HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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THIS WEEK

IN FOCUS

CMS PAYMENT NOTICE SIGNALS SHIFT IN COVID-19 POLICIES FOR MEDICARE ADVANTAGE, PART D

This week our *In Focus* section reviews the *Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* issued by the Centers for Medicare &

Medicaid Services (CMS) on February 1, 2022. The Advance Notice includes proposed updates to MA payment rates and guidance to plan sponsors as they prepare their bids for CY 2023. It also shows CMS' updates to Part D benefit parameters. Comments are due by 6:00 PM EST on March 4, 2022. The final Rate Announcement will be published by April 4, 2022.

Overall, the proposed 2023 payment updates and policy provisions are aligned with the administration's stated commitment to address equity in health and health care. Notably, CMS states MA organizations and Part D sponsors have "a key role to play in advancing health equity."

The Advance Notice identifies specific proposals that could address health equity among MA enrollees and promote person-centered care linked to reimbursement. CMS solicits information on several concepts as it lays the groundwork for future potential policy changes to better align the Star Rating program with its goals. However, the agency would still need to refine and advance many of these proposals through separate rulemaking in future years.

Highlights from the Advance Notice are noted below. The analysis and insight reflect the combined expertise of HMA and its companies including the Wakely Consulting Group and The Moran Company.

MA Plan Payment Changes. Based on the Advance Notice, MA plan revenues are expected to increase by 7.98 percent in 2023. CMS included in this year's projection the anticipation that risk scores will increase by 3.50 percent. Absent that impact, MA revenues will increase an estimated 4.48 percent compared to an estimated 4.08 percent increase in 2022.

CMS is also proposing to modify the methodology used to calculate the normalization factor for 2023. This factor accounts for the estimated change in fee-for-service (FFS) risk scores that are the basis for MA payments. CMS found that the most recent year (2021) of FFS risk scores was lower than prior years, which under the normal methodology would have resulted in an additional payment increase for MA plans. CMS is proposing to not use the most recent year, and instead rely on older FFS data to determine the normalization factor.

CMS also intends to rebase the county-level FFS rates for 2023. Rebasing rates will adjust the county-specific estimated FFS payment and could move some counties to higher or lower benchmark quartiles.

- ***Takeaway:*** Plan-specific changes in payments will reflect both the change in the county-level rates from rebasing rates as well as the individual plan's change in risk scores. The payment increase of nearly 8 percent will likely garner the attention of Congress and Administration officials, particularly amidst ongoing conversations about Medicare Trust Fund insolvency. Payment and risk adjustment policies could be subject to structural changes in the future, though there is currently no consensus in Congress on specific policy solutions.

Risk Adjustment Models. For CY 2023, CMS plans to continue to calculate 100 percent of the risk score using the 2020 CMS- hierarchical condition categories (HCC) model. For CY 2023 payment to PACE organizations, CMS will continue to use the 2017 CMS-HCC model to calculate risk scores. In addition, CMS asks for comments on whether additional predictive factors regarding costs of MA enrollees could be incorporated in the risk adjustment model to address the impact of social determinants of health on beneficiary health

status. The agency also makes updates to the ESRD model used in CY 2020 to account for differences in cost patterns of dual eligible individuals.

- ***Takeaway***: CMS continues to face pressure from Congress, MedPAC and some stakeholders to ensure the risk adjustment models result in appropriate levels of payment for MA enrollees. The examples CMS provides and forthcoming stakeholder input signal potential future adjustments that will continue to leverage and refine the use of encounter data.

Star Rating Program. The biggest change in the Star Rating Program from 2022 to 2023 is not what is in the Advance Notice but what is missing: there is no mention of a continuation of the Public Health Emergency Disaster Adjustment.

- ***Takeaway:*** Without the COVID-19 guardrails, applied to all plans in 2022, many plans could lose their current Star Rating as the advantages afforded of the "hold harmless" provisions will no longer be available. In addition, the change in the weights of most of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures will have a significant impact on overall Star Ratings.

Updates to Star Ratings Measures. Among the potential updates to the clinical specifications for the Star Ratings measures in future years, CMS is considering adding the Complaints Tracking Module category 1.30 (CMS Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker). According to CMS' analysis of the 2019 CTM data, adding category 1.30 complaints would have produced an 11 percent increase in the complaint volumes for calculating the performance measures overall, leading to a decrease in the star assignments for almost one-quarter of MA-prescription drug (MA-PD) contracts and no change for Prescription Drug Plan (PDP) contracts. In addition, CMS makes technical changes to existing Star Rating Measures, for example, for Statin Use for Persons with Diabetes and the three Medication Adherence measures among others.

- ***Takeaways***: Like the CY 2023 Part C and D policy proposed rule, CMS has again raised concerns with plan marketing activities. This is a clear signal that the Agency is paying much closer attention to how beneficiaries are choosing MA plans. Adding additional pressure via the Star Ratings process could encourage plans to understand the potential impact and identify areas where additional education and training strategies may be needed. Without significant improvement, some plans may experience lower scores.

Expanded Focus on Health Equity: In the Advance Notice CMS discusses plans to develop and incorporate a Health Equity Index in the Star Ratings programs. CMS envisions that the index would consolidate existing health equity measures to provide a more holistic view of the plan's performance for enrollees with social risk factors (SRFs). Using the Star Ratings program, CMS is exploring how it can incentivize plan sponsors to better identify and then address disparities in care provided to members with a particular SRF. CMS is considering replacing the current reward factor based upon overall Star Ratings with the health equity index. The agency would need to establish the health equity index through separate rulemaking.

Related to the Health Equity Index, CMS is also considering a potential measure concept for screening enrollees for social needs such as food, housing and transportation.

- ***Takeaway***: Incorporating a Health Equity Index would be a significant change. The agency will be evaluating specific measures and approaches that could be most impactful to achieve health equity. In the future, a Health Equity Index could provide a competitive advantage for plans with benefit designs, including supplemental benefits and relationships with community-based organizations, that address social risk factors and begin to reduce disparities among members.

Risk Stratification. CMS is also considering stratification of additional process and outcomes measures as well as additional variables for stratification. The agency's goal is to incentivize plans to deliver better care and services to beneficiaries with similar needs and risk factors. This is expected to lead to within-contract improvement. The agency suggests it could display stratified reporting on its website, the Medicare.gov Plan Finder tool or both.

- ***Takeaway***: Making these data accessible to beneficiaries increases the information individuals possesses as they review and select plans. This will assist beneficiaries if these data are relevant and understandable to the individual. While CMS is clearly interested in shifting competition to focus more on plan performance, the agency recognizes the nuances and complexities in selecting the measures that would underly this transformation.

Transparency in Part C Value-Based Care Arrangements. CMS is exploring approaches to improve the agency's understanding of value-based care arrangements between MA organizations and providers as well as how these relationships impact health outcomes and quality of services provided to enrollees. For example, CMS asks for feedback on how to potentially structure a measure pertaining to value-based contracts.

- ***Takeaway***: CMS has a goal of ensuring all Medicare beneficiaries are in accountable relationships by 2030. This measure will help inform the agency's understanding of the breadth and level of accountability that exists among MA organizations and providers, and whether the agency is on track to meet its goal. As value-based models are often complex and individualized, providing input to CMS on the measure will likely help it to encompass many options.

HMA's Medicare practice has deep experience with the development and implementation of best practices to improve compliance with Medicare Advantage and Part D regulations. Specifically, we have been working with clients to understand the potential impact of these policy changes to improve Star Rating performance and helping plans achieve economies of scale around maximizing their year-round Medicare stars strategy. For information on our Medicare practice, please contact HMA colleagues Julie Faulhaber, Amy Bassano, Eric Hammelman, Aimee Lashbrook, Andrea Maresca, Tim Courtney, Kevin Kirby, or Sarah Owens.

HMA Medicaid Roundup

Arizona

Arizona to Offer HCBS Providers Incentive for EVV Use. The Arizona Health Care Cost Containment System (AHCCCS) announced on February 4, 2022, that home and community based providers will receive a differential adjusted payment increase of one percent if they log at least one visit in the state's electronic visit verification (EVV) system for at least 80 percent of members from January 1, 2021, to March 31, 2022. Read More

Arkansas

Arkansas PASSE Empower Healthcare Gets Investment from Trive Capital. *Magnolia Reporter/The Arkansas Non-Profit News Network* reported on February 7, 2022, that Dallas-based Trive Capital has acquired a 16.67 percent stake in Empower Healthcare Solutions, an Arkansas Provider-led Arkansas Shared Savings Entity (PASSE) that covers roughly 20,000 beneficiaries. State regulators also notified Empower that it had passed its readiness review, allowing the company to enroll new members. The 16.67 percent stake acquired by Trive was previously owned by Anthem's Beacon Health Options. Read More

California

California Releases Medi-Cal Managed Care Plans RFP for Two-Plan, GMC, and Regional Models. The California Department of Health Care Services (DHCS) released on February 9, 2022, a request for proposals for the state's Medi-Cal managed care program, with the intention to procure contracts for three of the state's Medicaid managed care plan models in 24 counties. The state plans to award contracts to one health plan for each of the 14 two-plan model counties, two plans each for the two counties served by the geographic managed care (GMC) model, and two plans each for the five counties that offer managed care through the regional model. As of January 1, 2024, the remaining 37 counties in California will be served by County Organized Health Systems plans or the new single-plan model; the Imperial and San Benito managed care models will no longer exist. Contracts will run from January 1, 2024, through December 31, 2028. Proposals are due by April 11, with awards expected in August. Read More

Medicaid Beneficiaries Struggle to Fill Prescriptions after Switch to Single PBM. *Kaiser Health News* reported on February 9, 2022, that California Medicaid beneficiaries have been struggling to fill prescriptions after the state switched to a single pharmacy benefit manager (PBM) to administer its Medicaid drug program for 14 million beneficiaries. Magellan Health has struggled with a high number of absentees at its call centers because of COVID-19 and has not received all of the necessary data from the organizations that previously administered the benefit, known as Medi-Cal Rx. The switch to a single PBM is intended to save the state $414 million in fiscal 2023. Read More

California Awards Statewide Medicaid Managed Care Contract Prior to Procurement Process. *California Healthline* announced on February 3, 2022, that California has awarded Kaiser Permanent a five-year, statewide Medi-Cal Medicaid managed care contract prior to the state's upcoming procurement process. The no-bid agreement, which would take effect in 2024 pending legislative approval, would allow Kaiser to continue serving its existing Medicaid enrollees while expanding its reach in the state. Kaiser, which serves about 900,000 Medi-Cal members, can also contract directly with the state to serve members it currently subcontracts from other Medicaid managed care plans. Read More

Lawmakers Pull Bill to Establish Universal Healthcare System. *The Wall Street Journal* reported on January 31, 2022, that a bill to establish a single-payer healthcare system in California was pulled from consideration before a planned vote in the state Assembly. The bill lacked enough support to pass. Read More

Florida

Florida Senator Introduces Spending Plan to Raise Nursing Home Employee Wages to $15 per Hour. *Florida Politics* reported on February 4, 2022, that Florida Senator Aaron Bean (R-Jacksonville) introduced a $47.8 billion health care spending plan that includes $685.5 million for nursing homes and health care workers providing care to individuals with intellectual and developmental disabilities. About $304 million would go toward nursing home rate increases, provided the funds are used to increase employee wages to at least $15 per hour. Read More

Georgia

Georgia Senate Advances Bill to Extend Postpartum Medicaid Coverage to 1 Year. *Georgia Health News* reported on February 7, 2022, that the Georgia state Senate unanimously passed a bill (Senate Bill 338) to extend postpartum Medicaid coverage from six months to one year. Medicaid covers over 50 percent of the births in Georgia. Read More

Illinois

Governor's Budget Proposal Increases Funding for Behavioral Health Services, Supports Staff Retention. *Health News Illinois* reported on February 3, 2022, that Illinois Governor JB Pritzker unveiled a $45.4 billion budget proposal, including increased funding for behavioral health services in the state. The budget also proposes funding for Medicaid providers to use for staff bonuses, retention, education, and recruitment. Read More

Illinois Bill Allowing Dental Hygienists to Practice Preventive Care in Long-Term Care Facilities Clears Senate Committee. *Illinois Health News* reported on February 3, 2022, that a plan to allow dental hygienists to practice preventive care in long-term care settings was approved by a state Senate committee. Officials from the Illinois State Dental Society oppose the plan and instead are calling for expanded access to teledentistry. Read More

Kansas

Kansas Lawmakers, Advocates Question Bill to Extend KanCare Medicaid Managed Care Contracts Through 2025. *The Kansas Reflector* reported on February 4, 2022, that a bipartisan group of Kansas House members, administration agencies, and healthcare advocates oppose proposed legislation (House Bill 2463) to extend the state's current KanCare Medicaid managed care contracts through 2025. The contracts are currently set to expire at the end of 2023, and the state has been preparing to release a request for proposals in October 2022. Kansas Medicaid is worth roughly $3.9 billion and serves about 440,000 individuals. Current plans are CVS/Aetna, Centene/Sunflower State Health Plan, and UnitedHealthcare. The extension would mean the contract would remain in place until after the governor's race. Read More

Missouri

House Budget Panel Advances Constitutional Amendment on Medicaid Expansion Funding. *The St. Louis Post-Dispatch* reported on February 8, 2022, that a Missouri House budget panel advanced a proposed constitutional amendment (House Joint Resolution 117) that would subject Medicaid expansion funding to an annual legislative appropriation and implement Medicaid work requirements. If passed by the legislature, the measure would go before voters in November. Missouri began processing Medicaid expansion applications in October 2021. Read More

Missouri Medicaid Recipients Incorrectly Flagged as Out-of-State Face Loss of Coverage. *The Kansas City Star* reported on February 7, 2022, that Missouri Medicaid recipients face loss of coverage after being incorrectly identified as out-of-state after a residency check utilizing the LexisNexis database. LexisNexis has faced similar complaints in Washington and Arkansas. Read More

Lawmakers Seek Amendment Limiting Medicaid Expansion Eligibility. *The St. Louis American* reported on February 2, 2022, that Missouri voters would decide on a state constitutional amendment limiting Medicaid expansion eligibility to a year when an appropriation is made, according to a House joint resolution under consideration. The amendment, which would appear on the November ballot, would also create Medicaid work requirements. Missouri began processing Medicaid expansion applications in October 2021, and enrollment has been slower than expected with only 58,000 of the estimated 230,000 newly eligible individuals enrolled. Read More

New Hampshire

Senate Committee Advances Bill to Enhance Medicaid Dental Benefits. *The New Hampshire Bulletin* reported on February 2, 2022, that the New Hampshire Senate Health and Human Services Committee unanimously passed a bill (Senate Bill 422) to provide coverage for routine dental care to 80,000 Medicaid beneficiaries. New Hampshire is one of 10 states where Medicaid only covers emergency dental care. Funding is expected to come from a recent Medicaid pharmacy benefits settlement. Read More

House Consider Bill to Waive 5-Year Medicaid Coverage Waiting Period for Immigrant Children, Pregnant Women. *The New Hampshire Bulletin* reported on February 2, 2022, that the New Hampshire House is considering a bill that would lift the five-year waiting period to access Medicaid for immigrant children and pregnant women. If the bill passes, there are an estimated 300 individuals who would gain coverage. Read More

New Hampshire Medicaid Recipients Struggle with Administrative Barriers, Report Finds. *The New Hampshire Bulletin* reported on February 1, 2022, that New Hampshire Medicaid members struggle with long wait times when applying for benefits along with other administrative barriers, according to a recent report from Rights & Democracy and The Center for Public Democracy. The report recommends standardizing staff training, writing documents in plain language, developing a real-time eligibility determination process, and alerting applicants to missing documents at the time of their application. New Hampshire has roughly 202,000 Medicaid recipients. Read More

New Jersey

New Jersey Controller Recommends Sanctions on Low-Quality Nursing Homes That Do Not Improve. *The New Jersey Monitor* reported on February 2, 2022, that the New Jersey Office of the State Comptroller recommended in a report that nursing homes with a one-star quality rating be required to improve if they want to remain in the Medicaid program. The report noted that some nursing homes have had low ratings for years and appear unlikely to improve.

New Mexico

New Mexico to Release Medicaid Managed Care RFP in September 2022. The New Mexico Department of Health and Human Services announced on January 24, 2022, the request for proposals (RFP) for the state's Centennial Care Medicaid managed care reprocurement will be released on September 2, according to a presentation to the Medicaid Advisory Committee. Proposals will be due by November 4. Current incumbents are Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, and Centene/Western Sky Community Care. Read More

New York

New York Advocacy Groups Ask State Officials to Repeal Prescription Drug Carveout. *Spectrum News* reported on February 8, 2022, that advocacy organizations sent a letter to New York State officials pushing for the permanent repeal of the Medicaid prescription drug carveout. Advocates worry that the carveout disproportionately affects low income individuals and people of color with HIV/AIDS. Read More

New York Medicaid Plans Have Low Denial Rates for Serious Mental Health Care Authorizations, Study Finds. *The American Journal of Managed Care* reported on February 3, 2022, that 1.5 percent inpatient and 0.4 percent of outpatient mental health care authorization requests were denied by New York Medicaid plans during utilization review from 2017-18, a study shows. The study says more research is needed to analyze the impact of low denial rates on care quality and outcomes. The study is based on 264,901 requests for inpatient mental health service authorizations and 53,687 requests for outpatient mental health service authorizations at 15 managed care plans. Read More

North Carolina

North Carolina to Participate in Medicaid Alternative Payment Pilot. North Carolina announced on February 3, 2022, that it was one of four states selected to participate in a new multi-stakeholder Alternative Payment Model initiative in partnership with the Health Care Payment Learning & Action Network and the Centers for Medicare & Medicaid Services. The initiative, which will build directly on the state's Medicaid managed care efforts, is aimed at rewarding better health outcomes, integrating physical and behavioral health, and investing in non-medical interventions. Other states participating in the pilot include Arkansas, California, and Colorado. Read More

North Carolina Seeks to Amend Medicaid Managed Care Demonstration Waiver. The Centers for Medicare & Medicaid Services (CMS) announced on February 3, 2022, that North Carolina has submitted for federal approval an amendment to its Medicaid managed care demonstration waiver. The amendment would extend the end date of the demonstration to June 30, 2026, adjust the the populations covered under behavioral health intellectual/development disability plans, modify the implementation of Health Opportunity Pilots that address social determinants of health, and exclude the COVID-19 testing group from mandatory managed care. CMS is accepting public comments through March 4. Read More

Ohio

Ohio Medicaid Plan Selection Change Will Not Disrupt Care, Medicaid Director Says. *The Statehouse News Bureau* reported on February 2, 2022, that a state policy requiring Medicaid managed care members to select a plan annually will not disrupt care, according to Ohio Medicaid director Maureen Corcoran. Members who do not select a plan will be auto-assigned. Previously, members were automatically reenrolled in their current plan. Enrollees will have opportunities to switch back to their old plans if they are not satisfied with the state's selection. Read More

Oregon

Oregon to No Longer Waive Early and Periodic Screening, Diagnostic, and Treatment Requirement for Children. The Oregon Health Authority announced on February 8, 2022, that it will no longer waive the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement for Medicaid children and adolescents. The change will appear in the state's 1115 Medicaid waiver renewal and was made in response to feedback received during the public comment period. Read More

Oregon Tops 95 Percent Health Coverage Statewide, Survey Finds. *KTVZ* reported on February 8, 2022, that 95.4 percent of Oregonians had health coverage in 2021, an all-time high, compared to 94 percent in 2019, according to the biannual Oregon Health Insurance Survey. Medicaid enrollment alone increased 29 percent in 2021, driven by continuous eligibility policies implemented during the pandemic. Oregon may seek to maintain aspects of continuous eligibility through a waiver amendment, according to a state Medicaid official. Read More

Pennsylvania

Governor Proposes Investments in Long-Term Care, Behavioral Health in Fiscal 2023 Budget. Pennsylvania Governor Tom Wolf proposed on February 8, 2022, increased Medicaid funding for skilled nursing provider rates, the personal care home supplementary payment program, county mental health, and substance use treatment providers as part of the state's fiscal 2023 budget. The proposal would also extend Medicaid postpartum coverage to one year. Read More

Pennsylvania Counties Receive $28 Million in Federal Funds for Behavioral Health Programs. Pennsylvania Governor Tom Wolf announced on February 1, 2022, that nearly $28 million in additional federal funding had been distributed to 30 counties for behavioral health programs. Programs will support crisis intervention, telehealth, student assistance programs, residential treatment services, and assisted outpatient treatment. Read More

Governor Approves $225 Million Relief Package for Hospital Staffing Shortage. Pennsylvania Governor Tom Wolf signed on January 26, 2022, legislation that will provide $225 million to hospitals to recruit and retain health care workers in the face of a staffing shortage. The figure includes $110 million for critical access hospitals, hospitals with a large share of Medicaid beneficiaries, and hospitals with inpatient behavioral health services. Read More

South Dakota

Senate Committee Holds Hearing on Medicaid Expansion Funding Bill. *The Argus Leader* reported on February 4, 2022, that the South Dakota Senate Health and Human Services committee held a hearing on a Medicaid expansion funding bill introduced by Sen. Wayne Steinhauer (R-Hartford), who has also introduced a separate Medicaid expansion bill. South Dakota voters will also have a chance to decide on Medicaid expansion in a ballot measure in November. Read More

House Passes Bill to Increase Medicaid Dental Provider Reimbursements. *Keloland News* reported on February 2, 2022, that the South Dakota House of Representatives voted 61-6 to pass legislation that would increase Medicaid reimbursements for dental providers. If enacted, the bill would require the state to publish a reimbursement schedule for Medicaid dental services that better covers the cost of services. Read More

Texas

Texas Releases Draft of STAR+PLUS Medicaid Managed Care RFP. The Texas Health and Human Services Commission (HHSC) released on February 4, 2022, a draft request for proposals (RFP) for the state's STAR+PLUS Medicaid managed care program, which serves aged, blind, and disabled populations. The RFP will be released March 29, 2022. Responses are due May 31, 2022, with awards anticipated in January 2023, and contracts implemented in September 2023. HHSC plans to award six-year contracts with three, two-year renewal options to at least two managed care plans in each of the state's service areas. Contracts will be worth $10.3 billion. The current STAR+PLUS plans are Amerigroup/Anthem, Cigna, Centene, Molina, and UnitedHealthcare. Read More

Texas Medicaid Begins Covering Applied Behavior Analysis for Children with Autism Spectrum Disorder. *Autism Speaks* reported on January 28, 2022, that Texas has begun covering applied behavior analysis for children with autism spectrum disorder (ASD) on Medicaid. To qualify, individuals must be under 21 years old, not enrolled in the Children's Health Insurance Program, and have had an ASD diagnosis within the last three years. Read More

Texas Medicaid Plans Recover Nearly $7 Million in Medicaid Fraud in Fiscal 2021, Report Shows. *Texas Dentists for Medicaid Reform* reported on February 4, 2022, that Texas Medicaid plans and dental maintenance organizations recovered about $6.8 million in fraudulent payouts in fiscal 2021, according to a state report. Read More

Wisconsin

Legislature Considers Bills to Tighten Eligibility Requirements for Medicaid. *Wisconsin Public Radio* reported on February 8, 2022, that the Wisconsin Assembly Committee on Public Benefit Reform is considering bills that would tighten eligibility requirements for Medicaid. One bill would require the Department of Health Services (DHS) to review individual Medicaid eligibility every six months and prevent the state from supplying individuals with pre-filled forms. The other bill would require certain beneficiaries to accept offers of employment to remain eligible for benefits. Read More

National

U.S. Senators Announce Plans for Legislative Package to Address Mental Health. *CQ News* reported on February 8, 2022, that members of the Senate Finance Committee announced plans to draft a legislative package by this summer addressing five key areas of mental and behavioral health. The bipartisan effort will center on workforce issues; integration, coordination and access to care; behavioral health parity; telehealth; and access to behavioral health care for children and adolescents. Read More

MACPAC Issue Brief Shows Differences in Sources of Care, Utilization by Race, Ethnicity. The Medicaid and CHIP Payment and Access Commission (MACPAC) issued a brief in February 2022 showing significant differences between racial and ethnic groups in sources of care and services utilized, according to data from the 2015-18 National Health Interview Survey. For example, white adult Medicaid beneficiaries were more likely to have received primary and mental health care in the past 12 months. White beneficiaries were also more likely to report a health center or clinic as their usual source of care. Read More

Minority Groups on Medicaid Report Significantly Worse Care Experiences, Study Finds. *Becker's Hospital Review* reported on February 7, 2022, that racial and ethnic minorities enrolled in Medicaid managed care plans reported significantly worse care experiences, according to a study in Health Affairs. The study, which is based on data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), looked at access to needed care, access to a personal doctor, timely access to checkup or routine care, and timely access to specialty care. Read More

HHS Issues Guidance to Providers to Ensure Individuals with Disabilities Receive Equal Care. *Fierce Healthcare* reported on February 6, 2022, that the U.S. Department of Health and Human Services (HHS) issued guidance reminding providers that discriminating against individuals with disabilities when divvying up care resources is a violation of federal civil rights law. Advocates have expressed concern about health care access for individuals with disabilities because of the strain in resources due to COVID-19. Read More

Industry News

BayMark's AppleGate Recovery Acquires Lucina Treatment Centers. BayMark Health Services' AppleGate Recovery announced on February 7, 2022, the acquisition of Indiana-based Lucina Treatment Centers, which has five office-based opioid treatment (OBOT) programs. BayMark now operates 50 OBOT programs across 13 states. Read More

Foresight Mental Health Acquires Psychiatric Addictive Curative Therapies. *Behavioral Health Business* reported on February 7, 2022, that Foresight Mental Health acquired Georgia-based Psychiatric Addictive Curative Therapies Atlanta, a multidisciplinary mental health practice with 14 clinics. Foresight provides services in 25 states and recently raised $25 million in a second round of financing. Read More

Encompass Health, Baptist Health South Florida Expand Home Health Venture. Encompass Health announced on February 1, 2022, that it has expanded its joint venture with Baptist Health South Florida to include home health services in Miami-Dade and Monroe counties. Encompass Health is the nation's fourth largest provider of Medicare-certified skilled home health services. Read More

ConcertoCare Closes on $105 Million Funding Round, Acquisition of Crown Health. ConcertoCare announced on February 3, 2022, the closing of $105 million in a funding round led by Wells Fargo Strategic Capital and the acquisition of Crown Health, a home-based primary care practice in the Pacific Northwest. The funding round also included investments from Obvious Ventures, Vast Ventures, The Schusterman Family Foundation, SteelSky Ventures, Pennington Partners, and returning investor Deerfield Management. Read More

RFP CALENDAR

RFP information and dates reflect publicly available state information.

Date	State/Program	Event	Beneficiaries
November 5, 2021 - Delayed	Louisiana	Awards	1,600,000
2022	Georgia	RFP Release	1,800,000
2022	Nebraska	RFP Release	331,000
February 16, 2022	Iowa	RFP Release	745,000
February 18, 2022	Minnesota Senior Health Options, Senior Care Plus	Proposals Due	64,000
February 18, 2022	Minnesota Special Needs BasicCare	Proposals Due	63,000
March 4, 2022	MississippiCAN, CHIP	Proposals Due	480,000
March 15, 2022	Delaware	Proposals Due	280,000
March 29, 2022	Texas STAR+PLUS	RFP Release	538,000
April 1, 2022	Minnesota MA Families and Children, MinnesotaCare	Proposals Due	470,000
April 11, 2022	California Medi-Cal: Two-Plan, GMC, Regional	Proposals Due	3,100,000
May 2022	Indiana MLTSS	RFP Release	*NA*
May 9, 2022	Minnesota Senior Health Options, Senior Care Plus	Awards	64,000
May 9, 2022	Minnesota Special Needs BasicCare	Awards	63,000
May 31, 2022	Texas STAR+PLUS	Proposals Due	538,000
June 2022	Texas STAR Health	Awards	43,700
June 1, 2022	Delaware	Awards	280,000
July 2022	MississippiCAN, CHIP	Awards	480,000
July 1, 2022	Ohio	Implementation	2,450,000
July 1, 2022	North Carolina - BH IDD Tailored Plans	Implementation	*NA*
July 1, 2022	Missouri	Implementation	850,000
July 1, 2022	Louisiana	Implementation	1,600,000
June 24, 2022	Minnesota MA Families and Children, MinnesotaCare	Awards	470,000
August 2022	California Medi-Cal: Two-Plan, GMC, Regional	Awards	3,100,000
Fall 2022	Florida	RFP Release	3,500,000
September 2, 2022	New Mexico	RFP Release	800,000
Sep. 2022 - Nov. 2022	Texas STAR & CHIP	RFP Release	3,700,000
November 4, 2022	New Mexico	Proposals Due	800,000
First Quarter 2023	Indiana MLTSS	Awards	*NA*
January 2023	Texas STAR+PLUS	Awards	538,000
January 1 2023	Delaware	Implementation	280,000
January 1, 2023	Tennessee	Implementation	1,500,000
January 1, 2023	Minnesota MA Families and Children, MinnesotaCare	Implementation	470,000
January 1, 2023	Minnesota Senior Health Options, Senior Care Plus	Implementation	64,000
January 1, 2023	Minnesota Special Needs BasicCare	Implementation	63,000
Mar. 2023 - May 2023	Texas STAR & CHIP	Awards	3,700,000
Mar. 2023 - May 2023	Texas STAR Kids	RFP Release	166,000
July 1, 2023	Rhode Island	Implementation	303,500
Sep. 2023 - Nov. 2023	Texas STAR Kids	Awards	166,000
Sep. 2023 - Nov. 2023	Texas STAR Health	Implementation	43,700
September 2023	Texas STAR+PLUS	Implementation	538,000
2024	Indiana MLTSS	Implementation	*NA*
January 1, 2024	California Medi-Cal: Two-Plan, GMC, Regional	Implementation	3,100,000
Jun. 2024 - Aug. 2024	Texas STAR & CHIP	Implementation	3,700,000
Dec. 2024 - Feb. 2025	Texas STAR Kids	Implementation	166,000

HMA WELCOMES

Jane Longo - Principal

Building her career in publicly funded healthcare and state government, Jane Longo is a program, policy, financial, and operations expert. She returns to HMA after serving the State of Illinois as deputy director of New Initiatives in the Department of Healthcare and Family Services, the most recent appointment in a long career with the state's budget and health and human services departments.

In her most recent position, Jane oversaw all eligibility activities for Medicaid, CHIP, and state-funded health benefit programs and served as business lead for operations and technical refresh of the Illinois Integrated Eligibility Edibility Systems operations.

Jane previously served as a principal with HMA, working with public clients on Medicaid and related policy and operational issues. Public clients included the Indiana Family and Social Services Administration, the Cook County (Illinois) Health and Hospitals System (CCHHS), and Pace Suburban Bus (Illinois). Additionally, Jane developed extensive experience with eligibility and enrollment issues including eligibility expansions, presumptive eligibility, ACA early expansion waiver implementation, provider operations, managed care enrollment policy and operations, and Part D eligibility. She also worked with private clients who work with Medicaid and other public programs.

While with HMA, Jane served as interim director of eligibility and enrollment for the CCHHS, Department of Managed Care. In this role, she organized and led staff and vendors in development, implementation, and operations related to eligibility and enrollment for newly eligible ACA adults in the Cook County Early Expansion waiver program and the transition from a waiver program to the CountyCare Medicaid health plan serving multiple Medicaid populations. She also led Cook County communications with the Illinois Department of Healthcare and Family Services and the Illinois Department of Human Services regarding eligibility, waiver, and managed care policies and procedures. During her tenure, enrollment efforts resulted in CountyCare waiver membership of more than 102,000 in 18 months.

Ilia Rolon - Senior Consultant

With a proven track record in successful execution of complex, high-level projects that increase services for underserved communities, Ilia Rolon has worked for more than 30 years in non-profit, healthcare, and managed care organizations.

Before joining HMA, she served as director of community and clinical outreach with CHOC Children's Health System where she oversaw operations of community-based population health programs and worked with the county office of education to create wellness spaces at seven public secondary schools. In this role, she secured funding to conduct a randomized controlled trial to test a social drivers of health intervention for parents of infants receiving primary care at community health centers.

Ilia also led health programs and policy as director at First 5 Orange County and guided multiple teams as they developed, implemented, and managed

large, cross-sector children's health initiatives. During her tenure, Ilia was successful in facilitating four Medicaid rate range intergovernmental transfer transactions, generating several million dollars of increased funding for maternal child health programs in her county.

A dynamic and collaborative leader, Ilia has spearheaded numerous multi-agency service partnerships to successfully apply for and secure Medicaid Demonstration Project (1115 Waiver) funding and state department of social services grants, resulting in expanded healthcare and home visiting services, respectively, for socioeconomically disadvantaged communities.

In various positions with CalOptima, she served as director of strategic development, manager of strategic operations, manager of long-term care integration, and senior program manager. In her increasingly senior roles, Ilia secured grant and private funding, wrote the business plan for Orange County's first Program for All Inclusive Care for the Elderly (PACE) site, coordinated the transition of more than 70,000 people from county indigent care to expanded Medicaid, and provided leadership and counsel to executive teams, including development of two strategic plans.

Ilia earned a Master of Public Health from San Diego State University and a bachelor's degree in health science from California State University, Long Beach.

Michelle Ford – Principal

Michelle L. Ford has more than 20 years of executive leadership, change management and fund development experience across several industries, including corporate, non-profit, healthcare and foundations.

Prior to joining HMA, she served as the director of Health and Well-Being with the Alliance for Strong Families and Communities (Alliance) and the Council on Accreditation. She worked to position the organization's strategic action network of community-based organizations as a central resource and authority for achieving health equity by addressing the social determinants of health, building organizational capacity to contract with the health industry, and developing best practices, necessary systems, and respective policy change.

Serving in a series of executive positions with non-profit organizations, Michelle is the former executive director of the United Neighborhood Centers of Milwaukee, where she managed organizational operations and financial oversight whiles working to advance the organization's mission, culture, goals, and outcomes while serving as spokesperson and community representative.

Michelle served as director of regional corporate relations, senior director of community engagement, and director of community partnerships for the American Cancer Society in the Midwest division. Additionally, she managed community partnerships and fund development for Wisconsin's largest hospital system, Aurora Healthcare, and led its annual giving campaign.

She was recently awarded an honorary doctorate in humanities from the Medical College of Wisconsin. She earned a Master of Business Administration from Cardinal Stritch University, where she served as an adjunct instructor in the College of Business and Management, and a Bachelor of Arts degree from Alverno College.

Michelle serves as a national thought leader working on several advisory boards, including the Morehouse School of Medicine's National Resiliency

Network, Camden Coalition's National Center for Complex Health and Social Needs, Field Coordinating Committee, Social Interventions Research Evaluation Network (SIREN), Root Cause Coalition and the Expert Advisory Group for Raising the Bar through the National Partnership for Women and Families.

Tom Lutzow – Principal

An accomplished healthcare administrator and business leader, Tom Lutzow is experienced in launching new product lines, developing supporting structures, managing multi-level operations, preparing, and implementing strategic plans, and engaging teams to achieve desired goals and outcomes.

Before joining HMA, he served in leadership positions including chief administrative officer, president, and CEO, for Independent Care Health Plan (iCare). He started iCare as a joint venture with Humana and the Milwaukee Center for Independence, a local rehabilitation agency. This venture became a nationally recognized model for integrated care in serving individuals with special needs. Upon Humana's full acquisition of the plan, he managed the transition to Humana's national business and member care models. He prepared the annual business plan for the Humana Wisconsin subsidiary enhancing both Medicare and Medicaid membership growth.

During his tenure as CEO, Tom modernized the plan's electronic health record and core processing systems, expanded the plan's business portfolio and service area, achieved 4-star or higher ratings, introduced quality incentive programs, strengthened the plan's Hierarchical Condition Category (HCC) documentation practices, applied multiple utilization management protocols for improved value, and enhanced the plan's "members first" culture.

A strong facilitator and alliance builder, he is skilled in developing business opportunities, partnerships and initiatives with key resources and organizations at the state and national level, whether through start-up join ventures, expansions, acquisitions, or other collaborations. He is grounded in performance measure and HCC management. He has a history of penetrating operational barriers through analysis and strategic action.

Tom also served as president of Matarah Industries and vice president of the Milwaukee Center for Independence.

He earned a Master of Business Administration from the Keller Graduate School of Management as well as a Doctor of Philosophy from Marquette University where he also served as adjunct faculty. Tom holds two United States patents and is Chair Emeritus of the Milwaukee County Mental Health Board.

Michele Bosworth - Principal

A physician leader dedicated to collaboration and strategic approaches to healthcare solutions, Michele Bosworth, MD, is an academic innovator and clinical expert. She joins HMA after serving in various leadership positions with the University of Texas Health Science Center at Tyler (UTHSCT).

She previously served as executive director of the UTHSCT Center for Population Health, Analytics, and Quality Advancement. While there, she achieved maximum financial performance of 1115 Waivers, oversaw externally funded programs, and aligned academic, clinical and community initiatives.

Additionally, Dr. Bosworth is also the former chief quality and patient safety officer with UTHSCT where she led strategic councils and committees as well as developed and deployed safety and effectiveness programs. As chief medical information officer with UTHSCT, she championed electronic health records and information technology implementations as well as cultivated a safety-focused culture of optimization within the organization.

As a practicing physician, she worked in the UTHSCT Family Medicine Residency Program as core faculty and became the program's clinic director. She completed her family medicine residency training at Mountain Area Health Education Center (MAHEC) in Asheville, N.C., where she was asked to develop and operate MAHEC's first satellite clinic upon graduation. As such, Dr. Bosworth served as the founding medical director for MAHEC's Cane Creek Family Health Center in Fairview, N.C., where she practiced full-spectrum family medicine while maintaining a teaching faculty presence in the MAHEC Family Medicine Residency Program.

She earned a Medical Doctorate at West Virginia School of Medicine in Morgantown, W.V., as well as a bachelor's degree in biology from West Virginia University. She is a Fellow of the American Academy of Family Physicians, a diplomat of the American Board of Preventive Medicine in clinical informatics, and a Lean Six Sigma Green Belt.

Elizabeth Ritter - Senior Consultant

Elizabeth Ritter is a dedicated and enthusiastic professional with over a decade of leadership experience managing various operational aspects of projects and strategic corporate initiatives with proven success in the healthcare, health plan and government programs space.

Before joining HMA, Elizabeth worked at Capital Blue Cross where she focused on Medicare product development and administration. Most recently Elizabeth was the corporate planning manager responsible for coordination and development of the organization's three-year strategic plan and annual corporate plan documents for presentation to the organization's board of directors. She also served on a team that was responsible for the presentation of key performance indicators and strategic goal successes to Capital's executive team.

While at Capital Blue Cross, she has served in several leadership roles. She managed the annual recurring work for the Medicare product team, successfully led the corporate project team that transitioned the organization to use of the Medicare Beneficiary Identifier (MBI) in 2018, integrated the functions and operations of a newly acquired start-up Medicare Advantage plan, and guided the transition to a new pharmacy benefits manager in 2019.

Elizabeth's professional experiences also include implementing enrollment and core processing systems and the pharmacy benefit manager contract for a start-up Medicare Advantage plan and working at the Hospital and Health System Association of Pennsylvania serving as project coordinator for the Pennsylvania Hospital Engagement Network (PA-HEN). The PA-HEN was part of the Partnership for Patients initiative, implemented by CMS in 2011, to improve the quality, safety, and affordability of healthcare of all Americans.

She earned a Bachelor of Science degree in International Business from Elizabethtown College with concentrations in management and marketing, and a minor in Spanish.

HMA News

Leavitt Partners White Paper: Navigating the Digital Health Landscape. Leavitt Partner colleagues Jeremy Bahr, Christopher Loumeau, MHA, and Tanner Evensen published a white paper looking at the Digital Health Landscape. Download the whitepaper at our website, and sign up for one of the two upcoming webinars for investors (February 23) and innovators (March 23). Download the white paper or register for upcoming webinars here.

Provider Level Data Analytics that Drive Key Performance Indicators for Direct Contracting Entities. The Global and Professional Direct Contracting (GPDC) model is the Center for Medicare and Medicaid Innovation (CMMI)'s recent model for value-based care in the Medicare market. Direct Contracting Entities (DCEs) often partner with several providers or provider groups in operating the GPDC model. In this whitepaper, Ivy Dong and Brad Heywood explain the need for DCEs to track performance at the provider level and they explore the data analytics needed to enable provider level performance reporting and management. Download the white paper here.

Second Behavioral Health Issue Brief Focuses on Workforce Crisis and Call for Immediate Action. The National Council for Mental Wellbeing (National Council) and HMA have release the second in the series of three issue briefs examining the ongoing, and exacerbated, workforce and staffing crisis facing behavioral health services providers and facilities. The brief, Immediate Policy Actions to Address the National Workforce Shortage and Improve Care, focuses on clinical transformation and provides short-term recommendations to support states in addressing the workforce shortages, provider burn-out, recruitment and retention. Read more

New this week on HMA Information Services (HMAIS):

Medicaid Data

- New Mexico Medicaid Managed Care Enrollment is Up 4.6%, Aug-21 Data
- New York CHIP Managed Care Enrollment is Down 4.4%, Aug-21 Data
- New York Medicaid Managed Care Enrollment is Up 4.3%, Aug-21 Data
- Ohio Medicaid Managed Care Enrollment is Up 6.5%, Oct-21 Data
- Tennessee Medicaid Managed Care Enrollment is Up 7.4%, 2021 Data
- Virginia Medicaid Managed Care Enrollment is Up 8%, Jul-21 Data
- Virginia Medicaid MLTSS Enrollment is Up 4.2%, Jul-21 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- California Medi-Cal Managed Care Plans RFP: Two-Plan, GMC, and Regional Models, Feb-22
- California Fiscal Intermediary – Dental Business Operations RFP, 2021
- Georgia Electronic Visit Verification Program RFP, Awards, and Related Documents, 2018-20
- Georgia Et Al. Third Party Liability Services RFP, Scoring, and Award, 2020-22
- Kentucky Medicaid Utilization Management RFP, Feb-22
- North Carolina Medicaid NEMT Services for Cleveland County RFP, Feb-22

- Pennsylvania MMIS Quality Assurance, IT Consulting, Project Management Contract, 2019-23
- Puerto Rico External Quality Review Organization RFP and Amendments, 2021-22
- South Carolina Business Intelligence System Contract and Amendments, 2016-22
- South Carolina MMIS Contract, SFY 2020-25
- South Carolina Multi-Vendor Integrator Contract and Amendments, 2018-23
- Texas STAR+PLUS Draft RFP, Feb-22

Medicaid Program Reports, Data and Updates:

- Arizona Medicaid Annual Reports, 2014-21
- Colorado Department of Health Care Policy & Financing Annual Reports, 2015-21
- Illinois Medicaid State Plan, Feb-22
- Mississippi Medicaid Annual Reports, 2013-21
- New York Medicaid Global Spending Cap Reports, 2019-21
- Texas Medicaid CHIP Data Analytics Unit Quarterly Reports, 2018-22
- Vermont Medicaid and Exchange Advisory Board Meeting Materials, Jan-22

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:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.