HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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Edited by:
Alona Nenko
Email

Carl Mercurio
Email

Mary Goddeeris, MA
Email

Lissete Diaz
Email

Scott Silberberg
Email

THIS WEEK

IN FOCUS

MEDICAID NON-EMERGENCY TRANSPORTATION BENEFIT: STAKEHOLDER PERSPECTIVES ON TRENDS AND INNOVATIONS

This week, our *In Focus* section reviews key takeaways from the report, *Medicaid Non-Emergency Transportation Benefit: Stakeholder Perspectives on Trends and Innovations*, prepared by Health Management Associates (HMA) for the Medicaid and CHIP Payment and Access Commission (MACPAC). The report was written by Principal Sharon Silow-Carroll, Principal Kathy Gifford, Senior

Consultant Carrie Rosenzweig, Consultant Anh Pham, and former Managing Principal Kathy Ryland (retired).

States are required to provide non-emergency medical transportation (NEMT) to Medicaid beneficiaries with no other means of transportation. In December 2020, following the completion of this study, Congress added a requirement for states to provide NEMT to the Social Security Act (the Act) through the Consolidated Appropriations Act of 2021 (P.L. 116-260). Previously, NEMT was mandated by federal regulations derived from the general statutory requirement that states must "ensure necessary transportation" for Medicaid beneficiaries to assure access "to and from providers" (42 CFR 431.53). Within these guidelines, states have significant flexibility in how they deliver the NEMT benefit to best meet the unique challenges and needs of their beneficiaries, including the delivery system model, reimbursement approach, and transportation modes.

To better understand the state policy decisions, implementation challenges, and innovative practices related to this critical benefit, HMA conducted an environmental scan of all 50 states and the District of Columbia (DC), focusing on criteria including variation in NEMT delivery system models, geographic diversity, innovations, and notable quality requirements. Based on this scan, HMA and MACPAC selected six states: **Arizona, Connecticut, Georgia, Indiana, Massachusetts, and Texas** to study further through interviews with 51 NEMT stakeholders, including federal and state officials, NEMT providers, transportation broker representatives, MCO representatives, beneficiary advocates, and NEMT subject matter experts.

States use a variety of NEMT delivery system models and reimbursement approaches. These include: managing the benefit in-house (i.e., within the Medicaid agency) and paying for NEMT on a fee-for-service (FFS) basis; contracting with transportation brokers on a capitated or FFS basis (e.g., trip cost plus administrative fee) to manage all or some aspects of NEMT on a state's behalf; and carving the NEMT benefit into a capitated managed care arrangement with a Medicaid managed care organization (MCO) that either administers the benefit directly or subcontracts with a broker. Approximately a dozen states employ more than one model, using, for example, different models for different Medicaid populations or for different geographic areas. The delivery system models for each of the six study states are outlined in ***Table 1*** below.

Table 1: Study State Medicaid NEMT Delivery System Models and Changes

State	Model/Risk Arrangement[i]	Recent or Planned Changes
Arizona	MCO Carve-In/MCOs at risk In-house for American Indian/Alaska Native (AIAN) individuals not enrolled in MCOs/State at risk	N/A

[i] Risk Arrangement indicates whether an entity is financially responsible for changes in trip volume and costs. An MCO or broker receiving capitated, per-member-per-month payments is considered "at risk." A state that pays directly for transportation services or pays a broker on a per-ride basis is "at risk."

Connecticut	Statewide Broker/Broker at risk	2018: Shifted Broker Model from FFS to capitation
Georgia	Regional Brokers/Brokers at risk	N/A
Indiana	MCO Carve-In/MCOs at risk Statewide Broker for FFS population/ Broker at risk	2018: Transitioned FFS population from in-house to broker model
Massachusetts	Regional Brokers coordinating with human service transportation/State at risk	2021: New contracts will reduce number of brokers, increase performance incentives
Texas	Regional Brokers/Brokers at risk In-house for one region/State at risk	2021: Shift from regional brokers[ii] to MCO carve-in model

Report findings and common themes include:

- **Policy Considerations**: States consider a wide variety of factors when designing their NEMT program including financial and staff resources, known patterns of care, coordination with managed care or other human services transit programs, and a desire to incentivize targets outcomes.
- **NEMT Utilization**: The most frequent NEMT utilizers are individuals with physical, intellectual, or developmental disabilities and who routinely attend medical appointments multiple times a week, such as those receiving dialysis, Medication for Opioid Use Disorder (MOUD), cancer treatment, or adult day health programs. While the COVID-19 pandemic significantly reduced NEMT utilization and may have long-term effects on NEMT service demand, many beneficiaries will continue to need transportation assistance for critical services that cannot be delivered virtually.
- **Performance Issues:** Late pick-ups and no-shows were the primary reasons for complaints by beneficiaries, health care providers, and MCO care managers. Interviewees identified GPS tracking and other technologies as essential to improving timeliness, efficiency, and beneficiary satisfaction.
- **Program Integrity:** While contracts for brokers, MCOs, and transportation providers often include NEMT performance standards and incentives, some advocates interviewed expressed frustration about the adequacy of state oversight and enforcement, stressing the need for greater consumer feedback and involvement. Most interviewees did not perceive NEMT fraud, waste, and abuse to be a significant problem, particularly with the shift to broker models and new technologies.

[ii] Exception: NEMT is administered by the state in one region.

- **Transportation Network:** NEMT programs often face significant challenges maintaining an adequate transportation network, particularly in rural areas. Interviewees cited the high cost of insurance as a substantial barrier to NEMT provider participation and reported that Transportation Network Companies (TNCs), such as Uber and Lyft, offer several advantages and opportunities for supplementing NEMT supply for able-bodied, independent beneficiaries. However, most agreed that TNCs are not appropriate for a large segment of the NEMT population, including those who have physical or intellectual and developmental disabilities.
- **Stakeholder's View on the Value and Role of NEMT:** All interviewees emphasized the importance of the NEMT benefit in helping Medicaid beneficiaries access the health care they need. Several highlighted the value or potential value of NEMT in improving health outcomes and reducing disparities, and some interviewees opined that NEMT would offer even greater value if beneficiaries and health care providers received more education about the benefit.

Link to Report

HMA Medicaid Roundup

Connecticut

Connecticut Fails to Pass Public Option Plan This Legislative Session. *The CT Mirror* reported on August 22, 2021, that Connecticut's push for a public option plan failed to pass this year with only two weeks left in the legislative session despite Democratic support. The proposed plan would have used the state's purchasing power to negotiate an insurance policy for individuals and modify rates annually based on claims. The insurance industry lobbied strongly against the plan. The prospect for another public option legislative effort next year is unlikely. Read More

Connecticut Opens Public Comment Period for Substance Use Disorder Waiver Demonstration. The Centers for Medicare & Medicaid Services (CMS) announced on August 20, 2021, the start of a public comment period through September 19, 2021, for Connecticut's Substance Use Disorder (SUD) section 1115 waiver demonstration. The waiver, which requests that Institutions for Mental Diseases be paid as a Medicaid-covered setting, seeks to reimburse inpatient treatment services provided to eligible Medicaid or Children's Health Insurance Program enrollees diagnosed with a SUD. The demonstration does not seek to change the delivery system of services, eligibility criteria, or cost-sharing requirements. Read More

District of Columbia

MedStar Health May Drop CareFirst, AmeriHealth Caritas Medicaid Plans from Network. *The Washington Post* reported on August 23, 2021, that MedStar Health, which operates both a Medicaid plan and one of the largest health systems in the District of Columbia, may no longer allow Medicaid members from CareFirst and AmeriHealth to access the organization's network of primary care providers and specialists, according to Wayne Turnage, DC deputy mayor for health and human services. A decision by MedStar to end its network contracts with the insurers, which Turnage said could happen by fall, would impact more than 165,000 Medicaid beneficiaries. CareFirst and AmeriHealth members would still be able to visit the emergency rooms at MedStar Washington Hospital Center and MedStar's Georgetown University Hospital. Read More

Iowa

Medicaid Enrollment Increases by 15.6 Percent Since Start of Pandemic. *The Gazette* reported on August 23, 2021, that Medicaid enrollment in Iowa rose 15.6 percent to 487,193 from March 2020 to July 2021 as unemployment increased and eligibility redeterminations were halted due to the COVID-19 pandemic. Medicaid enrollment included 280,905 children, 90,436 adults, 83,231 disabled Iowans and 32,621 elderly residents. Read More

Illinois

Lawmakers Pass Bill to Carve Non-Emergency Ambulance Transportation Out of Medicaid Managed Care. *KPVI* reported on August 24, 2021, that Illinois lawmakers passed a bill to transition non-emergency ambulance transportation to fee-for-service by carving it out of Medicaid managed care. Governor J.B. Pritzker's spokesman said the administration is concerned the bill may disrupt care and reduce the quality of services. Read More

Illinois Medicaid to Expand Maternal, Child Health Programs. *MyRadioLink.com* reported on August 25, 2021, that the Illinois legislature passed a bill to expand contraceptive coverage, address maternal mortality, and improve post-partum care through a Family Planning State Plan Amendment. Governor JB Pritzker is expected to sign the legislation. Read More

Health Plan Faces Renewed Lawsuit Alleging Fraudulent Medicaid Billing Practices. *Reuters* reported on August 19, 2021, that the Seventh U.S. Circuit Court of Appeals revived a lawsuit against Illinois Medicaid managed care organization Molina, accusing the insurer of fraudulently billing the state Medicaid program for healthcare services on behalf of nursing home residents that it did not actually provide. The lawsuit claims that after terminating its contract with GenMed, Molina continued to collect payments for skilled nursing facility care. The case was originally dismissed by U.S. District Judge Virginia Kendall. Read More

Louisiana

Orleans County Demands $1.6 Million in Medicaid Reimbursements. *Orleans Hub* reported on August 18, 2021, that Orleans County is demanding Louisiana pay $1.6 million owed in Medicaid reimbursements from April 2016 to April 2020. The county claims that 80 percent of federal Medicaid matching dollars should have been allocated to counties, but the state last reconciled with counties in fiscal 2016. County lawmakers are calling on the state legislature and the Governor's office to release the funds. Read More

Mississippi

Mississippi Seeks To Change Medicaid Managed Care Procurement Process. The Mississippi Division of Medicaid (DOM) announced on August 18, 2021, that it submitted a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services to give the state more flexibility in the methods used to procure for Medicaid managed care organizations. The state has altered the language to eliminate requests for proposals (RFPs), allowing for other competitive processes. The tentative effective date is August 1, 2021. DOM intends to implement this SPA during its next managed care procurement cycle, beginning in the summer of 2021. Currently, the state contracts with Centene, Molina and UnitedHealthcare. Read More

Mississippi Medicaid to Require MCOs to Adopt Uniform Credentialing Process. *Open Minds* reported on August 18, 2021, that Mississippi will require its Medicaid managed care organizations (MCOs) to adopt a uniform credentialing process for professionals and provider organizations under the Mississippi Coordinated Access Network (MississippiCAN) program. The state hopes to implement the process by December 1, 2021. Read More

Missouri

Missouri Will Not Finalize Medicaid Expansion Applications Until October 1. *The Examiner* reported on August 24, 2021, that Missouri will not finalize Medicaid expansion applications until October 1, when the state has completed a system upgrade. A press release from Gov. Mike Parson's office said that qualifying health care costs incurred between the time a person applies and is approved for expansion coverage "may be reimbursed at a later date." Read More

Missouri Medicaid Director Slated to Return to Post in September. *Missouri Independent* reported on August 19, 2021, that Missouri Medicaid Director Todd Richardson is slated to return to work mid-September, interim director Kirk Mathews announced during a MO HealthNet Oversight Committee. Richardson has been out on leave since April. Separately, Missouri officials also reiterated it will still be several months of fine-tuning until Medicaid expansion applications can be approved. Read More

New Jersey

New Jersey Comptroller Finds 15 Percent of All Improper Medicaid Payments Were Self-Reported. *The New Jersey Globe* reported on August 20, 2021, that New Jersey Medicaid providers self-disclosed nearly $6.5 million in Medicaid payments they received and were not entitled to, according to the New Jersey State Comptroller. This accounted for 15 percent of all improper Medicaid payments. Providers must self-disclose Medicaid payments within 60 days or face penalties. Read More

New York

New York Submits Medicaid 1115 Waiver to Address Health Disparities. The New York State Department of Health announced on August 25, 2021, that it submitted a section 1115 waiver demonstration proposal requesting $17 billion in new Medicaid funding over five years to address health disparities and systemic delivery systems issues highlighted by the COVID-19 pandemic. The proposal includes four goals: building a more resilient, flexible, and integrated delivery systems; developing supportive housing and alternatives to institutions for the long-term care population; redesigning and strengthening health and behavioral health system capabilities; and creating statewide digital health and telehealth infrastructure. Read More

Pennsylvania

Pennsylvania Unveils Interactive Tool to Help Promote Health Equity. The Pennsylvania Departments of Health and Human Services announced on August 18, 2021, the interactive PA Health Equity Analysis Tool (HEAT), to help promote health equity through the use of Medicaid and population health data. HEAT provides population health measures by state, county, zip code, and census track. Read More

Texas

Texas Ten-Year Medicaid Waiver Extension Upheld by Federal Judge. *Modern Healthcare* reported on August 22, 2021, that a federal judge has issued a ruling that would reinstate a ten-year extension of Texas' Medicaid 1115 waiver. In April, the Biden administration revoked the extension, which had been approved by the prior administration, claiming the approval process did not include the normal opportunity for public notice and comment. That decision was challenged in federal court by Texas' Attorney General, Ken Paxton. Read More

Wisconsin

Wisconsin Releases Draft RFP for Medicaid Managed Long-Term Care. On August 25, 2021, the Wisconsin Department of Health Services (DHS) released a draft request for proposals (RFP) for the upcoming procurement of its Family Care Medicaid managed long-term care program. DHS is seeking comments from potential managed care organizations on whether requirements are restrictive, duplicative, unclear, missing, or deficient. Comments are due September 15, 2021.

National

Uninsured Rate Holds Steady, Report Finds. *Healthcare Dive* reported on August 24, 2021, that the uninsured rate remained steady at about 11 percent from March 2019 to April 2021, according to a report from the Urban Institute funded by the Robert Wood Johnson Foundation. Efforts to sustain enrollment in publicly sponsored healthcare programs, including increased Exchange subsidies and a moratorium on Medicaid disenrollment, helped offset losses in employer-sponsored coverage. Read More

Medicare Advantage Spending Higher Than Traditional Medicare, Analysis Finds. *Fierce Healthcare* reported on August 18, 2021, that the federal government spent $7 billion more for Medicare Advantage (MA) plan enrollees compared to traditional Medicare beneficiaries in 2019, according to an analysis by the Kaiser Family Foundation. The report found that Medicare spending for MA enrollees was $321 higher per person compared to traditional Medicare. The increase in spending is attributed to higher rebates and benchmarks. Read More

Dental Advocacy Groups Sign Letter Urging Congress to Require Medicaid Coverage of Dental Care. *U.S. News/HealthDay News* reported on August 20, 2021, that the American Dental Association and nearly 130 other organizations signed a letter to Congress urging lawmakers to support the Medicaid Dental Benefit Act, which would require dental care as a component of Medicaid coverage for beneficiaries in every state. The ADA identified the bill as a way for lawmakers to "promote a sustainable economic recovery and reduce vast health inequities by guaranteeing dental coverage to all adults who count on Medicaid, no matter where they live." Read More

U.S. Senator, Representative Introduce Bill to Increase Telehealth Access for Medicaid, CHIP Beneficiaries. *Delaware Business Times* reported on August 19, 2021, that U.S. Senator Tom Carper (D-DE) and Representative Lisa Blunt Rochester (D-DE) introduced the Telehealth Improvement for Kids' Essential Services (TIKES) Act, which would help states expand telehealth services for beneficiaries enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The bill would provide states with guidance on how to integrate telehealth into their Medicaid and CHIP programs, require a Government Accountability Office (GAO) study examining data on the impact of telehealth on Medicaid members, and require another GAO study reviewing opportunities for better coordination among federal agency telehealth policies. Read More

Biden Pegs Federal Medicaid, Medicare Funding to Vaccines for Nursing Home Staff. *CBS News* reported on August 19, 2021, that the Biden administration is ordering the U.S. Department of Health and Human Services to require nursing home staff to be vaccinated against COVID-19 in order for facilities to continue to receive federal funding from Medicaid and Medicare. The deadline for the vaccine requirement, which would apply to more than 15,000 nursing facilities and 1.3 million workers, has yet to be set. Read More

INDUSTRY NEWS

GuideWell to Acquire Triple-S Management. Florida-based not-for-profit GuideWell Mutual Holding Corporation announced on August 24, 2021, an agreement to acquire Triple-S Management for approximately $900 million. Triple-S Management will operate as a wholly owned subsidiary of GuideWell and will continue to be led by its current management team. The deal is expected to close in the first half of 2022. Read More

HHS Awards Medicare, Medicaid Data Sharing Contract to CGI. *Market Watch* reported on August 25, 2021, that the U.S. Department of Health and Human Services awarded CGI a $34.4 million contract to enable data sharing between Medicare and Medicaid. CGI will implement an application programming interface to aggregate data from multiple sources at the Centers for Medicare & Medicaid Services' Center for Program Integrity. Read More

Independent Living Systems Completes $120 Million Stock Buyback. *South Florida Business Journal* reported on August 19, 2021, that Florida-based Independent Living Systems (ILS) has gone independent after Fordham Holdings, owned by ILS founder and chief executive officer Nestor Plana, bought back $120 million in stock. Since 2012, Connecticut-based Oak Investment Partners has held a major stake in ILS, which provides nutrition, housing and transportation services to health plans and hospital systems. Read More

PBM Trade Group Files Lawsuit Against Trump Administration-era Rule on Price Transparency. *The Ohio Capital Journal* reported on August 20, 2021, that the Pharmaceutical Care Management Association filed a lawsuit in federal court against a Trump administration-era rule that would require pharmacy benefit managers (PBMs) to publicly disclose their net prices in the Medicare Part D program in a readily available computer-readable format. The lawsuit claims that increased transparency on negotiated prices between PBMs and drug manufacturers would open the door for "manufacturers to tacitly collude with each other to increase drug prices." The Biden administration delayed implementation of the rule, which advocates believe can rein in increasing drug costs. Read More

Cityblock Health to Serve BCBS-NC Medicaid, Medicare Advantage Members. Cityblock Health, a value-based care provider, announced on August 18, 2021, its collaboration with Blue Cross and Blue Shield of North Carolina by serving the insurer's Medicaid managed care and Medicare Advantage beneficiaries through five clinics in Charlotte, Fayetteville, Greensboro, High Point, and Winston-Salem, effective July 1. Cityblock will support members through a community-focused care model that addresses physical health, behavioral health, and social determinants of health. Cityblock currently serves 90,000 members across Connecticut, Massachusetts, New York, North Carolina, and Washington, DC. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Summer 2021	Rhode Island	RFP Release	276,000
July 1, 2021 - Delayed	Missouri	RFP Release	756,000
August 2021	Texas STAR Health	RFP Release	36,500
August 31, 2021	Tennessee	Proposals Due	1,500,000
September 3, 2021	Louisiana	Proposals Due	1,600,000
October 2021	Minnesota Seniors and Special Needs BasicCare	RFP Release	120,000
October 1, 2021	Oklahoma	Implementation	742,000
October 8, 2021	Tennessee	Awards	1,500,000
November 2021	Missouri	Awards	756,000
November 5, 2021	Louisiana	Awards	1,600,000
December 1, 2021	Delaware	RFP Release	240,000
December 22, 2021	Iowa	RFP Release	745,000
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
Dec. 2021 - Feb. 2022	Texas STAR+PLUS	RFP Release	538,000
First Quarter 2022	Indiana MLTSS	RFP Release	*NA*
January 2022	Minnesota MA Families and Children, MinnesotaCare	RFP Release	543,000
January 1, 2022	Minnesota MA Families, Children; MinnesotaCare (metro)	Implementation	548,000
January 1, 2022	Nevada	Implementation	600,000
January 1, 2022	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2022	North Dakota Expansion	Implementation	19,800
January 5, 2022	Ohio	Implementation	2,450,000
January 7, 2022	Indiana Hoosier Healthwise and HIP	Awards	1,200,000
February 2022	Texas STAR Health	Awards	36,500
July 1, 2022	Rhode Island	Implementation	276,000
July 1, 2022	North Carolina - BH IDD Tailored Plans	Implementation	*NA*
July 1, 2022	Missouri	Implementation	756,000
July 1, 2022	Louisiana	Implementation	1,600,000
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
Mar. 2022 - May 2022	Texas STAR+PLUS	Awards	538,000
Fourth Quarter 2022	Indiana MLTSS	Awards	*NA*
Sep. 2022 - Nov. 2022	Texas STAR & CHIP	RFP Release	3,700,000
Dec. 2022 - Feb. 2023	Texas STAR & CHIP	Awards	3,700,000
January 1, 2023	Tennessee	Implementation	1,500,000
January 1, 2023	Minnesota MA Families and Children, MinnesotaCare	Implementation	543,000
January 7, 2022	Indiana Hoosier Healthwise and HIP	Awards	1,200,000
Mar. 2023 - May 2023	Texas STAR Kids	RFP Release	166,000
Jun. 2023 - Aug. 2023	Texas STAR Kids	Awards	166,000
Jun. 2023 - Aug. 2023	Texas STAR Health	Implementation	36,500
Sep. 2023 - Nov. 2023	Texas STAR+PLUS	Implementation	538,000
2024	Indiana MLTSS	Implementation	*NA*
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
Jun. 2024 - Aug. 2024	Texas STAR & CHIP	Implementation	3,700,000
Dec. 2024 - Feb. 2025	Texas STAR Kids	Implementation	166,000

HMA WELCOMES

Megan Beers – Senior Associate

A strategic thinker with a record of driving transformation in multiple settings, Megan Beers is a successful program developer, leader, and consultant focused on systems of care and services for children and families, as well as behavioral health across the lifespan.

Before joining HMA, she served as chief operations and program officer for Childhaven in Seattle, where she provided leadership for programs across the organization's continuum of care, including early learning, outpatient mental health, Wraparound with Intensive Services (WISe), and Part C Early Intervention.

As a member of the senior management team, she provided structure and leadership with transparency, vulnerability, compassion, and reflection at the center. Focused on evidence-based, community- centered processes, she enhanced organizational outcomes by strategically initiating new programs, services, and ventures.

In addition, Megan previously served in various roles with Wellspring Family Services where she was responsible for program development and leadership for a variety of services supporting families experiencing homelessness. With expertise in infant-early childhood mental health and trauma-informed care, she provided staff training and consultation to drive quality improvement.

Megan has also held several positions as staff psychologist, researcher and professor and is an author and contributor to academic journals, conferences, and forums.

She earned a Doctor of Philosophy and Master of Science, both in psychology, from the University of Oregon and a bachelor's degree in biopsychology from Vassar College. She completed her psychology internship at the Child Development and Rehabilitation Center, Oregon Health and Science University and a postdoctoral fellowship in Early Childhood Mental Health at the Warren Alpert Medical School of Brown University and Bradley Hospital.

Gregory Uszak – Consultant

Greg Uszak is a multidisciplinary certified public accountant focused on healthcare finance, business operations, and strategy development.

Before joining HMA, he worked with providers as a senior healthcare advisor providing support to create strategic plans as well as conduct financial research and analysis and recommed business improvements based on market and competitive trends.

In addition, Greg's experience includes conducting due diligence for mergers and acquisitions to ensure regulatory compliance as well as modeling financial impact to assist leadership in transaction development. He gained extensive healthcare experience at the OhioHealth hospital system, where he provided broad-based tax and financial reporting services, financial analysis for senior

leadership, and supported the organization's corporate development initiatives.

A strategic thinker and liaison, he has helped organizations develop policies and procedures and worked across departments to ensure the financial state of the organization was included in decision making processes.

A former tax commissioner agent for the state of Ohio Department of Taxation, he helped the public interpret applicable state and federal tax laws, and assisted with the development of a new department database and web-based tax return filing platform.

Greg earned a Master of Science degree in healthcare management from Johns Hopkins University, a bachelor's degree in forensic accounting from Franklin University, and a bachelor's degree in criminology and criminal justice studies from The Ohio State University. In addition to being a certified public accountant, he is also a certified healthcare financial professional with the Healthcare Financial Management Association.

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Georgia Medicaid Management Care Enrollment is Up 8.5%, Aug-21 Data
- Illinois Dual Demo Enrollment is Down 1.9%, Apr-21 Data
- Illinois Medicaid Managed Care Enrollment is Up 3.0%, Apr-21 Data
- New York CHIP Managed Care Enrollment is Down 2.9%, Mar-21 Data
- North Dakota Medicaid Expansion Enrollment is Up 16.5%, Jun-21 Data
- Ohio Medicaid Managed Care Enrollment is Up 3.9%, Jun-21 Data
- Texas Medicaid Managed Care Enrollment is Up 6.1%, May-21 Data
- Virginia Medicaid Managed Care Enrollment is Up 14.5%, Jul-20 Data
- Washington Medicaid Managed Care Enrollment is Up 3.5%, Jun-21 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Nevada Medicaid Managed Care RFP, Responses, Scoring, and Related Materials, 2021
- New York Medicaid External Quality Review and Other Activities RFP, Aug-21
- Pennsylvania Medicaid Independent Audit Services RFP, Aug-21
- Wisconsin Family Care MLTC Draft RFP, Aug-21

Medicaid Program Reports, Data and Updates:

- Alabama Medicaid Agency Annual Reports 2012-19
- Arkansas DMS Medicaid Quality Strategy, 2020
- Arkansas Works Section 1115 Medicaid Waiver Annual Report, 2020
- Connecticut Medicaid Section 1115 Substance Use Disorder Demonstration Waiver Application, Aug-21
- Indiana D-SNP Medicaid Agency Contracts (SMAC), 2019-21
- Mississippi MississippiCAN State Plan Amendment for Procurement Method, Aug-21
- New York Department of Health Audit: Improper Medicaid Payments for Claims Not in Compliance With Requirements, Aug-21
- New York Section 1115 Waiver Demonstration Concept Paper, Aug-21
- Utah 1115 Primary Care Network Demonstration Waiver Documents, 2016-21

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