June 5, 2019, 1-2 pm EDT

New this week on HMA Information Services (HMAIS):

Medicaid Data

- DC Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- DC Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- Georgia Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Bed Days Per 1000 Members Average 426 for Georgia MCOs, 2018 Data
- Illinois Dual Demo Enrollment is Down 1.9%, Apr-19 Data
- Bed Days Per 1000 Members Average 1141 for New York Medicaid MCOs, 2018 Data
- MLRs at 10 New York Medicaid MCOs Average 88.6%, 2018 Data
- New York Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- New York Medicaid Managed Care Enrollment is Down 0.5%, Apr-19 Data
- New York Dual Demo Enrollment is Down 17.2%, Apr-19 Data
- North Carolina Medicaid Enrollment by Aid Category, May-19 Data
- Rhode Island Dual Demo Enrollment is 14,916, May-19 Data
- South Carolina Dual Demo Enrollment is Up 18.6%, Apr-19 Data
- Texas Dual Demo Enrollment is 39,982, May-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Louisiana Medicaid Managed Care Organizations (MCO) RFP and Related Documents, 2019
- Massachusetts One Care Amended and Restated RFR, 2019
- Minnesota Innovative Forms of Health Care Delivery under Alternative Payment Arrangements to Medical Assistance (MA) and MinnesotaCare Enrollees Through Integrated Health Partnerships (IHP) RFP, May-19
- New Hampshire Medicaid Care Management Services Amended Contract, 2019-24
- New Hampshire Medicaid Managed Care Contracts and Extension, SFY 2019
- Pennsylvania Office of Long-Term Living Application and Enrollment Services RFI, Mar-19

Medicaid Program Reports, Data and Updates:

- Arkansas Monthly Enrollment and Expenditures Report, Apr-19
- California Medi-Cal 2020 Demonstration 1115 Waiver and Documents, 2015-18
- Iowa Medical Assistance Advisory Council (MAAC) Meeting Materials, May-19
- New Hampshire DHHS Preliminary Draft State Plan on Aging 2020-23, Apr-19

- New Hampshire Governor and Executive Council Meeting Minutes, 2019
- New Hampshire Medical Care Advisory Committee Meeting Materials, Apr-19
- Oregon Medicaid Advisory Committee Meeting Materials, May-19
- Pennsylvania Medical Assistance Advisory Committee (MAAC) Meeting Materials, May-19
- South Carolina Medicaid Enrollment by County and Plan, Apr-19
- South Carolina Medicaid Managed Care Enrollment is Up 2.3%, May-19 Data
- Virginia Medicaid Forecast and Rate Setting Review Report, May-19
- Wisconsin Medicaid MCO Actuarial Rate Certifications and Capitation Rates, 2018-19
- GAO Medicaid Demonstrations Study – Approvals of Major Changes Need Increased Transparency, Apr-19

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