

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... September 23, 2020



[RFP CALENDAR](#)
[HMA News](#)

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THIS WEEK

- **IN FOCUS: CMS EYES MEDICAID ALTERNATIVE PAYMENT MODELS (APM) EXPANSION TO CONTROL GROWTH IN SPENDING**
- DELAWARE APPROVES FOUR ACOS TO SERVE MEDICAID POPULATION IN 2021
- NEW YORK FINDS \$700 MILLION IN IMPROPER MEDICAID PAYMENTS
- VERMONT ACO PILOT PROGRAM FAILED TO MEET ENROLLMENT, SPENDING TARGETS
- HOUSE PASSES FEDERAL FUNDING BILL TO RELAX REPAYMENT TERMS FOR COVID-19 MEDICARE LOANS
- CMS ANNOUNCES ADDITIONAL \$165 MILLION MFP FUNDING FOR 33 STATES
- JUSTICE GINSBURG'S DEATH COULD JEOPARDIZE THE ACA
- CMS INNOVATION AGENCY ANNOUNCES ROLL OUT OF RISK-BASED MODEL FOR DUAL ELIGIBLES
- METLIFE TO ACQUIRE VERSANT HEALTH FOR \$1.7 BILLION
- **NEW THIS WEEK ON HMAIS**

IN FOCUS

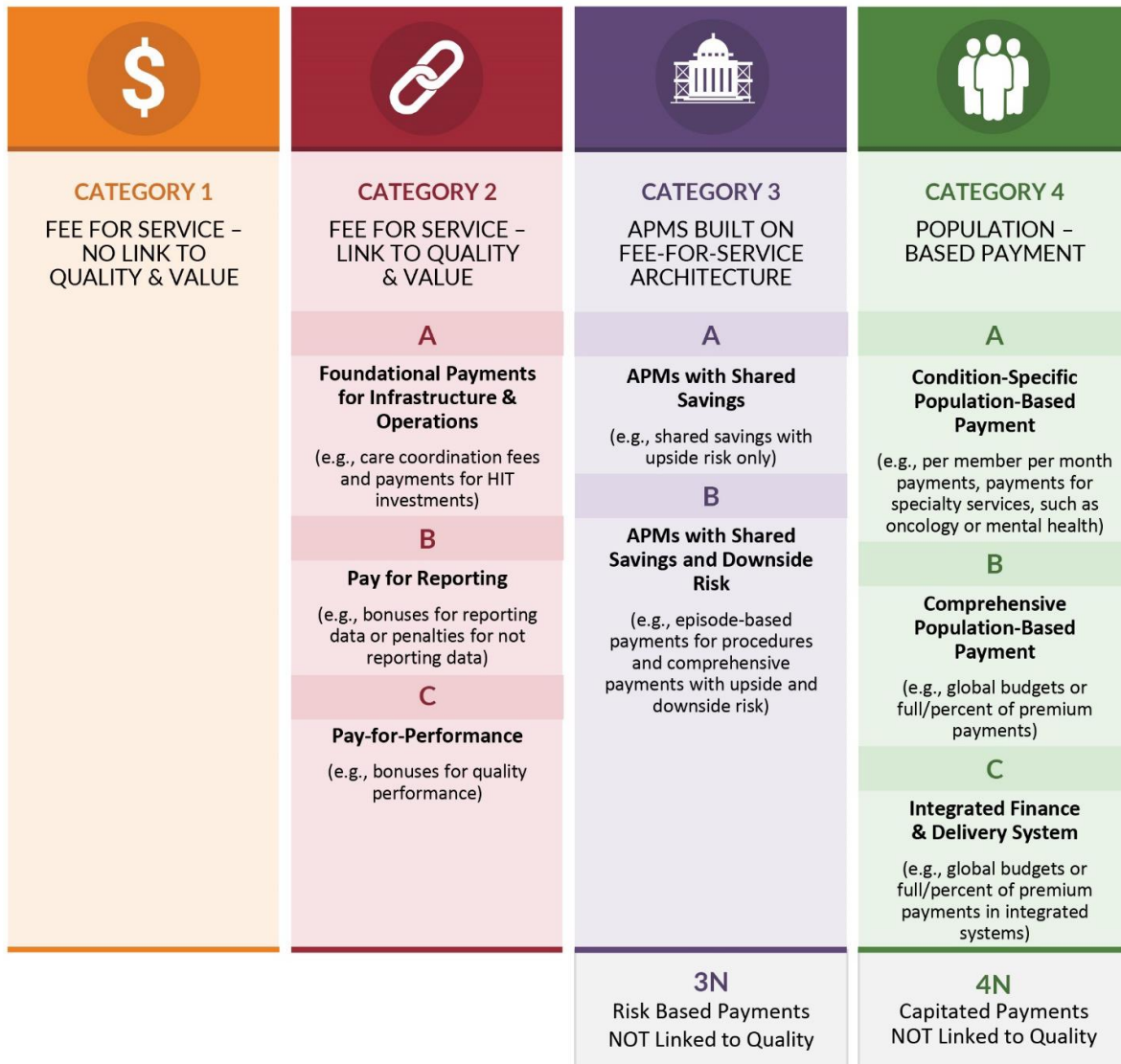
CMS EYES MEDICAID ALTERNATIVE PAYMENT MODELS (APM) EXPANSION TO CONTROL GROWTH IN SPENDING

On September 15, 2020, the Centers for Medicare & Medicaid Services (CMS) released State Medicaid Director (SMD) letter #20-004 regarding value-based

care (VBC) opportunities in Medicaid.ⁱ In the letter, CMS lays out a road map for state Medicaid agencies to adopt value-based payment (VBP). The SMD describes how states can use existing - or obtain new - authorities to adopt VBP. It lists examples of successful VBP designs in other states and identifies key enabling factors from its examination of lessons learned over the last ten years of investments in VBC activities.

The SMD reaffirms the framework maintained by the Health Care Payment Learning & Action Network (HCP-LAN) defining elements and categories of VBP. Figure 1 summarizes the HCP-LAN framework for categorizing VBPs.

Figure 1. The HCP-LAN Framework (2017)



ⁱ SMD #20-004. Re: Value-Based Care Opportunities in Medicaid. September 15, 2020. <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf>. Accessed September 19, 2020.

CMS believes there is opportunity to expand VBP in Medicaid. Based on 2018 data reported by the HCP-LAN, CMS highlights that Medicaid participation in VBP greatly lags that of Medicare. In fact, CMS reports that while 90 percent of traditional Medicare payments were part of VBP arrangements in categories 2-4, **only 32 percent of Medicaid payments** were made under such arrangements in 2018.ⁱⁱ

Figure 2 displays the percent of Medicaid payments in VBP arrangements in 2017, by HCP-LAN category. Figure 3 shows the percent of payments by payer in VBP arrangements in 2017, by HCP-LAN category.^{iii,iv}

Figure 2. Percent of Medicaid Payments in VBP 2017

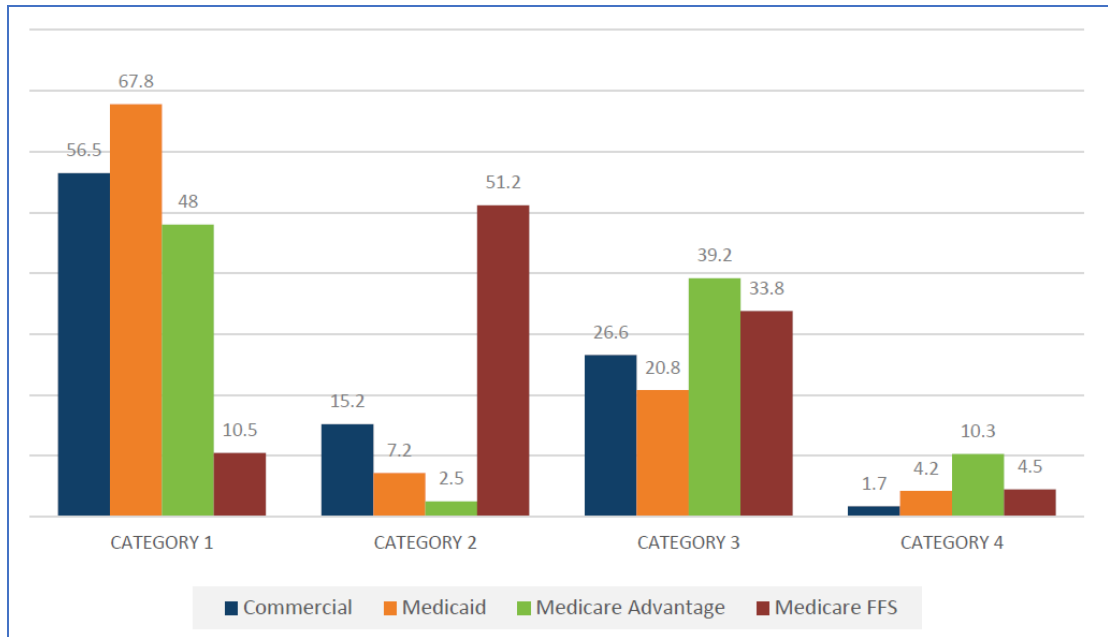
CATEGORY 1	TOTAL 67.8%
CATEGORY 2	TOTAL 7.2%
<ul style="list-style-type: none"> Foundational payments to improve care (2A) 	SUBTOTAL 0.1%
<ul style="list-style-type: none"> Fee-for-service plus pay for reporting (2B) 	SUBTOTAL 0.2%
<ul style="list-style-type: none"> Fee-for-service plus pay for performance payments (2C) 	SUBTOTAL 6.9%
CATEGORY 3	TOTAL 20.8%
<ul style="list-style-type: none"> Traditional shared-savings, Utilization-based shared-savings (3A) 	SUBTOTAL 17.6%
<ul style="list-style-type: none"> Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B) 	SUBTOTAL 3.2%
CATEGORY 4	TOTAL 4.2%
<ul style="list-style-type: none"> Condition-specific population based payment, Condition-specific bundled/episode payments (4A) 	SUBTOTAL 1.8%
<ul style="list-style-type: none"> Full or percent of premium population-based payments (4B) 	SUBTOTAL 2.2%
<ul style="list-style-type: none"> Integrated finance and delivery programs (4C) 	SUBTOTAL 0.2%
CATEGORIES 3 & 4, COMBINED	TOTAL 25%

ⁱⁱ Cited as in SMD#20-004: "These rates are calculated by summing HCP-LAN categories 2, 3, and 4 from the CY2018 payment results tables (p.18 and p.20) in the HCP-LAN 2019 Methodology and Results report."

ⁱⁱⁱ APM Measurement. Progress of Alternative Payment Models. LAN Insights into APM Adoption. 2018. Health Care Payment Learning & Action Network (HCP-LAN). <http://hcp-lan.org/workproducts/apm-discussion-2018.pdf>. Accessed September 21, 2020.

^{iv} APM Measurement. Progress of Alternative Payment Models. 2019 Methodology and Results Report. 2019. Health Care Payment Learning & Action Network (HCP-LAN). <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>. Accessed September 21, 2020.

Figure 3. Percent of Payments in VBP by Payer, 2017



Based on results of multiple evaluation and rapid cycle reports across the last ten years of innovation activities, CMS identifies the following factors as being important to success of VBP design and operations:

Factor	Description	Discussion
Level and scope of financial risk	Existing CMS models range in scope and risk	Episode-based Models Direct Contracting Model (DCM) Primary Care Capitation Payment Capitated, risk-adjusted monthly payment
Benchmarking	Setting appropriate benchmarks and targets are key to success	If benchmarks are set too high, model participants will earn more than anticipated in reconciliation payments and the model will not result in program savings (e.g., Comprehensive Care for Joint Replacement Model). Adverse selection of only those providers who believe they will financially benefit is also possible if benchmark is inaccurate.
Payment operations	Attribution and claims processing	Accurate determination and tracking of the defined population for which provider—or groups of providers—are accountable is essential for financing management and quality scoring.

CMS goes on to say that states can facilitate shifts to VBP by:

1. Participating in multi-payer efforts
2. Conducting delivery system readiness reviews
3. Supporting robust health information exchange and technology
4. Seeking extensive stakeholder engagement
5. Targeting quality measure selection
6. Focusing on sustainability and continued aligned incentives

There are three payment strategies for state's consideration described in Table 1 of the SMD letter (included for ease of reference below):

1. Payment models built on a fee-for-service architecture
2. Episodes of care payments
3. Payments involving total cost of care accountability

HMA staff have extensive experience in the design and implementation of VBPs for State Medicaid Agencies and on behalf of Medicaid MCOs. In fact, HMA staff provided technical assistance in both the design and implementation of VBPs in the states highlighted in the SMD letter. HMA continues to support these states and managed care organizations in the monitoring of VBPs and creating roadmaps for movement along the continuum of VPB categories. If your state is interested in assessing its VBP opportunities, contact our expert VPB team for a consultation at ksuter@healthmanagement.com.

[Link to Guidance](#)

Figure 4: Innovative Payment Strategies and Key Features (Excerpt from CMS SMD Letter 20-004)

Payment Strategy	Key Features	Examples of Models ⁹	Social Security Act Authority Necessary for Medicaid Implementation	HCP-LAN Category ¹⁰
Payment models built on fee-for-service architecture	<ul style="list-style-type: none"> State or payer pays healthcare provider directly on a fee-for-service basis for all populations or sub-populations for some or all services received, either retrospectively, or prospectively based on value-based advanced payment methodologies. Adjustments (usually retrospective) for the cost and quality of services provided relative to benchmarks. 	<ul style="list-style-type: none"> Primary care case management (PCCM), PCCM-entity (PCCM-E) Primary Care Medical Homes (PCMH) (e.g. South Dakota health home benefit) Shared Savings models (e.g. Arkansas, Maine, Ohio) Massachusetts Model B (Primary Care Accountable Care Organization (ACO)) Home Health Value-Based Purchasing (HHVBP) Model*¹¹ 	<p><i>To implement through fee-for-service: 1905(t) – primary care case management¹²</i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> 1915(a) – voluntary via contract 1932(a) – State Plan option 1915(b) – managed care via waiver 	Categories 2-3

⁹ Innovation Center models are denoted via asterisk. Descriptions of Innovation Center models can be found at the following website:

<https://innovation.cms.gov/initiatives/#views=models>

¹⁰ Category 1 – FFS with no link to quality and value; Category 2 – FFS with link to quality and value; Category 3 – APMs built on FFS architecture; Category 4 – Population-based payment. For detailed definitions of HCP-LAN categories, please consult the APM Framework 2017 Refreshed Report (p. 23-29) available at <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

¹¹ The HHVBP Model is a Medicare model.

¹² States may use the authority under section 1905(t) of the Social Security Act to offer coordinating, locating, and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures, including PCCMs and PCCM entities as defined under 42 CFR part 438.2.

Payment Strategy	Key Features	Examples of Models ⁹	Social Security Act Authority Necessary for Medicaid Implementation	HCP-LAN Category ¹⁰
	<ul style="list-style-type: none"> Providers may be eligible for payments based on performance for a subset of total care (“upside risk”), for example on primary care services, if they also meet related performance and quality targets. Providers may also owe money (“downside risk”) if they do not meet performance and quality targets. 			
Episode of care payments	<ul style="list-style-type: none"> States or payers pay healthcare providers a bundled payment for some or all services associated with episodes of care during a defined period of time, the amount of which may be established by comparing actual 	<ul style="list-style-type: none"> Bundled Payments for Care Improvement (BPCI) Advanced*¹³ Oncology Care Model (OCM)*¹⁴ Comprehensive Care for Joint Replacement (CJR)*¹⁵ Arkansas Medicaid Health Care Payment Initiative Episodes of Care 	<p><i>To implement through fee-for-service: 1905(a)</i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> 1915(a) – voluntary via contract 1932(a) – State Plan option 	Categories 2-3

¹³ BPCI Advanced is a Medicare model.

¹⁴ OCM is a Medicare model.

¹⁵ CJR is a Medicare model.

Payment Strategy	Key Features	Examples of Models ⁹	Social Security Act Authority Necessary for Medicaid Implementation	HCP-LAN Category ¹⁰
	<p>episode expenditures to an established benchmark price.</p> <ul style="list-style-type: none"> Allows state or payer to use benchmark price to determine savings. Incentivizes quality over volume of services. Conducive to multi-payer alignment. Providers may be eligible for payments (“upside risk”) or may owe money (“downside risk”) based on performance relative to the benchmark price for the episode of care. 	<ul style="list-style-type: none"> Tennessee Medicaid Delivery System Transformation Episodes of Care Program 	<ul style="list-style-type: none"> 1915(b) – managed care via waiver, specifically for PCCMs and PCCM entities 	
Payments involving total cost of care accountability	<ul style="list-style-type: none"> Payers may pay providers a number of different ways – bundled payments, fee-for-service, capitated payments, or global payments. 	<ul style="list-style-type: none"> ACO initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model¹⁶) Maryland Total Cost of Care Model* 	<p><i>To implement through fee-for-service: 1905(a)</i></p> <p><i>To implement through managed care:</i></p> <ul style="list-style-type: none"> 1915(a) – voluntary via contract 	Categories 3-4

¹⁶ The ACO initiatives within this bullet are specific to Medicare.

Payment Strategy	Key Features	Examples of Models ⁹	Social Security Act Authority Necessary for Medicaid Implementation	HCP-LAN Category ¹⁰
	<ul style="list-style-type: none"> Healthcare providers are held accountable for all populations or sub-populations for some or all services. Healthcare providers may be responsible and at risk for all aspects of a patient’s care, or just specific condition(s). Provides flexibility to payers and healthcare providers in addressing community needs. Healthcare providers may be eligible for payments (“upside risk”) and/or may owe money (“downside risk”) based on their performance. 	<ul style="list-style-type: none"> MassHealth ACO Model A (Accountable Care Partnership Plan) Vermont All-Payer ACO Model* 	<ul style="list-style-type: none"> 1932(a) – State Plan option 1915(b) – managed care via waiver 	



HMA MEDICAID ROUNDUP

Delaware

Delaware Approves Four ACOs to Serve Medicaid Population in July 2021.

On September 22, 2020, Delaware's Department of Health and Social Services announced that it has approved four Medicaid Accountable Care Organizations (ACOs) to negotiate and enter into agreements directly with AmeriHealth Caritas Delaware and Highmark Health Option, the state's two Medicaid managed care organizations (MCOs), effective July 1, 2021. The four ACOs are Aledade Delaware, Delaware Care Collaboration, Delaware Children's Health Network, and Delaware Medicaid Quality Partners. [Read More](#)

Florida

Florida Medicaid to Reduce the Number of People on the Long-Term Care Wait List.

CBS Miami reported on September 17, 2020, that the Florida Agency for Health Care Administration will begin removing people from the long-term care waitlist, reducing the number of people from 59,259 to about 1,562 in the coming months. The state passed legislation to ensure that the list only includes residents who are most at risk of nursing-home placement. Those with "low priority" scores will not go on the list. [Read More](#)

Georgia

Georgia May Need to Repay \$76 Million for Improper Reimbursements.

Georgia Health News reported on September 22, 2020, that Georgia could be on the hook for \$76 million for improper reimbursements made to a nursing home network through a federal program, according to an investigation by *Georgia Health News* and *ProPublica*. The nursing home, Community Health Services of Georgia, allegedly used a loophole to receive \$300 million in bonus Medicaid payments over two decades for which it did not qualify. Georgia's Department of Community Health has appealed a 2014 decision from the Centers for Medicare & Medicaid Services (CMS) that ruled that a portion of the bonus payments were "inappropriate" and sought \$76 million to be repaid by the state. The case now lies with the U.S. Department of Health and Human Services' Departmental Appeals Board. [Read More](#)

Montana

Montana Medicaid Expansion Benefited Businesses, Economy, Report Shows. *The Bozeman Daily Chronicle* reported on September 15, 2020, that Montana's Medicaid expansion has been beneficial to businesses, workers, and the state economy, according to a report unveiled by Governor Steve Bullock. The report, released by the Departments of Revenue, Labor and Industry and Health and Human Services, found that over 23,400 businesses employed a worker who was enrolled in Medicaid expansion since 2016. Approximately 59 percent of businesses had workers enrolled in Medicaid in 2018 and 2019, with 70 percent of those eligible for Medicaid expansion. Expansion brings in \$600 million annually, and has created 5,900 to 7,500 jobs. [Read More](#)

New Jersey

New Jersey Bill Proposes Improvements to Medicaid Pediatric Network Standards. On September 21, 2020, New Jersey introduced legislation to improve Medicaid managed care network adequacy standards for pediatric primary care providers and pediatric medical specialists. Assembly bill 4688 seeks to align existing network adequacy standards for pediatric primary and specialty care with federal network adequacy standards under Medicare Advantage. [Read More](#)

New York

New York Comptroller Finds Over \$700 Million in Improper Medicaid Payments. New York Comptroller Thomas P. DiNapoli released on September 21, 2020, five audits of the state's Medicaid program, which found \$706.6 million in unnecessary, improper or questionable payments. The audits identified \$605 million in unnecessary drug costs from the state's Medicaid managed care program for the period January 1, 2016, through December 31, 2019. Other improper payments include \$47.8 million in fee-for-service claims for Medicaid members with multiple Client Identification Numbers, \$11.7 million for beneficiaries who had terminated coverage, \$4.9 million for deceased beneficiaries, \$8.2 million in improper claims processing, and \$29 million for drugs dispensed after they had been removed from the market. [Read More](#)

Oregon

Oregon Hospitals See Large Drop in Margins Due to COVID-19. On September 22, the Oregon Health Authority (OHA) reported that total hospital margins fell 19.4 percentage points to -8.8 percent in the first quarter of 2020, compared to the same quarter in 2019. The steep drop is attributed to the COVID-19 pandemic; however, the report does not reflect financial assistance that was provided to the health systems in response to the pandemic. The report also found that hospital utilization and revenue dropped in the same period. [Read More](#)

Tennessee

Tennessee Medicaid Block Grant Proposal Delayed Due to Pandemic. *The Tennessean* reported on September 18, 2020, that Tennessee's Medicaid block grant funding proposal, currently under consideration by the Trump administration, has been delayed due to the COVID-19 pandemic, according to a federal official. The proposal would convert nearly \$8 million in federal funding to a block grant and allow the state more latitude to change Medicaid coverage criteria. Tennessee Governor Bill Lee submitted the block grant proposal in November 2019. [Read More](#)

Vermont

Vermont ACO Pilot Program Failed to Meet Enrollment, Spending Targets, CMS Says. *VTDigger* reported on September 18, 2020, that the Centers for Medicare & Medicaid Services (CMS) issued a warning to Vermont for failing to meet goals for its all-payer Medicaid Accountable Care Organization model in 2018 and 2019. Managed by OneCare, a network of for-profit providers and hospitals, the pilot program was supposed to meet 50 percent of its target enrollment by now, yet has only achieved 30 percent. In addition, the model has failed to reduce spending or increase primary care utilization. State officials acknowledged the program needs to be reformed, as small providers have had to deal with large barriers to entry and take on more financial risk to join the Medicare component of OneCare. Vermont has 90 days to respond to the CMS letter. [Read More](#)

National

CMS Announces Additional \$165 Million MFP Funding for 33 States. On September 23, 2020, the Centers for Medicare & Medicaid Services (CMS) announced \$165 million in new supplemental funding for thirty-three states operating Money Follows the Person (MFP) demonstration programs. Each eligible state will receive up to \$5 million in federal funds to assist state Medicaid programs in transitioning individuals with developmental disabilities and the elderly from institutions to home and community-based settings. States participating in the MFP program include: Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Maryland, Maine, Minnesota, Missouri, Montana, North Carolina, North Dakota, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Washington, Wisconsin, and West Virginia. [Read More](#)

Trump Administration Reimposes Public Charge Rule Following Court Ruling. *The Hill* reported on September 22, 2020, that the Trump administration is moving forward to reimpose its "public charge" rule, retroactively applying it following the Second Circuit Court of Appeals' ruling to overturn a nationwide injunction on the policy that had been imposed earlier in the year due to COVID-19. The rule, which will allow immigration officials to consider legal immigrants' use of Medicaid and other public benefits in determining eligibility for green cards, will apply to all future and pending applicants submitted as of February 24, 2020. [Read More](#)

House Passes Federal Funding Bill to Relax Repayment Terms for COVID-19 Medicare Loans. *Modern Healthcare* reported on September 22, 2020, that the House overwhelmingly passed a bill that would extend federal funding through December 11 and relax repayment terms for \$100 billion on Medicare Accelerated and Advance Payment Program loans. Initially meant to begin this month, repayments would begin one year after the loans were issued. Recoupment rates would also be lowered from its current 100 percent level to 25 percent for the first 11 months of repayment, and 50 percent for the six months afterward. Hospitals would have 29 months to begin paying back funds in full before interest rates, which the bill lowered from 9.6 percent to 4 percent, would apply. Additionally, the bill would delay cuts to disproportionate-share hospital (DSH) payments until December 11. [Read More](#)

MACPAC Meeting Is Scheduled for September 24-25. The Medicaid and CHIP Payment and Access Commission (MACPAC) announced on September 21, 2020, that its next meeting will be held September 24-25. Topics to be discussed are:

- Prototype Countercyclical Financing Adjustment for Medicaid
- Relief Funding for Medicaid Providers Affected by the COVID-19 Pandemic
- Medicaid's Response to COVID-19
- Medicaid Estate Recovery Analyses
- Medicaid Drug Rebates and Medications Used for Opioid Use Disorder
- Behavioral Health in Medicaid
- Analyzing Racial and Ethnic Disparities in Medicaid and CHIP
- Integrating Care for Dually Eligible Beneficiaries through Medicare-Medicaid Plans
- State Management of Waiting Lists for Home- and Community-Based Services
- Medicaid Coverage of Vaccines
- Pediatric Oral Health Services in Medicaid Managed Care [Read More](#)

States Look to Medicaid Provider, Managed Care Rate Cuts to Close Budget Shortfalls. *Modern Healthcare* reported on September 19, 2020, that hospitals and other providers can expect lower Medicaid reimbursement rates across the country for the foreseeable future due to the COVID-19 pandemic, according to industry experts. As Medicaid enrollment steadily increases, states face average budget shortfalls of 10 percent and 20 percent in 2020 and 2021, respectively. While some states have made Medicaid provider rate cuts, others look toward more targeted cuts to ancillary benefits or Medicaid managed care rate reductions. [Read More](#)

Justice Ruth Bader Ginsburg's Death Could Jeopardize the ACA. *The Washington Post* reported on September 19, 2020, that the death of Supreme Court Justice Ruth Bader Ginsburg has increased the chances that the Affordable Care Act (ACA) could be struck down. The U.S. Supreme Court is scheduled to hear a case concerning the constitutionality of the Affordable Care Act (ACA) on November 10, one week after the presidential election. [Read More](#)

States Warn of Medicaid Cuts Without Additional Federal Matching Funds. *Morning Consult* reported on September 17, 2020, that state Medicaid agencies are likely to cut Medicaid provider rates, increase cost-sharing, or curtail health benefits if they do not receive increased federal matching funds to balance their budgets due to the pandemic. Congress increased Federal Medical Assistance Percentage (FMAP) matching funds for Medicaid by 6.2 percentage points, despite states urging to increase matching by at least 12 percentage points in order to help stabilize their programs. As Medicaid enrollment continues to increase and an additional COVID-19 relief bill looks unlikely to pass this year, states will look to Medicaid cuts to close budget shortfalls. [Read More](#)

Trump Administration Likely to Pass Drug Importation Program. *Kaiser Health News* reported on September 18, 2020, that the Trump administration is likely to pass a drug importation program before the November elections that would allow states to import some prescription medicines from Canada. Colorado, Florida, Maine, New Hampshire, New Mexico and Vermont have all sought federal approval to participate in the drug importation program, with Florida going so far as releasing a procurement for companies to bid on a three-year, \$30 million contract to run the program. However, states have expressed concern over the program's restriction to only one Canadian drug wholesaler, which could result in higher prices than officials have hoped. [Read More](#)

CMS Innovation Agency Announces Roll Out of Risk-Based Model for Dual Eligibles. *Healthcare Dive* reported on September 16, 2020, the Center for Medicare & Medicaid Innovation (CMMI) announced the upcoming trial of a new direct contracting model that will allow managed care organizations to assume financial risk for patients dually enrolled in Medicare and Medicaid. The new model will allow insurers that assume risk for a Medicaid managed care member to also assume risk for the same member enrolled in fee-for-service Medicare. Separately, CMMI plans to introduce a geographic direct contracting model in which insurers assume risk for a portion of Medicare lives in a specific geographic region in exchange for greater flexibility in the structure of their program. [Read More](#)



INDUSTRY NEWS

Private Health Plans Paid More for Hospital Care than Medicare, Study Finds. *Modern Healthcare* reported on September 18, 2020, that private health plans paid, on average, 247 percent more than what Medicare paid for hospital care in 2018, according to a RAND Corporation study. The study, which analyzed claims data from 2016 to 2018 representing \$33.8 billion in spending at 3,112 hospitals across all 50 states, found that health systems varied greatly with respect to the prices insurers paid for their inpatient and outpatient services. The study lists John Muir Health, Parkview Health System and Orlando Health as the top three most expensive health systems, with a relative price of 401 percent, 388 percent, and 374 percent of Medicare, respectively. [Read More](#)

Traditions Health Acquires Two Hospice Providers. Hospice and home health provider Traditions Health announced on September 17, 2020, its acquisition of Oklahoma-based Physician's Choice Hospice and Palladium Hospice and Palliative Care. The move will strengthen Traditions Health's footprint in Georgia and Oklahoma as well as expand its services into Mississippi and South Carolina. [Read More](#)

LearnWell Acquires New York-Based Comprehensive Counseling. Mental health services company LearnWell announced on September 16, 2020, that it has completed the acquisition of New York-based counseling practice Comprehensive Counseling LCSWs backed by an investment from 424 Capital and Eagle Private Capital. The acquisition will allow LearnWell to expand mental health services to partners in school districts, hospitals and treatment facilities. The president of Comprehensive Counseling, James Hickey, joins LearnWell as vice president of Counseling Services. LearnWell will initially offer the new services in Massachusetts, New Jersey and New York. [Read More](#)

MetLife to Acquire Versant Health for \$1.7 Billion. MetLife announced on September 17, 2020, that it has entered into a definitive agreement to acquire Versant Health for about \$1.68 billion in cash from an investor group led by Centerbridge Partners. Versant Health owns managed vision care marketplace brands Davis Vision and Superior Vision. With the addition of Versant Health, MetLife will serve roughly 38 million members. The deal is expected to close in the fourth quarter of 2020, and is subject to customary closing conditions. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2020	Ohio	RFP Release	2,360,000
October 1, 2020	Washington DC	Implementation	224,000
October 2020	North Dakota Expansion	RFP Release	19,500
Fall 2020	Oklahoma	RFP Release	800,000
Late 2021	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	RFP Release	1,640,000
Late 2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
Late 2021	California Imperial	RFP Release	75,000
Late 2021	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	286,000
Late 2021	California San Benito	RFP Release	7,600
January 2021	Nevada	RFP Release	465,000
January 1, 2021	Kentucky Rebid	Implementation	1,200,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
January 1, 2021	Washington Integrated Managed Care (Expanded Access)	Implementation	NA
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
July 1, 2021	North Carolina - Phase 1 & 2	Implementation	1,500,000
Early 2022 – Mid 2022	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Awards	1,640,000
Early 2022 – Mid 2022	California GMC - Sacramento, San Diego	Awards	1,091,000
Early 2022 – Mid 2022	California Imperial	Awards	75,000
Early 2022 – Mid 2022	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Awards	286,000
Early 2022 – Mid 2022	California San Benito	Awards	7,600
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

COMPANY ANNOUNCEMENTS

Bernadette Minton Joins Panel on Global Health and Technology at the 2020 Population Health Colloquium

HMA NEWS

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Colorado RAE Enrollment is Up 18.8%, Aug-20 Data
- Ohio Dual Demo Enrollment is Up 12.0%, Sep-20 Data
- Pennsylvania Medicaid Managed Care Enrollment is Up 9.2%, Aug-20 Data
- Rhode Island Dual Demo Enrollment is Down 8.2%, Sep-20 Data
- Utah Medicaid Managed Care Enrollment is Up 36.2%, Sep-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Connecticut Behavioral Health Home ASO RFP and Contract, 2014-21
- Florida Canadian Prescription Drug Importation Program ITN, 2020
- New York Using Advanced Technology in Medicaid Program Integrity and Efficiency RFI, Sep-20
- Ohio Technical Assessment of the OH Benefits System RFP, Sep-20
- Vermont Needs Assessments for Adults with I/DD RFP, Sep-20

Medicaid Program Reports, Data and Updates:

- Colorado Children's Health Plan Plus Caseload by County, Aug-20
- Florida Medicaid Eligibility by County, Age, Sex, Jul-20 Data
- Hawaii QUEST Integration Section 1115 CMS Quarterly Reports, 3Q20
- Michigan Health Link Medicaid Capitation Rate Certification Report, CY 2020
- Minnesota Medicaid Managed Care Rate Certifications, 2020
- Montana Medicaid Expansion and Employers Report, Sep-20
- Nebraska Governor's Budget Recommendations, Mid-Biennium Proposed Budget Adjustments, 2019-21
- New York State Comptroller Audits of Medicaid Program, Sep-20
- North Dakota Medicaid Expansion Program Annual Technical Reports, 2017-19
- Oregon Medicaid Capitation Rate Certifications, CY2020
- Pennsylvania HealthChoices Medicaid Expansion Enrollment, Aug-20
- South Carolina Medicaid Managed Care Rate Certifications, SFY 2019-21
- Tennessee Medicaid Advisory Committee Meeting Materials, May-20
- Vermont Green Mountain Care Board Advisory Committee Meeting Materials, Sep-20
- Vermont Green Mountain Care Board Annual Reports, 2014-19
- Vermont Health Care Expenditure Analyses, 2013-18
- Vermont Non-Compliance with ACO Scale Targets CMS Warning, Sep-20
- Vermont Report on Financial Health of VT's Critical Access Hospitals, Jan-19
- Wyoming WINGS Medicaid Management Information System Legislative Report, Jan-20

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