HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 16, 2019

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THIS WEEK

IN FOCUS

PENNSYLVANIA RELEASES HEALTHCHOICES PHYSICAL HEALTH RFA

This week, our *In Focus* section reviews the Pennsylvania HealthChoices Physical Health Medicaid managed care request for applications (RFA), issued by the Pennsylvania Department of Human Services on October 15, 2019. Medicaid managed care organizations (MCOs) will serve the five HealthChoices zones covering all 67 counties: Southeast, Southwest, Lehigh-Capital, Northwest, and Northeast. Contracts are worth nearly $13 billion.

Previous Procurements

Pennsylvania failed to implement new contracts and negated awards from 2016 as well as the awards from the 2017 rebid. As result, the HealthChoices program is currently operating under extensions of contracts originally awarded in 2012. The most recent awards in early 2017, which would have been for a three-year, $12 billion contract, were for the following plans:

- Southeast Region: Gateway Health, Health Partners Plans, PA Health and Wellness (Centene), UPMC for You, Vista–Keystone First Health Plan
- Southwest Region: Gateway Health, PA Health and Wellness (Centene), UPMC for You, VistaAmeriHealth Caritas Health Plan
- Lehigh/Capital Region: Gateway Health, Geisinger Health Plan, Health Partners Plans, PA Health and Wellness (Centene)
- Northeast Region: Gateway Health, Geisinger Health Plan, UPMC for You
- Northwest Region: Gateway Health, UPMC for You, Vista-AmeriHealth Caritas Health Plan

However, after protests from Aetna, UnitedHealthcare, and AmeriHealth Caritas, the state elected to cancel the RFP and reissue the procurement. These three plans are incumbent plans serving about one half of all HealthChoices enrollees as of July 2019. Aetna and UnitedHealthcare were not awarded contracts for any regions and AmeriHealth Caritas, which serves more than thirty percent of all HealthChoices enrollees, was a successful bidder for two of the five regions.

Awards

Multiple MCOs will be selected for each of the five regions.

- **Southeast Zone: 4-5 MCOs**
  - Bucks, Chester, Delaware, Montgomery, and Philadelphia counties
- **Southwest Zone: 3-5 MCOs**
  - Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties
- **Lehigh-Capital Zone: 3-5 MCOs**
  - Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties
- **Northwest Zone: 3-4 MCOs**
  - Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, potter, Venango, and Warren counties
- **Northeast Zone: 3-4 MCOs**
  - Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Susquehanna, Tioga, Union, Wayne, and Wyoming counties

Evaluation

Technical applications will be scored based on:

- **Soundness of Approach (85 percent)**
  - Accounting for the unique healthcare resources available to and healthcare challenges faced by members in the particular zone.
  - Addressing all work statement requirements.

  - Approach has been crafted to address the particular demographic, cultural, economic, geographic, or other relevant characteristics of the counties of the zone.
  - Addressing how past performance has improved quality, access, and value for the HealthChoices program or a similar program.
- **Personnel Qualifications and Staffing (5 percent)**
  - Overall organizational structure and proposed functions, staff, and subcontractors.
  - Education, experience, qualifications, and other information for executive management, key administrative, and subcontracted staff.
- **Prior Experience and Performance (10 percent)**
  - Corporate background and history
  - Corporate qualifications and experience in Medicaid managed care systems

MCOs can score an additional 3 percent of the total score for domestic workforce utilization.

The total raw score for the technical submittal for each zone must be 75 percent or greater.

Timeline

Applications are due December 17, 2019, and contracts are expected to begin January 2021, running for five years, with an option to extend for an additional period of three years. An award date was not announced.

RFP Activity	Date
RFP Issued	October 15, 2019
Proposals Due	December 17, 2019
Implementation	January 1, 2021

Current Market

Current Medicaid incumbents are Aetna, AmeriHealth Caritas, Gateway, Geisinger, Health Partners Plans, UnitedHealthcare, UPMC, serving approximately 2.26 million members.

Enrollment in Pennsylvania Managed Medicaid by Plan, 2013-18, July 2019				
Plan	2016	2017	2018	Jul-19
AmeriHealth Caritas	**689,192**	**713,298**	**719,549**	**715,477**
% of total	*30.4%*	*30.8%*	*31.5%*	*31.6%*
UPMC	**405,144**	**420,756**	**420,018**	**420,898**
% of total	*17.9%*	*18.2%*	*18.4%*	*18.6%*
Gateway	**310,211**	**304,022**	**288,077**	**282,023**
% of total	*13.7%*	*13.1%*	*12.6%*	*12.5%*
Health Partners	**245,736**	**252,441**	**245,224**	**235,619**
% of total	*10.8%*	*10.9%*	*10.8%*	*10.4%*
UnitedHealthcare	**223,737**	**228,699**	**223,456**	**222,285**
% of total	*9.9%*	*9.9%*	*9.8%*	*9.8%*
Aetna	**211,040**	**206,949**	**200,980**	**202,783**
% of total	*9.3%*	*8.9%*	*8.8%*	*9.0%*
Geisinger	**181,554**	**188,441**	**183,510**	**182,694**
% of total	*8.0%*	*8.1%*	*8.0%*	*8.1%*
Total Pennsylvania	**2,266,614**	**2,314,606**	**2,280,814**	**2,261,779**
+/- between reporting periods	*138,896*	*47,992*	*(33,792)*	*(19,035)*
% chg. between reporting periods	*6.5%*	*2.1%*	*-1.5%*	*-0.8%*
Source: PA Dept. of Human Services, HMA				

Population Group Enrollment by Zone, July 2019				
Zone	TANF/MAGI	SSI/BCC	Newly Eligible	Grand Total
Southwest	233,707	80,557	148,780	463,044
Southeast	430,722	116,222	269,523	816,467
Lehigh/Capital	276,089	73,420	143,236	492,744
Northeast	169,614	46,432	100,704	316,750
Northwest	82,348	27,499	47,495	157,342
Total	**1,192,480**	**344,130**	**709,738**	**2,246,348**
Some totals do not sum due to rounding.				
Source: PA Dept. of Human Services, HMA				

Link to Pennsylvania HealthChoices RFP

HMA Medicaid Roundup

Arkansas

Arkansas Drops Coverage for 18,000 Over First 10 Months of Medicaid Work Requirements. *The Wall Street Journal* reported on October 13, 2019, that the implementation of Medicaid work requirements in Arkansas resulted in more than 18,000 beneficiaries losing coverage over the first 10 months of the program, according to a federal report. Many Medicaid beneficiaries did not know or were confused by the new rules, which require them to report at least 80 hours of work or related activities each month. Arkansas also did not set up a system to monitor gains in employment, and several studies found little evidence that beneficiaries found jobs as a result of the requirements. Read More

California

California Wholesale Drug Prices Rise 26 Percent, State Report Shows. *California Healthline* reported on October 11, 2019, that the median wholesale acquisition cost (WAC) of prescription drugs in California rose 25.8 percent from January 1, 2017, to June 30, 2019, according to a report from the Office of Statewide Health Planning and Development. Generic drugs increased by a median of 37.6 percent during the same time period. The report is the first based on data gathered as a result of California's 2017 transparency law, which requires drug makers report quarterly WAC pricing. Read More

Florida

Lawmaker Refiles Bill to Address Shortage of Medicaid Dental Providers. *Florida Phoenix* reported on October 15, 2019, that Florida Senator Jeff Brandes (R-St. Petersburg) has refiled a bill that would allow dental therapists to perform many of the tasks of dentists, such as filling cavities, placing temporary crowns, and extracting teeth. Brandes first filed the bill during the 2019 legislation, but it never advanced out of committee. Read More

Georgia

Georgia Readies Expansion, Reinsurance Waiver Proposals for Release. *Georgia Health News* reported on October 10, 2019, that Georgia is drafting waiver proposals for Medicaid expansion and Exchange reinsurance programs, with at least one of the proposals expected to be released in early November. The Section 1115 expansion waiver could propose an increase in Medicaid eligibility to 100 percent of poverty. Separately, the state also unveiled regulations related to the state's new hospital financial disclosure law, which require about 160 not-for-profit hospitals to report executive compensation and the financial holdings, among other information. Read More

Louisiana

Louisiana to Resume Auto-Disenrollment of Medicaid Members Who Don't Respond to Renewal Notices. *U.S. News/The Associated Press* reported on October 11, 2019, that Louisiana will resume auto disenrollment of Medicaid members who don't respond to annual renewal notices by the end of the month. As many as 82,000 Medicaid beneficiaries could lose coverage. The auto-disenrollment feature, which is part of the state's new eligibility system, had been temporarily suspended. Read More

Michigan

Governor Signs FY 2020 Budget. A partial shutdown of Michigan state government on October 1, 2019, was avoided when Democratic Governor Gretchen Whitmer signed into law all state budgets for fiscal year 2020 on September 30. Whitmer, stating her dissatisfaction with many of the provisions in the budget bills, made a possibly unprecedented number of vetoes when she vetoed 147 items across all budgets, including 48 vetoes in the budget for the Michigan Department of Health and Human Services, the agency responsible for all public assistance and healthcare programs, including Medicaid and behavioral health. In total, the vetoes cut almost a billion dollars from the budgets and impacted several critical services and funding streams.

On October 1, the State Administrative Board held a special meeting at the Governor's request and approved transfer of more than $600 million between line items in the various department budgets. This approach to budget modifications by the executive branch of government has not been used for almost three decades and, along with the many vetoes, was not well received by the Republican-controlled Legislature.

It soon became clear that part of the objective behind the vetoes, which also included items the Governor supported, was to get legislative leaders back to the table to craft a budget more in line with her vision, including a long-term commitment to addressing infrastructure issues such as the state's roads and bridges. Her leadership team summoned several lobbyists to a meeting in the hope they could persuade members of the Legislature to meet with her administrative team to develop supplemental budget bills agreeable to all.

Although legislative leaders have expressed their reluctance to revisit the budgets, saying the "budget is done," meetings have occurred and several

supplemental budget bills have been introduced from both sides of the aisle and within both chambers of the Legislature. Some of the bills are line-item specific and they have all been assigned to the various appropriations subcommittees. How quickly they will be addressed and how the entire budget situation will be resolved is at this point unclear. Read More

New Hampshire

New Hampshire Health Commissioner to Step Down in December. *The Concord Monitor* reported on October 14, 2019, that New Hampshire Department of Health and Human Services commissioner Jeffrey Meyers will step down on December 6 at the end of his four-year term to pursue opportunities in the private sector. A search will begin for a replacement. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Not-For-Profits Hackensack Meridian Health, Englewood Health to Merge. *Modern Healthcare* reported on October 15, 2019, that two of New Jersey's leading not-for-profit health care organizations, Hackensack Meridian Health and Englewood Health, have signed a definitive agreement to merge. The merger agreement includes a commitment by Hackensack Meridian to invest $400 million in new operating rooms, expanded cardiac facilities, and outpatient sites for Englewood. The two organizations have had an academic partnership since 2015. The deal is subject to regulatory approvals and is expected to be completed in a year. Read More

New Jersey Utilization Review Auditing Role Awarded to Permedion. In October 2019, the New Jersey Division of Medical Assistance and Health Services (DMAHS) released a newsletter to inform Medicaid providers and managed care organizations (MCOs) that Permedion, an HMS subsidiary, was the successful bidder in a reprocurement of the Utilization Review (UR) audits. Permedion was the incumbent. The new Permedion contract expands the scope of hospital UR audits to include MCO encounter records.

New Jersey Is Approved for Hybrid State-Federal Health Insurance Exchange. *NJ Spotlight* reported on October 9, 2019, that New Jersey has received federal approval to set up a hybrid federal-state health insurance Exchange, the initial step in the state's eventual transition to a state-based exchange in 2021. The hybrid Exchange is expected to launched in time for the November 1 through December 15 open-enrollment period for coverage effective in 2020. Under the hybrid model, New Jersey will have more control over outreach and enrollment; however, the application and approval process will still reside on the federal HealthCare.gov website. Read More

New Jersey Medicare ACO Generates $4.6 Million in Savings. *NJBIZ* reported on October 14, 2019, that the Accountable Care Coalition of New Jersey saw $4.6 million in Medicare savings across 30 providers in 2018. The savings applied to 3,600 Medicare fee-for-service beneficiaries who received value-based care and occurred in the first year of the Accountable Care Organization (ACO) program. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York MCO to Sell YourCare Assets to Molina. Molina Healthcare announced on October 16, 2019, that it has reached an agreement to acquire certain assets of YourCare Health Plan, including the rights to serve approximately 46,000 Medicaid members in seven counties in the Western New York and Finger Lakes regions. YourCare is a not-for-profit subsidiary of Monroe Plan for Medical Care, which will continue to provide certain management and administrative services to YourCare through its MP CareSolutions division. The deal is subject to regulatory approvals and is expected to close early 2020. Read More

New Rate Structure for Consumer Directed Personal Care Program Overturned by Court. *Crain's New York* reported on October 14, 2019, that an Albany County Supreme Court judge has ruled against the state of New York in its plan to implement a new payment system for its Consumer Directed Personal Assistance Program. As part of the 2020 budget, New York enacted a change in the way fiscal intermediaries are reimbursed, moving from a rate structure based on the number of hours of care provided to a member to a fixed per member per month rate structure. Consumer advocates argue that the new rates are inadequate to support the agencies that provide fiscal intermediary services, and, should the change be implemented, those agencies will be forced out of business, effectively ending the Consumer Directed Personal Care program. Home care and independent living advocates filed a suit seeking to block implementation of the change. The judge ruled that the payment methodology violated the State Administrative Procedure Act (SAP), and was null and void. The ruling did not address whether the rates are adequate, or the potential impact on the program; the ruling was limited to the procedural issue raised in the case. The ruling concludes that the change in reimbursement is, in fact, a rule or regulation that cannot be promulgated without complying with SAP mandates, including filing with the Department of State prior to implementation. The Department of Health is directed to return to its previous reimbursement methodology "until such time as a new rate is introduced in compliance with SAP." Read More

New York Releases Delivery System Reform Incentive Payment Program Evaluation. As part of its Delivery System Reform Incentive Payment (DSRIP) Program, New York is required to conduct an evaluation of the initiative. The evaluation, conducted by the State University of New York Research Foundation, assessed program effectiveness with regard to achieving the triple-aim of improving health care quality, improving health, and reducing cost; evaluating the effectiveness of specific DSRIP initiatives; and obtained feedback from stakeholders on the health care experience under DSRIP reforms. The evaluation looks at the first three years of DSRIP performance, and cautions that findings are preliminary. They conclude that positive movement has been seen on some improvements in behavioral health services and population health, but that little change was seen in reducing avoidable hospital use. The report also found little progress in health system transformation, including care transitions, up-to-date care coordination, and use of preventive services. The evaluation also notes wide variation in performance across Performing Provider Systems (PPSs), the provider networks established to implement DSRIP initiatives. In trying to understand differences in performance, the evaluation looks at size of PPS, behavioral health patient mix, and location (New York City vs rest-of-state), but no trends were discernable. Read More

New York Medicaid Costs Rising. On October 9, 2019, the Citizens Budget Commission (CBC) released a report that examines New York Medicaid spending from state fiscal years 2011 to 2019. They note that enrollment rose significantly following the implementation of the Affordable Care Act, from under 4.7 million in 2010 to over 6.2 million in 2016, an increase of over 30 percent. Yet total Medicaid spending during that time period only grew by 15 percent, from $53.7 billion to $61.5 billion, because per capita spending dropped significantly, from $11,435 to $9,973. That trend has turned around since 2016, and per capita spending has increased in each of the last three years. According to the report, the increased cost per enrollee has multiple causes, including increases in the minimum wage for some providers, growth in long-term care due to an aging population, and increased supplemental payments to distressed hospitals. They note that total Medicaid spending has increased 25 percent from fiscal year 2016 to fiscal year 2019 despite essentially flat program enrollment. The state's decision to defer $1.7 billion in Medicaid payments from the 2019 fiscal year to the 2020 fiscal year hides the true extent of cost growth. CBC concludes that the program will experience spending gaps over the state's four-year budget plan of $3.5 to $6.6 billion per year, with a cumulative shortfall of $21.8 billion. They consider the policy of deferring Medicaid payments is imprudent fiscal management, burdening providers, obfuscating the state's actual financial picture, and creating a large liability that will ultimately have to be paid. Read More

New York Health Plan Faces Whistleblower Lawsuit. *Buffalo Business First* reported on October 9, 2019, that HealthNow New York, the parent company of BlueCross BlueShield of Western New York, is facing a whistleblower lawsuit alleging the company charged government entities inflated premiums for Medicaid, Medicare Advantage, and other types of healthcare coverage. The lawsuit alleges that HealthNow based its bids and applications for health plan contracts on inflated costs. The lawsuit, which was first filed in February 2016 and unsealed in October 2019, claims $85 million in inflated costs. Read More

New York City Health & Hospitals Reports Improved Fiscal 2019 Financial Performance. New York City Health & Hospitals (H&H) reported on October 10, 2019, that it had improved its financial performance in fiscal 2019, posting a net margin of $36 million and cutting its structural deficit by more than half. The organization cited progress in increasing revenues by negotiating higher reimbursement rates from health plans and through improved coding. It also pointed to decreased expenses and improvements in care coordination. Read More

Nursing Homes Expect Cuts from Change to Medicaid Reimbursement Model. *WBFO News* reported on October 10, 2019, that nursing homes in New York expect reimbursements cuts of $123 million ($246 million including federal match) from the state's decision to re-calculate the case-mix index (CMI) for the last reporting period. CMI for the latest period will average all nursing home assessments from August 8, 2018, to March 31, 2019, instead of taking a snapshot from January and July of each year. Read More

North Carolina

North Carolina Disputes 'Conflict of Interest' Concerns in Medicaid Managed Care Contract Awards. *WRAL.com* reported on October 13, 2019, that the North Carolina Department of Health and Human Services (DHHS) announced in a recent filing that the personal relationship between a DHHS employee and a Blue Cross Blue Shield of North Carolina employee does not constitute proof of an unfair scoring process resulting in Aetna losing out on the state's $6-billion-a-year Medicaid managed care contract award. DHHS and Blue Cross argue that the relationship does not equal a full-on conflict of interest, and they are asking a state tribunal to reject Aetna's complaints in its review of the solicitation process. The dispute is being reviewed by the state Office of Administrative Hearings. Read More

BCBS-North Carolina, Cambia Health Drop Merger Plans. *The Wall Street Journal* reported on October 11, 2019, that Blue Cross Blue Shield of North Carolina and Cambia Health Solutions have dropped plans to merge, the companies announced. The decision followed the resignation of BCBS-NC chief executive Patrick Conway. Read More

Oklahoma

Medicaid Expansion Advocates Gather Enough Signatures for 2020 Ballot Initiative. *The Tulsa World* reported on October 11, 2019, that healthcare advocates in Oklahoma have collected the 178,000 signatures needed for a Medicaid expansion ballot initiative in 2020, according to Amber England, campaign manager of "Yes on 802." Expansion would reach individuals up to 138 percent of poverty. Read More

Pennsylania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Expands Support to First-Time Moms, Children with Special Needs. Pennsylvania announced on October 9, 2019, that it is expanding home visiting supports to first-time mothers and mothers of children with special needs covered by Medicaid. Through a 2020 agreement with managed care organizations (MCOs), new parents and families with children with additional risk factors receive at least two home visits. Examples of services include:

- Regularly scheduled home visits with trained family development specialists
- Monthly parent meetings
- Routine screenings to identify post-partum depression, detect potential problems with vision, hearing, growth, and learning age-based milestones.

Read More

Lawmakers Make Another Attempt at Telehealth Legislation. *mHealth Intelligence* reported on October 9, 209, that the Telemedicine Act (SB 857), introduced in the Pennsylvania Senate, aims to establish definitions for telemedicine and telehealth, provide temporary evaluation and treatment guidelines and ground rules for reimbursement, and give state departments up to two years to draft permanent rules and regulations. A similar bill was defeated in the Pennsylvania House last year due to arguments over payment parity. The new bill would allow providers and insurers to negotiate rates for telehealth coverage. Read More

Texas

Texas Submits DSRIP Draft Transition Plan to CMS. On September 30, 2019, the Texas Health and Human Services Commission (HHSC) submitted its draft Delivery System Reform Incentive Payment (DSRIP) transition plan to the Centers for Medicare & Medicaid Services (CMS). Public comment period was from August 1 to 15, 2019.

National

Public Charge Rule Change Is Already Negatively Impacting Medicaid Enrollment. The Kaiser Family Foundation published a report on October 15, 2019, that found recent changes to the federal public charge rule are already causing immigrants to avoid enrolling in Medicaid. The new rule, which classifies immigrants as a "public charge" if they utilize Medicaid and certain food and housing programs, is also leading to a decrease in utilization of healthcare services, especially among pregnant women. Read More

Federal Judge Denies Request to Delay Opioid Trial. *The Washington Post* reported on October 15, 2019, that a federal trial involving the role of drug makers in the opioid crisis will begin as scheduled next week, after a U.S. District Court Judge Dan Aaron Polster denied a request to delay from a group of state attorneys general. The state attorneys general had requested additional time to negotiate an $18 billion settlement with drug distributors McKesson Corp., Cardinal Health and AmerisourceBergen. Read More

'Building on ACA' Remains Viable Reform Option, Study Shows. *Modern Healthcare* reported on October 16, 2019, that building on the existing Affordable Care Act (ACA) could decrease the number of uninsured Americans by 81 percent to 6.6 million while modestly decreasing overall national health spending, according to a study from the Urban Institute. The study, which analyzed eight different potential healthcare reform packages, found that building on the ACA would add about $1.5 trillion to federal healthcare outlays over 10 years. In contrast, a robust single-payer system would cover nearly every American, but add $34 trillion to federal healthcare outlays over 10 years. The study assumes that "building on the ACA" would include an insurance mandate, improved ACA subsidies, allowing workers to opt for subsidized non-group coverage, a public option, a cap on provider payment rates, reinsurance, and help for individuals in states that haven't expanded Medicaid. Read More

Federal Appeals Court Hears Arguments on Medicaid Work Requirements. *The New York Times* reported on October 11, 2019, that a federal appeals court heard arguments in a lawsuit involving Medicaid work requirements in Arkansas and Kentucky, with judges sharply questioning a Trump Administration attorney defending the policy. "You are failing to address the critical statutory objective, which is coverage," said Judge Harry T. Edwards. The court didn't issue a timetable on a decision, which would impact the future of work requirements. Read More

Federal Judges Temporarily Block Trump Policy to Deny Green Cards to Immigrants on Medicaid. *The New York Times* reported on October 11, 2019, that federal judges in California, New York, and Washington temporarily blocked President Trump's policy to deny green cards to immigrants who are enrolled in Medicaid. The ruling in favor of 21 states and the District of Columbia puts the new policy on hold while lawsuits proceed. Read More

States Seek to Shift ACA Exchanges to State-run Platforms, New Study Finds. *Modern Healthcare* reported on October 10, 2019, that Maine, Nevada, New Jersey, New Mexico, Pennsylvania, and Oregon are planning to transition from the federal HealthCare.gov insurance Exchange to state-run platforms, according to an Urban Institute report. Goals include protecting Exchanges from changes in federal policy, capturing cost savings, and flexibility. Read More

GAO Questions Administrative Costs to Implement Medicaid Work Requirements. *KTVZ.com* reported on October 10, 2019, that estimated costs to implement Medicaid work requirements and other eligibility waivers in five states ranged from less than $10 million to more than $250 million per state, according to a Government Accountability Office (GAO) report. The report calls for states to submit projections of administrative costs for future demonstrations, and for the Centers for Medicare & Medicaid Services (CMS) to improve oversight to ensure matching payments are appropriate and administrative costs are allowable. Read More

Trump Administration Proposes Safe Harbor for Incentive Payments, Data Sharing in Value-based Care. *Modern Healthcare* reported on October 9, 2019, that the Trump Administration has proposed new rules to provide a safe harbor from Stark anti-kickback laws for providers involved in value-based care arrangements. The proposed Department of Health and Human Services rules would allow specialists to share patient information with primary care physicians and coordinate hospital discharges uses data analytics; allow hospitals to make physician incentive payments in federal shared-savings programs; and participate in care coordination activities and value-based care relationships with downside risk. Read More

CMS Releases 2020 Star Ratings for MA, Part D Prescription Drug Plans. The Centers for Medicare & Medicaid Services announced on October 11, 2019, the release of its 2020 star ratings for Medicare Advantage (MA) and Part D prescription drug plans. Approximately 52 percent of MA plans that offer prescription drug coverage are rated at least four stars, up from 45 percent in 2019. About 81 percent of MA beneficiaries with prescription drug coverage will be in plans with at least four stars, up from 69 percent in 2017. In addition, CMS expects MA premiums to decline 23 percent. Medicare Open Enrollment begins on October 15, 2019, and ends on December 7, 2019. Read More

Industry News

Revelstoke Announces Investment In Home Health Provider. Revelstoke Capital Partners announced on October 16, 2019, an investment in The Care Team (TCT), a home health and hospice provider in Michigan. TCT founder Jason Laing will continue to serve as chief executive and remain a significant shareholder. Read More

Guidehouse Completes Acquisition of Navigant Consulting. Guidehouse, a portfolio company of Veritas Capital, announced on October 11, 2019, that it had completed the acquisition of Chicago-based Navigant Consulting, Inc. Financial terms were not disclosed. Read More

MEDNAX Announces Agreement to Sell MedData. MEDNAX, Inc. announced on October 10, 2019, a definitive agreement to sell its MedData business to Frazier Healthcare Partners for $250 million, with $50 million more contingent on performance. MEDNAX expects to use net proceeds from the sale for debt repayment, share repurchases, and acquisitions. MEDNAX also entered into a long-term services arrangement with MedData. The deal is subject to regulatory approvals and is expected to close during the fourth quarter of 2019. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2019	Washington DC	RFP Release	276,000
October 2019	Texas STAR+PLUS	Awards	530,000
December 1, 2019	Texas STAR and CHIP	Awards	3,400,000
December 17, 2019	Pennsylvania HealthChoices Physical Health	Proposals Due	2,260,000
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
Spring 2020	Washington DC	Awards	276,000
January 1, 2020	Louisiana - Protests May Delay Implementation Date	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	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	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
January 6, 2020	Hawaii	Awards	340,000
February 1, 2020	North Carolina - Phase 1 (delayed) & 2	Implementation	1,500,000
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
December 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	85,000
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 WELCOMES

Lisa Harrison – Principal

Lisa Harrison is an actively practicing physician assistant with more than 15 years of in-depth experience in clinical practice as a primary care provider in a Federally Qualified Health Centers (FQHC) and the acute care arena as an inpatient internal medicine hospitalist. Her broad background in direct patient care, health system design and delivery, informatics, and collaborative team leadership has improved clinical processes and outcomes across acute care and ambulatory settings.

She has extensive experience working with executive, clinical and performance improvement committees and projects in FQHC and non-profit healthcare network venues which integrated clinical service lines and promoted clinical transformation.

Lisa's experience in management, strategic planning, interoperability, provider engagement and clinical performance improvement has enhanced excellence in service delivery across the continuum. Her extensive background in innovative design, training and implementation of electronic health record systems has allowed for better integrated care for patients in acute care, ambulatory, primary and specialty care networks.

Prior to joining HMA, Lisa has served as a senior clinical informaticist for healthcare networks in both Philadelphia and Michigan. In that role, Lisa coordinated the advancement of clinical information systems to satisfy current and future data regulatory requirements, change capture/revenue cycle, and improve patient access workflow to provide solutions that support and improve organizational and departmental operations. She identified and streamlined clinical workflows which improved access to quality clinical care for populations in need.

She earned both Bachelor of Arts and Master of Science degrees in biological sciences from Towson University, a Master of Health Science in physician assistant studies from Drexel University and postgraduate certificates from Duke Business of Healthcare Academy and Stanford University in genetics and genomics. She is also fluent in Spanish.

Anne Shields – Principal

Anne Shields has more than 20 years of diverse experience in public health, behavioral health integration, primary care operations, and Medicaid benefits design and program implementation. She has held executive and senior leadership positions in public health, community health, and academic centers.

Anne joins HMA most recently from the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington, where she led an interdisciplinary team in providing technical assistance for sustainable models of integrated care. Her recent focus is "whole person" care including models that fully integrate medical, substance use, and mental health services in any healthcare setting.

A nurse by training, Anne also worked with state agencies, foundations and providers in Washington state's diverse opioid treatment networks to expand access to treatment medications in primary care, behavioral health agencies, emergency departments, jails and syringe exchange programs.

Other key initiatives at the AIMS Center included working with the Centers for Medicare and Medicaid Services and provider organizations in the design of the psychiatric collaborative care Medicare benefit and other integrated behavioral health services. Anne also works with state Medicaid agencies to plan integrated behavioral health strategies and benefits.

At the health department in Seattle, Anne directed investments in community health centers and school-based clinics. She was responsible for the design process and implementation of an evidence-based pilot that integrated primary care, mental health and substance use services for high-risk, high-cost individuals and low income pregnant and parenting women. This integrated program was expanded statewide and saved the state more than $10 million in its first two years of statewide operation. Anne was previously the associate director at HealthPoint, one of the largest community health center networks serving the Seattle metro area.

She earned her nursing degree from Seattle University and her Master of Health Administration from the University of Washington School of Public Health and Community Medicine.

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Kentucky Medicaid Managed Care Enrollment is Down 1.1%, Oct-19 Data
- Nebraska Medicaid Managed Care Enrollment Is Flat, Sep-19 Data
- Ohio Medicaid Managed Care Enrollment is Down 6.5%, Sep-19 Data
- Oregon Medicaid Managed Care Enrollment is Down 0.7%, Sep-19 Data
- South Carolina Dual Demo Enrollment is Up 19.6%, Sep-19 Data
- Tennessee Medicaid Managed Care Enrollment is Up 5.6%, Sep-19 Data
- Utah Medicaid Managed Care Enrollment is Down 3.8%, Oct-19 Data
- Virginia Medicaid MLTSS Enrollment is Over 242,800, Oct-19 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.6%, Sep-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alabama Medicaid Agency Accounting, Auditing, and Consulting Services RFP and Related Documents, 2019
- Colorado Medicaid Enterprise Systems Services Integrator RFI, Oct-19
- Hawaii Fiscal Agent and Pharmacy Benefits Manager Services RFP, 2019
- Hawaii Medicaid Provider Enrollment and Revalidation RFP and Amendments, 2019
- Maryland Quality of Life Surveys for Medicaid Long Term Services and Supports Participants RFP and Related Documents, 2019
- Minnesota Psychiatric Residential Treatment Facility Medicaid Benefit RFP, Oct-19
- New Hampshire Medicaid Care Management Services RFP, Proposals, Awards, and Scoring/Evaluations, 2018-19
- Pennsylvania HealthChoices Physical Health RFA, Model Contract, and Related Documents, Oct-19
- Pennsylvania MMIS 2020 Platform Project – Prior Authorization and Outbound Mail RFP, Aug-19
- Texas Financial Analysis and Financial Data Management and Modeling Services RFP, Oct-19
- Texas STAR Health Managed Care Services DRAFT RFP and Responses, 2019
- Wisconsin Medicaid D-SNP Model Contracts, 2019-20

Medicaid Program Reports, Data and Updates:

- California MCO Tax Approval Request, Sep-19
- Colorado Health Plan CAHPS Reports, 2017-19
- Connecticut Medical Assistance Program Oversight Council Meeting Materials, Oct-19
- Delaware FY 2020 Joint Finance Committee (JFC) Budget Presentations, Mar-19
- Idaho Medical Care Advisory Committee Meeting Materials, Jul-19
- Michigan Medicaid Health Plan Pharmacy Drug Coverage Transition Proposed Policy Draft, Sep-19

- Pennsylvania HealthChoices Behavioral Health Rate Development and Certifications, SFY 2019-20
- South Carolina Medicaid Enrollment by County and Plan, Sep-19
- Tennessee Medicaid Managed Care Enrollment by Age, Gender, County, 2015-18, Sep-19
- Texas Draft Delivery System Reform Incentive Payment (DSRIP) Transition Plan, Sep-19
- Texas OIG Inspection of Member Complaints Received by STAR+PLUS Medicaid Managed Care Organizations, Aug-19

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:

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