HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 12, 2019

RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

NEW OPPORTUNITIES AND REQUIREMENTS FOR INTEGRATED MANAGED CARE MODELS FOR MEDICARE-MEDICAID DUALLY ELIGIBLE INDIVIDUALS SERVED BY HEALTH PLANS

This week, our *In Focus* section provides a high-level overview and an analysis for how health plans should consider two related and significant policy statements from the Centers for Medicare & Medicaid Services (CMS) about opportunities to further integrate care for dually eligible individuals. Specifically, the CMS April 24, 2019, State Medicaid Director letter (SMDL)

outlines new opportunities for states, largely working with health plans, to test models of integrated care, including opportunities to continue current financial alignment initiatives (FAIs).[i] CMS also issued final rules related to Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) definitions and requirements for Medicare-Medicaid integration activities and unified grievances and appeals for calendar year 2021.[ii] Together, these guidance documents should present greater opportunities for health plans to partner with CMS and states to integrate care for dual eligible beneficiaries.[iii]

Options for Health Plans Following New CMS Rules and Policy Guidance

Health plans have three new options to offer integrated Medicare-Medicaid products as a result of the CMS April 24, 2019 SMDL and MA CY 2020 and 2021 Final Rule. They build on existing integrated managed care models administered through health plans including:

- Medicare-Medicaid financial alignment initiative (FAI) capitated model with Medicare and Medicaid services provided by Medicare-Medicaid plans (MMPs).
- Aligned Medicaid managed long-term services and supports plans (MLTSS) and Dual Eligible Special Needs Plans (D-SNPs) with dual integration requirements in state Medicaid contracts (SMACs) that D-SNPs must follow in order to operate in a state.[iv]
- Medicare Advantage Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) that provide Medicare and required Medicaid benefits by a single health plan entity.

The CMS April 24, 2019, SMDL further expands current integrated managed care model options. It encourages states to partner with CMS to offer the following models through health plans:

- Revise or continue current FAI capitated models via multi-year extensions and expand to new geographic areas within the state.
- Initiate new capitated FAI programs.
- Pursue state-specific models based on the FAIs or other delivery system reforms (e.g., alternative payment methodologies, value-based purchasing, or episode-based bundled payments).

The CMS April 2019 SMDL additionally highlighted state integration opportunities that do not require states to seek CMS demonstration authorities or waivers. They include integrating care through D-SNPs and other options included in the CMS December 18, 2018 SMDL.

For calendar year (CY) 2021, the Medicare Advantage (MA) CY 2020 and 2021 Final Rule identifies three types or levels of D-SNPs health plans may offer, subject to obtaining SMACs and CMS application approval. All participating health plans must coordinate the delivery of Medicare and Medicaid services for eligible individuals. Each option has varying service provision, integration, and unified grievance and appeals requirements:

- Highly Integrated Dual Eligible (HIDE) SNP: A D-SNP offered by a Medicare Advantage organization whose parent organization or another entity owned or controlled by the parent organization covers Medicaid LTSS and/or behavioral health services, as required under capitated contract with the state. HIDE SNPs with exclusively aligned enrollment

must maintain clinical and financial responsibility for the provision of Medicare and required Medicaid benefits and conduct unified grievances and appeals.[v]

- FIDE SNP: A D-SNP under capitated contract with the state that must cover specified primary care, acute care, behavioral health, and long-term services and supports consistent with state policy, and cover nursing facility services for a period of at least 180 days during the plan year through the same entity that contracts with CMS to operate as a Medicare Advantage plan. It is required to:
    - coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and
    - coordinate or integrate enrollee beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.
- D-SNPs that are not HIDE SNPs or FIDE SNPs: The D-SNP must meet additional state Medicaid agency contract requirements for integration, which include sharing data on hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals enrolled in the D-SNP. States have the authority to identify the high-risk group. D-SNPS may also provide coverage of Medicaid services, including long-term services and supports and behavioral health services for eligible individuals.

Health Plan Considerations for Integrated Medicare-Medicaid Offerings

Plans currently operating MMPs and D-SNPs, and those planning expansion and entrance into new markets, will need to assess new CMS requirements, current state integration models, and state capacity to continue or develop and oversee new integrated programs. Planning for entrance into potential new integrated markets requires a thorough assessment of plan capabilities to meet new federal and state requirements; state interest, readiness and capacity given other priorities; and input provided by stakeholders. Further considerations include:

- Medicare Advantage best practices to serve the dual eligible population and achieve high Star Ratings.
- Success with current capitated FAI programs in each state and interest in continuing and expanding the current program with refinements and possible geographic expansion. What have states and CMS grappled with to ensure enrollment and retention of members, financial viability of the program and ability to achieve appropriate utilization of services and costs savings?
- State interest in and capacity to move to or establish a Medicaid MLTSS program with D-SNP integration requirements. What would the state gain over the current status quo and what are the available state resources to design and oversee different types of D-SNPs with varying levels of required integration and unified grievances and appeals?
- Medicare Advantage market dynamics and penetration.

- State interest in and capacity to establish its own state-specific model. What experience does the state have with delivery system reform and internal expertise to build a new or hybrid model using alternative payment strategies?

Specific to assessing readiness to enter the MMP and integrated MLTSS and D-SNP markets, health plans must consider the following: Does the plan have separate Medicare and Medicaid teams that currently collaborate on market strategy, product design, and plan management? What experience does the plan have serving dual eligible populations and establishing a provider network to meet the unique needs of the population? What experience does it have in financial modeling for these products? What expertise must the plan demonstrate, build or acquire to effectively operate in the integrated managed care market?

Stakeholder engagement will be critical as planning moves forward to better meet the needs of the over 12 million dually eligible individuals across the country. Health plans can be important partners to states and CMS in obtaining stakeholder input to inform refinement of current integrated managed care models and design and implementation of new models.

For more information, please contact Sarah Barth, Principal, HMA.

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i CMS State Medicaid Director Letter #19-002 Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare, April 24, 2019.

ii Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021; Policy and Technical Changes (CMS-4185) (MA 2020 and 2021 Final Rule).

iii Please look for a forthcoming, separate HMA update on the current regulatory landscape and considerations for the Program of All-Inclusive Care for the Elderly (PACE).

iv D-SNPs must have SMACs in order to operate in states, providing leverage to states to include contract provisions related to D-SNP integration activities and other requirements such as reporting and data sharing.

v *Exclusively aligned enrollment* occurs when the state Medicaid agency limits a D-SNP's membership to individuals with aligned enrollment. *Aligned enrollment* occurs when a full-benefit dual eligible individual is a member of a D-SNP and receives coverage of Medicaid benefits from the D-SNP or from a Medicaid managed care organization that is:

- The same organization as the MA organization offering the DSNP;
- Its parent organization; or
- Another entity that is owned and controlled by the D-SNP's parent organization.

Only entities with exclusively aligned enrollment can hold *clinical and financial responsibility* for the provision of Medicare and Medicaid benefits (FIDE SNPs and HIDE SNPs with exclusively aligned enrollment) MA 2020 and 2021 Final Rule.

HMA Medicaid Roundup

Alaska

Alaska Awards Contract to Evaluate Medicaid Block Grant. *KTUU* reported on June 5, 2019, that the Alaska Department of Health and Social Services has awarded a $100,000 contract to Public Consulting Group to help the state evaluate whether it should shift to a block grant for federal Medicaid funds. Other options to be evaluated include work requirements and shifting some beneficiaries to subsidized private market plans. Public Consulting Group will submit a paper by June 30 evaluating the potential savings of these initiatives. Read More

California

Lawmakers Agree on Plan to Allow Undocumented Immigrants Ages 19 to 25 to Enroll in Medicaid. *Newsweek* reported on June 10, 2019, that California Democratic lawmakers have agreed on a plan that would offer Medicaid coverage to a projected 90,000 undocumented immigrants between the ages of 19 and 25. The measure is part of a budget plan that still needs legislative approval. The proposed budget also provides subsidies to middle-class families to help pay for monthly health insurance premiums. Read More

Florida

Governor Signs Prescription Drug Importation Bill. *ABC Action News* reported on June 11, 2019, that Florida Governor Ron DeSantis signed into law legislation that would allow the state to import cheaper prescription drugs from Canada and other countries. The plan still requires federal approval. Read More

Georgia

Georgia Medicaid to Disenroll 17,000 Disabled, Elderly Members. *McKnight's Long-Term Care News* reported on June 6, 2019, that the Georgia Department of Community Health will disenroll 17,000 elderly and disabled Medicaid members for failing to respond to renewal notices. Georgia Legal Services, which represents some of the affected patients, is trying to get the decision reversed. Read More

Massachusetts

Massachusetts Releases One Care Plan RFR Bidders List. On June 10, 2019, the Massachusetts Executive Office of Health and Human Services (EOHHS) released a list of six health plans that submitted bids for the state's One Care Dual Demonstration RFR:

1) Boston Medical Center HealthNet Plan
2) Commonwealth Care Alliance (incumbent)
3) Fallon Health
4) Senior Whole Health
5) Tufts Health Plan (incumbent)
6) United Healthcare Community Plan

EOHHS intends to award contracts to three plans, and no more than five.

Lawmakers to Hold Hearing on Medicare For All Bill. *The Boston Herald/Associated Press* reported on June 10, 2019, that Massachusetts lawmakers will host a public hearing on legislation that would introduce Medicare for all in the state. The hearing, scheduled for June 11, will address other health insurance measures as well. Read More

Drug Spending Jumps 4 Percent Prompting Calls for PBM Transparency. *Fierce Healthcare* reported on June 7, 2019, that Massachusetts is among a growing number of states calling for additional transparency for pharmacy benefit management (PBM) companies after a report by the Massachusetts Health Policy Commission (HPC) found that prescription drug spending grew 4.1 percent in 2017. The report also showed that from 2012 to 2017, MassHealth prescription drug spending nearly doubled from $1.1 billion to $1.9 billion. The state's new proposal, which would require PBMs to be transparent about their pricing and to limit PBM margins under contracts with public agencies, is projected to save $10 million. Read More

Michigan

Health Alliance Plan to Acquire Trusted HP-Michigan (Formerly Harbor). *Modern Healthcare* reported on June 10, 2019, that Health Alliance Plan (HAP) has agreed to acquire Trusted Health Plan – Michigan (formerly Harbor Health Plan), a 9,000-member Medicaid plan based in Detroit. The acquisition will expand HAP's reach into the state's Region 10 (Wayne, Oakland, and Macomb counties), which the company had served in the past. The acquisition, which is subject to regulatory approval, is expected to be completed in late summer. HAP currently offers Medicaid coverage to 3,500 members in Region 6, serving mid-Michigan and the Thumb, as well as Medicare-Medicaid dual coverage for 4,500 members in Wayne and Macomb counties. Read More

New Hampshire

Proposal to Raise Medicaid Reimbursement Rates Faces Opposition. *The Concord Monitor* reported on June 11, 2019, that a plan from Democratic lawmakers in New Hampshire to raise Medicaid reimbursement rates is facing opposition from Jeffrey Meyers, commissioner of the state Department of Health and Human Services. The Senate plan calls for a flat 3.1 percent annual increase for two years. In a letter to lawmakers, Meyers said the approach would result in "the inequitable allocation of rate increases" among providers, including redundant or overlapping increases in some cases. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Excellus to Enter Medicaid Market in Onondaga County After 6-Year Absence. *Syracuse.com* reported on June 11, 2019, that Excellus BlueCross BlueShield will reenter the New York Onondaga County Medicaid managed care market after a nearly six-year absence. Excellus received approval from the New York Health Department to offer HMOBlue Option and Blue Option Plus Medicaid. The insurer exited the market in 2013 after losing about $100 million on the program. Read More

New York Report Provides Framework for Provider-Social Service Partnerships. United Hospital Fund of New York (UHF) has developed a framework for primary care providers to establish social needs screening and referral programs in concert with human services partners. A recent report provides guidance on issues such as choosing a screening tool, developing a realistic workflow, identifying appropriate community based organization (CBO) partners, and building relationships, as well as exploring how these referral processes work in the real world. The report identifies four challenges in developing partnerships between the health care and social services sectors:

- There is no single standardized/interoperable approach to information technology that supports tracking social needs in the primary care practice.
- Increased screening is likely to increase the demand for services provided by CBOs. It is not clear that those organizations have the resources needed to increase service supply to meet growing demand.
- Beyond highly-targeted investments in specific services for high-cost, high-need patients, value-based payment methods are unlikely to generate the provider and payer investments needed to respond to the type and volume of social needs that may be identified.
- The effectiveness of these new programs needs to be evaluated—whether they work from the patients' perspective and whether they are effective at a population level in identifying and reducing social needs which underpin many disparities in care and outcomes. Read More

New York State Health Foundation Summarizes Options for Expanding Health Coverage. The New York State Health Foundation has developed a Policy Tracker that describes four different proposals for expanding health insurance coverage in New York. These include expanding the Essential Plan to undocumented immigrants; expanding the Essential Plan to allow low-income individuals to buy into the plan; expanding Medicare to include younger adults; and the New York Health Act, which would establish a single-payer system for New York. The tracker highlights differences in how these plans would work, the populations targeted by the policies, and potential coverage and cost impacts. Read More

New York Releases Transition Assistance RFA. The New York Department of Health released on June 6, 2019, a request for applications (RFA) for the Money Follows the Person (MFP) Transition Assistance program designed to shift health care priorities away from institutional care and rebalance them toward long term care provided in the community. The MFP program supports a number of rebalancing activities, including the operation of a statewide network of regionally based Transition Centers, which identifies potential participants in long-term care facilities, provides them with education on return-to-community options, and facilitates their transition from institutional to community-based care. New York is seeking an organization to operate a statewide Transition Center infrastructure, which will provide education about community living options, transition assistance, peer outreach and support, and education and outreach to nursing homes to support the transition of individuals from institutional to community-based settings. It is anticipated that $5.4 million per year ($27 million total) will be available to award one contract to a not-for-profit organization over a five-year period to deliver the Transition Center program statewide, including the core functions of transition assistance, peer outreach and support, and education and outreach to nursing homes. Applications are due by July 25, 2019. Read More

New York Long Term Care Planning Project to Hold Meeting July 9. The New York State Department of Health Long Term Care Planning Project (LTCPP) committee announced on June 10, 2019, that a third meeting for Evidence-Based Programs and Innovative Models in Aging and Long Term Care will take place on July 9 from 1:00 to 4:00 pm. This project aims to understand the needs of older adults in New York by examining the state's long-term care system. All meetings are open to the public. To access past presentations and meeting minutes you can click here.

Pennsylvania

Amendments to Office of Developmental Program Waivers Open for Comment. The Pennsylvania Department of Human Services is making available for public review and comment the Office of Developmental Programs' proposed amendments to the Consolidated, Community Living and Person/Family Directed Support (P/FDS) waivers.

UPMC Drops Planned Prepayment Policy. *The Pittsburgh Post Gazette* reported on June 5, 2019, that University of Pittsburgh Medical Center (UPMC) Health Plan no longer plans to require patients with Medicare Advantage coverage through Highmark to pay for services in advance once consent decrees between the Pittsburgh-based rivals expire July 1. UPMC notified the Pennsylvania Insurance Department of the reversal, which comes months after the prepayment policy was announced in October. In addition, UPMC said it will now accept direct payment for out-of-network emergency services from Highmark at the same rate that UPMC Health Plan pays Pittsburgh-based Allegheny Health Network hospitals, which are part of Highmark. Read More

Pennsylvania Bills Would Delay Transition to Medicaid NEMT Broker Model. *The Pittsburgh Post-Gazette* reported on April, 18, 2019, that Pennsylvania lawmakers introduced bills in both the House and Senate to delay the state's planned transition to a broker model for Medicaid non-emergency medical transportation services. The state is already evaluating bids from brokers, which would manage call centers and negotiate with transportation networks. The requirement to procure NEMT broker services statewide by region to replace the current county-based model was included in a budget bill that passed last year. Read More

Senate Panels to Host Discussion on Medicaid Work Requirements. *BCTV* reported on June 10, 2019, that two Senate committees will hold a joint workshop on Medicaid work requirements, with presentations expected from various state, advocacy, and employer groups. Legislation involving Medicaid work requirements has already been introduced in the Senate. The workshop, hosted by the Senate Majority Policy Committee and the Senate Health and Human Services Committee, is scheduled for June 12. Read More

South Carolina

South Carolina Applies for Medicaid Work Requirements. *The Hill* reported on June 10, 2019, that South Carolina submitted a waiver request to impose Medicaid work requirements. The policy would require able-bodied Medicaid beneficiaries to report 80 hours of work, school, or volunteering to maintain coverage. Beneficiaries who fail to meet the requirement for three months would have coverage suspended for three months or until they are in compliance, which ever comes first. If approved, the policy would take effect in July 2020. Read More

Virginia

Virginia Is Cited for Inadequate Oversight of Medicaid Eligibility Determinations. *The Daily Press* reported on June 5, 2019, that the Virginia Department of Social Services (DSS) didn't properly oversee how local social services departments determine eligibility for Medicaid beneficiaries, according to a report by the Office of the State Inspector General. The report found that of the 121 scheduled monitoring projects only 39 were conducted in fiscal years 2014-17. Other problems included a lack of standards for defining Medicaid eligibility and gaps in the communication of information about Medicaid eligibility and CHIP, according to the report. Read More

Washington

Washington Wins CMS Approval to Implement Value-Based Purchasing for Hepatitis C Drugs. On June 12, 2019, Washington won approval from federal regulators to negotiate supplemental rebate agreements for Hepatitis C drugs using value-based purchasing. Under the State Plan Amendment, which has been approved by the Centers for Medicare & Medicaid Services (CMS), Washington will pay a fixed annual amount to a drug maker to purchase an unlimited supply of Hepatitis C drugs. CMS has approved similar value-based arrangements in Oklahoma, Michigan, and Colorado. Read More

West Virginia

West Virginia University Health System to Acquire The Health Plan. *The Charleston Gazette-Mail* reported on May 7, 2019, that West Virginia University Health System/WVU Medicine will acquire The Health Plan in hopes of creating a fully integrated, provider-owned managed care organization. The Health Plan, which will operate under the WVU Medicine name, is a not-for-profit plan serving 200,000 Medicare, Medicaid, and commercial members in West Virginia and Ohio. Read More

Wyoming

Legislative Committee to Explore Using Medicaid Funds for Special Education Services in Schools. *Wyoming Public Media* reported on June 5, 2019, that the Wyoming Joint Education Committee will explore the possibility of using Medicaid funds to cover special education services in schools, including speech, occupational, and physical therapy. The state Department of Health and the Department of Education are working to draft a plan to implement the change in the 2020-21 school year, pending legislative approval. Wyoming is the only state that doesn't cover special education services in schools using Medicaid funds. Read More

National

Hospitals Oppose Cost Estimate Provision in Senate Transparency Proposal. *Modern Healthcare* reported on June 6, 2019, that in commenting on a draft Senate Health Committee transparency bill, hospitals opposed a provision mandating they provide cost estimates to patients within 48 hours of a request. Health plans and employers support the measure. Read More

Fewer Psychiatrists Are Taking Medicaid Patients, Report Shows. *Reuters* reported on June 7, 2019, that the percentage of psychiatrists accepting Medicaid patients has fallen from 48 percent in 2010-11 to 35 percent in 2014-15, even after states expanded coverage to include mental health services, according to a report in JAMA Psychiatry. The study suggests that expanding coverage may not by itself guarantee access to psychiatrists. The study found that the shortage of psychiatrists is changing the way they do business, pushing many to take patients only if they can pay out of pocket. Read More

Industry News

MVP Health Care CEO Denise Gonick to Step Down. *The Albany Business Review* reported on June 6, 2019, that Denise Gonick will step down as chief executive of MVP Health Care at the end of the summer. A successor has not yet been named. Gonick joined MVP in 1995 and became chief executive in 2012. Read More

Opioid Maker Insys Files for Bankruptcy Following DOJ Settlement. *The New York Times* reported on June 10, 2019, that Arizona-based drug maker Insys filed for bankruptcy protection after agreeing to a $225 million settlement with the U.S. Justice Department over claims the company had bribed doctors to prescribe opioids. Insys is the first drug maker to file for Chapter 11 bankruptcy because of a legal action related to the opioid crisis. Read More

Press Ganey to be Acquired by Consortium Led by Ares, Leonard Green. *Bloomberg* reported on June 11, 2019, that EQT Partners has signed a definitive agreement to sell Press Ganey Associates Inc. to a private equity consortium led by Ares Management Corporation and Leonard Green & Partners. Financial terms of the transaction, which is expected to close in the third quarter, were not disclosed. Press Ganey provides surveys used to measure quality of care and patient satisfaction. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
June 2019	Ohio	RFI #1 Release	2,360,000
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 2019	Ohio	RFI #2 Release	2,360,000
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 - March 2020	Ohio	RFP Release	2,360,000
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
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
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

HMA News

HMA Collaborates on Connecticut HEC Initiative. The Connecticut Office of Health Strategy and Department of Public Health recently announced that the State Innovation Model (SIM) Healthcare Innovation Steering Committee has approved the Health Enhancement Community (HEC) initiative proposed framework. This blueprint is designed to build or expand collaborations across the state to improve healthy weight and physical fitness, advance child well-being, and strengthen health equity. The HEC initiative will further residents' health and well-being by addressing both clinical need and the social determinants that impact overall health. Read More

New this week on HMA Information Services (HMAIS):

Medicaid Data

- MLRs at Alabama Medicare Advantage MCOs Average 82.5%, 2018 Data
- Arkansas PASSE Medicaid Managed Care Enrollment is 45,629, May-19 Data
- MLRs at Colorado Medicare Advantage MCOs Average 89.8%, 2018 Data
- California SNP Membership at 190,726, Mar-19 Data
- MLRs at Florida Medicare Advantage MCOs Average 84.5%, 2018 Data
- Illinois Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Indiana Medicaid Managed Care Enrollment is Flat, Apr-19 Data
- MLRs at Kentucky Medicare Advantage MCOs Average 82.2%, 2018 Data
- MLRs at Maine Medicare Advantage MCOs Average 85.9%, 2018 Data
- Michigan Medicaid Managed Care Enrollment is Down 1.6%, May-19 Data
- MLRs at Michigan Medicare Advantage MCOs Average 87%, 2018 Data
- Bed Days per 1000 Members Average 567 for Mississippi Medicaid MCOs, 2018 Data
- MLRs Average 88.5% Among Mississippi Medicaid MCOs, 2018 Data
- Mississippi Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- New Mexico Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- MLRs at New Jersey Medicare Advantage MCOs Average 86.1%, 2018 Data
- Nevada Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- MLRs at Oklahoma Medicare Advantage MCOs Average 83.7%, 2018 Data
- Oregon Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- MLRs at Rhode Island Medicare Advantage MCOs Average 82.8%, 2018 Data
- South Carolina Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Texas Medicaid Managed Care Enrollment is Down 2.9%, Feb-19 Data
- Utah Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Utah SNP Membership at 7,127, Mar-19 Data
- Virginia Medicaid Fee for Service vs. Managed Care Penetration, 2014-18

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Louisiana Dental Benefit Program Management RFP, Jun-19
- Massachusetts One Care RFR Respondents List, Jun-19
- Virginia Commonwealth Coordinated Care Plus MLTSS MCO Contracts, 2017-19

Medicaid Program Reports, Data and Updates:

- California Managed Care Advisory Group Meeting Materials, Jun-19
- Delaware State Innovation 1332 Waiver Application, May-19
- North Carolina Medicaid BH and IDD Tailored Plans Care Management Policy Paper, May-19
- Nevada Medicaid Encounter Data Validation Study Report, SFY 2018
- New York Long Term Care Planning Project Meeting Presentations and Related Documents, 2019
- Ohio Behavioral Health Care Coordination (BHCC) – Delayed Implementation Notice, Mar-19
- Ohio Medicaid Managed Care Capitation Rate Certification, CY 2019
- Ohio Medicaid Managed Care Financials, 1Q2019
- Ohio Medicaid Managed Care Financials, 2018
- Oklahoma Health Care Authority Medicaid Health Access Networks Evaluation, May-19
- Oregon CCO Incentive Metrics 2018 Deeper Dive Report, May-19
- Texas Medicaid, CHIP Caseload by Risk Group and County, Feb-19
- Texas Medicaid Managed Care Financial Statistical Reports for STAR, STAR Kids, STAR+PLUS, CHIP, and MMP, FY 2018
- Utah Medical Care Advisory Committee Meeting Materials, May-19
- Virginia Medicaid Recipients by Eligibility Category, Jun-19

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