HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP Calendar

HMA News

Edited by:
Greg Nersessian, CFA
Email

Annie Melia
Email

Alona Nenko
Email

Anh Pham
Email

THIS WEEK

IN FOCUS

CMS RENEWS HEALTHY INDIANA PLAN THROUGH 2021

This week, our *In Focus* reviews Indiana's approval from the Centers for Medicare & Medicaid Services (CMS) on February 1, 2018, to continue its long-standing Healthy Indiana Plan (HIP) with a three-year renewal. This CMS approval maintains the core of the HIP program and incorporates additional features, including expansion of the current Gateway to Work initiative to add required community engagement for non-exempt HIP members beginning in 2019. Also new is a substance use disorder component that will be available to all Indiana Medicaid members, including those enrolled in HIP.

HMA Medicaid Market Solutions helped the State of Indiana secure a renewal to their groundbreaking Medicaid Section 1115 Waiver, the Healthy Indiana Plan. Below is a summary of what the waiver entails.

Indiana has operated HIP through an 1115 demonstration waiver since 2008, when the program began covering nearly 60,000 childless adults and parents and caretakers who were not previously eligible for Medicaid. Since its inception, HIP has incorporated a member deductible funded by a Personal Wellness and Responsibility (POWER) account similar to a health savings account. Members are asked to make monthly contributions to their POWER account, and HIP contributes the remaining balance to ensure the member deductible amount is fully funded. Like commercial plans, after the deductible is met HIP assures full provision of health coverage by the member's health plan.

Indiana leveraged HIP to expand Medicaid in February 2015, adding additional benefit packages and increasing the POWER account and deductible amount from $1,100 to $2,500. Today, HIP covers over 400,000 childless adults, and parents, and caretakers. Under this renewal, HIP coverage will continue to be available and incorporate the program modifications below.

Renewal Updates to HIP

- HIP POWER account contributions move from two percent of household income to a flat rate tiered amount ranging from $1 to $20 based on enrollee federal poverty level.
- HIP health plan enrollment, benefit limits, and POWER accounts are based on a calendar year and will be tracked and reinstated for individuals who disenroll and then reenroll in HIP.
- Pregnant women at the HIP income level may enroll and stay in HIP for the duration of their pregnancy, with all Medicaid cost-sharing and benefit protections in place. This eliminates coverage transitions between HIP and Indiana's Hoosier Healthwise program during and after pregnancy.
- HIP adds a tobacco cessation surcharge to the required POWER account contribution for individuals who attest to tobacco use and do not successfully quit within the following year. The first tobacco surcharges will be applied in 2019.
- Expansion group HIP members who are required to provide information to renew their coverage and fail to do so will have 90 days to re-enter the program after coverage termination. They then will be subject to a three-month period of non-eligibility unless they qualify for an exemption.

Gateway to Work

Gateway to Work was included in Indiana's initial expansion of HIP in 2015. This program provided voluntary referrals to workforce programing for HIP members not working over 20 hours per week. Under the waiver renewal, Indiana will expand the Gateway to Work program and make community engagement mandatory for non-exempt HIP members beginning in 2019. Exempt members include, but are not limited to, the homeless, students, individuals in active substance use disorder treatment, people who are medically frail, people over age 59, and parents or caretakers of school-age children. Individuals must meet the work hour requirement through a variety of means, including working, community service or volunteer work, job training, homeschooling, and caregiving.

This is the second community engagement initiative in Medicaid that CMS has approved. As with the Kentucky HEALTH approval, this community engagement initiative only applies to non-disabled adults and does not have an impact on other Medicaid coverage categories including aged, blind, disabled, pregnant women, or children. Indiana's approved Gateway to Work program includes the following components:

- An hour phase-in starts at zero hours and ramps up to a minimum of 20 hours per week over a period of 18 months.
- Non-exempt HIP members must meet the Gateway to Work requirement in 8 out of 12 months of the calendar year.
- The program requirement operates as a calendar year lookback and will suspend HIP benefits effective on January 1 of each year for any non-exempt members who did not meet the requirement in the previous year.

Substance Use Disorder

The HIP renewal includes a substance use disorder component that will add new services and gain federal financial participation on inpatient services provided in Institutions for Mental Disease (IMD) to address the growing opioid use and substance use disorder epidemic. All Indiana Medicaid enrollees will have access to these expanded services.

For the full waiver approval documents please click here.

Written by Kaitlyn Feiock, MPH Senior Consultant with HMA Medicaid Market Solutions, kfeiock@hmamedicaidmarketsolutions.com.

HMA Medicaid Roundup

Alaska

Lawmakers Consider Narrowing Medicaid Eligibility to Address Budget Shortfall. *Alaska Public Media* reported on February 1, 2018, that some Alaska lawmakers are considering policies to narrow Medicaid eligibility in the face of a funding shortfall, including the possibility of implementing work requirements. Supplemental budget funding proposed by Governor Bill Walker to cover higher-than-expected Medicaid costs may not be enough. Read More

Arkansas

Senator Proposes Amendment to Address Abuse of State's Medicaid Expansion Program. *Arkansas Matters* reported on February 1, 2018, that Arkansas Senator Bryan King (R-Green Forest) has proposed a constitutional amendment to address fraud and abuse in the state's hybrid Medicaid expansion program, which provides coverage through the health insurance Exchange. The amendment would allow the state to recoup costs incurred by ineligible Medicaid expansion members. Read More

California

Budget Proposal Includes $117 Million to Expand Treatment for Inmates. The *Los Angeles Times* reported on February 2, 2018, that Governor Jerry Brown has allocated $117 million in his fiscal 2019 state budget to expand the number of beds and mental health programs for inmates with mental illness. The funds would be distributed across 15 counties in California with the largest populations of felony offenders found incompetent to stand trial. Read More

Florida

Molina Invited to Negotiate in Florida Region 11 Only. Molina Healthcare announced on February 6, 2018, that it was selected by Florida as a candidate to negotiate a Medicaid managed care contract for Region 11, which includes Miami-Dade and Monroe counties. Florida issued an Invitation to Negotiate for its Statewide Medicaid Managed Care business in 2017, with contract awards expected in April 2018. Molina had about 350,000 Medicaid members in eight Florida regions as of September 30, 2017, including 59,000 in Region 11. Read More

Indiana

Indiana Drops 25,000 Medicaid Expansion Members for Failing to Pay Premiums. *Kaiser Health News* reported on February 1, 2018, that Indiana dropped approximately 25,000 Medicaid expansion members between 2015 and October 2017 for failure to pay premiums. In 2015 and 2016, about 10,000 enrollees were subject to a six-month lockout for failing to pay premiums for two months in a row. The state offers expansion coverage through its Health Indiana Plan, which was recently approved by federal regulators for another three years. Read More

Iowa

Amerigroup to Take on Additional Iowa Medicaid Members. *The Des Moines Register* reported on February 2, 2018, that Amerigroup, a subsidiary of Anthem Inc., will be taking on additional Iowa Medicaid managed care members beginning March 1, 2018. Initially, Amerigroup said it wasn't able to take on any more members after AmeriHealth Caritas decided to leave the market. As a result, Medicaid services for about 10,000 Iowa Medicaid recipients that opted for Amerigroup have been administered directly by the state. Most of AmeriHealth's members ended up transitioning to UnitedHealth Group. Read More

Iowa Unveils Plan to Improve Access to Mental Health Services. *The Des Moines Register* reported on February 3, 2018, that the Iowa Department of Human Services has unveiled a plan to improve access to mental health services. The proposal, which is expected to be included in legislation this month, would double the number of treatment teams monitoring people with chronic mental illness, add six new centers offering short-term help to people having a mental health crisis, and launch a 24-hour crisis phone line. The proposal is based on a December state report that recommended improvements to Iowa's mental health system. Read More

Iowa Reveals Trusted Health Plan is Among Potential Bidders for Medicaid Managed Care Contract. The Iowa Department of Human Services revealed on February 1, 2018, that Trusted Health Plan has submitted a letter of intent to bid for a contract to serve the state's Health Link Medicaid managed care business. Iowa issued a request for proposals (RFP) last year to add another Medicaid plan to the market. Iowa Total Care/Centene is the only other plan considering a bid.

Louisiana

Louisiana to Spend $612 Million Less Than Expected on Medicaid. *The Wichita Eagle* reported on February 7, 2018, that Louisiana is expected to spend approximately $612 million less than projected on Medicaid in fiscal 2018, ending June 30. About $26 million of the surplus would be state funding that can be allocated elsewhere; the remainder would be federal funds. Read More

Maryland

Maryland State Senator Proposes Limited Dental Benefits for Adults on Medicaid. *The Baltimore Sun* reported on February 7, 2018, that Maryland Senator Thomas Middleton (D-Charles County) is sponsoring a bill that would require the state's Medicaid program to include limited dental benefits to adults. The Maryland Department of Health estimates that the new benefit would cost the state an additional $50 million to $160 million per year. Maryland currently spends about $4.6 million annually on inpatient admissions for dental problems. Read More

Mississippi

Mississippi Senate Votes to Renew Medicaid. *The Clarion Ledger* reported on February 6, 2018, that the Mississippi Senate voted 31-16 to reauthorize the state's Medicaid program. The bill now moves to the House for debate. The current Medicaid program expires on June 30. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Providers Concerned Over Inclusion of Arbitration in Out-of-Network Bill. The *NJ Spotlight* reported on February 6, 2018, that New Jersey healthcare providers are concerned over a recent amendment to the out-of-network bill (A2039) that adds an arbitration process. The amendment, which is meant to protect patients from unexpected healthcare charges, would require that the state appoint a third-party to resolve payment disputes between providers and insurers. Providers argue that the arbitration element would weaken their ability to negotiate contracts with insurers and may drive providers out of state. Read More

Assemblyman Gary Schaer Introduces Bill to Pilot Value-Based Payment Program for Home Health Agencies. On February 1, 2018, New Jersey Assemblyman Gary Schaer (D-Bergen and Passaic) introduced, a bill (A2394) that would pilot an incentive-based value payment system for home health agencies and health care service firms providing services to Medicaid and NJ FamilyCare recipients. The pilot program would reward agencies for achieving improved performance outcomes for at least four core measures that will be dependent on whether the agency is delivering private duty nursing or personal care assistant services. These measures include, but are not limited to, preventable hospital admissions and readmissions; medication reconciliation; collaboration with other health care providers; patient and nurse retention; patient satisfaction; and service hours authorized compared with service hours provided. The bill would also establish a Home Health Services Value Payment System Advisory Board that will be tasked with developing requirements and regulations around the core measures and performance targets, establishing a performance baseline, and creating a payment schedule. If passed, the program would take effect January 1, 2017.

New Jersey Camden Coalition Selects New CEO. The Camden Coalition of Healthcare Providers announced on February 2, 2018, that Kathleen Noonan would succeed founder, Dr. Jeffrey Brenner, who launched the organization in 2003. Dr. Brenner recently transitioned to a new role as Senior VP of integrated health and human services at UnitedHealthcare. Ms. Noonan will join the organization in March 2018. She comes from Children's Hospital of Philadelphia where she co-founded PolicyLab, a pediatric research institute. Read More

New Mexico

Molina Files Lawsuit Against New Mexico Over Medicaid Managed Care Loss. The *Santa Fe New Mexican* reported on January 31, 2018, that Molina Healthcare has filed a lawsuit against New Mexico after the company lost its bid to retain its Medicaid managed care contract with the state. The lawsuit, filed in state District Court in Santa Fe, alleges that Molina's bid score was impacted by numerous irregularities by the New Mexico Human Services Department. Molina's contract with the state expires in 2019, as the state awarded its Medicaid managed care business to Centene/Western Sky Community Care., Blue Cross Blue Shield of New Mexico and Presbyterian Health Plan. Read More

New Mexico Medicaid Buy-In Option Gains Momentum. The *Associated Press* reported on January 31, 2018, that the New Mexico legislature is considering initial studies and next steps for a plan to allow individuals to buy into the state's Medicaid program. Under the program, which is being pushed by Democratic lawmakers, subsidies for Exchange coverage would be redirected to Medicaid. New Mexico is already a Medicaid expansion state. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Attorney General Sues Fentanyl Manufacturer. New York Attorney General Eric T. Schneiderman announced on February 1, 2018, that the office has filed a lawsuit against Insys Therapeutics, Inc., a company that sells a highly addictive fentanyl drug called Subsys. Although Subsys was approved by the Food and Drug Administration (FDA) to treat excruciating cancer-related breakthrough pain, the complaint alleges that Insys recklessly marketed the drug for much wider use, covering a much broader set of patients. Additionally, the company allegedly engaged in a pattern of deceptive and illegal conduct by downplaying the drug's risks of addiction, bribing doctors to prescribe the drug, and lying to healthcare providers to skirt their authorization process. As a result, the Attorney General's office is seeking penalties and disgorgement of all revenues accumulated during the period of misconduct—up to $75 million. Read More

New York Exchange Enrollment Beats Records. NY State of Health, New York's state-based Exchange, announced on February 1, 2018, that more than 4.3 million New Yorkers have enrolled in health coverage through NY State of Health, an increase of 700,000 people from 2017. The 2018 Open Enrollment Period closed on January 31 with nearly 1 million people enrolling in a Qualified Health Plan and the Essential Plan, an increase of 84,000 since the end of open enrollment in 2017. New York decided to extend the 2018 Open Enrollment Period by six weeks from December 15, 2017 to January 31, 2018. An additional 24,000 individuals gained coverage during this period. Read More

North Carolina

Republican Lawmakers Still Oppose Medicaid Expansion Even With Work Requirements. *The Winston-Salem Journal* reported on February 5, 2018, that North Carolina Republican leaders continue to oppose Medicaid expansion, despite the option of including work requirements. Lawmakers remain concerned that the federal government may not be able to keep its promise of covering 90 percent of expansion costs. Read More

North Carolina Medicaid Posts Fiscal 2017 Budget Surplus. North Carolina released its Medicaid annual report on February 1, 2018, showing a budget surplus of $86 million for fiscal 2017, the fourth consecutive year that the Medicaid program will return funds to the state treasury. The report highlighted several fiscal 2017 initiatives, including efforts to implement safe prescriber policies, prepare for the transition to managed care, and increase access to waiver programs for adults with disabilities. Read More

Pennsylvania

Pennsylvania Telemedicine Legislation Clears Committee Vote. The Hospital & Healthsystem Association of Pennsylvania reported on January 30, 2018, that Pennsylvania Senate Bill 780 gained unanimous approval from the Senate Banking and Insurance Committee. SB 780 defines telemedicine for Pennsylvania, offering guidelines, outlining who can provide telemedicine services, and providing clarity around insurance company reimbursement for these services. The bill awaits consideration by the full Senate. Read More

Tennessee

Tennessee Wins Federal Approval for Drug Management Pilot. *Modern Healthcare* reported on February 5, 2018, that the Centers for Medicare & Medicaid Services has approved a Tennessee proposal to launch a two-year pilot designed to improve prescription drug adherence and effectiveness for Medicaid beneficiaries. As part of the pilot, pharmacists will work with Medicaid beneficiaries enrolled in patient-centered medical homes to ensure medications are appropriate, safe, and taken as directed. As many as 300,000 enrollees may be affected by the pilot. Read More

Texas

Lawmaker Calls for Investigation of Medicaid Managed Care Contract Oversight. *The Texas Tribune* reported on January 31, 2018, that Texas House Speaker Joe Straus (R-San Antonio) is calling for an investigation of how the state oversees Medicaid managed care contracts. The remarks come after a state audit questioned the appropriateness of bonuses and incentive payments made by a Medicaid plan to the employees of medical providers. According to the report by the State Auditor's Office, the Texas Health and Human Services Commission allowed Centene/Superior HealthPlan, Inc. to report $29.6 million in payments not allowed under its contract with the state. Read More

Wisconsin

Wisconsin Moves to Mandatory Enrollment for Certain SSI Beneficiaries. The Wisconsin Department of Health Services reported that through June 2018 the state will roll out mandatory enrollment for many Supplemental Security Income (SSI) beneficiaries in Medicaid managed care. Disability advocates estimate that 28,000 beneficiaries may be impacted. The change impacts members who live an SSI managed care service area, are age 19 or older, and have a Medicaid SSI or SSI-related disability. Previously, SSI beneficiaries could opt out of managed care after two months. Up to two-thirds of eligible beneficiaries typically opted out of managed care. Read More

National

Medicaid Work Requirements to Help Individuals Out of Poverty, Says CMS Administrator. In an editorial published on February 4, 2018, in *The Washington Post*, Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS), wrote that Medicaid work requirements will help move people out of poverty. Eleven states have submitted proposals to implement work requirements, and CMS has already approved work requirements in Kentucky and Indiana. Read More

Proposed Class Action Lawsuit to Challenge Medicaid Premiums. *Modern Healthcare* reported on February 3, 2018, that a proposed class action lawsuit would challenge whether the federal government has the authority to allow states to charge premiums to Medicaid recipients under federal law. The lawsuit argues that the Centers for Medicare & Medicaid Services (CMS) violated a Congressional amendment when it recently approved an 1115 waiver in Kentucky allowing the state to charge members premiums. The lawsuit further argues that CMS is using its waiver authority to "comprehensively transform Medicaid" without necessary Congressional approval. Read More

Trump Administration Considers Lifetime Coverage Limits for Medicaid. *McClatchy DC Bureau* reported on February 5, 2018, that the Trump administration is considering whether to grant waivers allowing states to impose a lifetime limit on the number of months an adult can be on Medicaid. Arizona, Kansas, Utah, Maine and Wisconsin have applied. The policy wouldn't impact children, pregnant women, and individuals with disabilities. Read More

GOP Budget Plan Delays Medicaid DSH Payment Cuts. *Modern Healthcare* reported on February 5, 2018, that GOP lawmakers released a stopgap budget plan that delays $5 billion in Medicaid disproportionate share hospital (DSH) payment cuts to hospitals for 2018 and 2019. Among a long list of other changes, the proposal would alter DSH allotments, modify long-term hospital payments, rescind unspent Medicare and Medicaid Improvement Funds, cut the Affordable Care Act Prevention and Public Health Fund, extend funding for Medicare home health programs and community health centers, expand telemedicine, make Medicaid the payer of last resort for prenatal claims, and enact the CHRONIC Care Act, which aims to increase flexibility for Medicare Advantage special needs plans. Read More

GAO Report Finds Gaps in Regulation of Assisted Living Facilities. *The New York Times* reported on February 3, 2018, that a federal investigation by the Government Accountability Office found gaps in the regulation of assisted living facilities. The report found that more than half of states were unable to provide information on abuse, neglect, exploitation, or unexplained deaths of Medicaid beneficiaries in assisted living. Only 22 states provided data on "critical incidents," including physical, emotional, or sexual abuse, totaling 22,900 incidents. The report states that the Centers for Medicare & Medicaid Services (CMS) provided "unclear guidance" to states and did not monitor the use of federal funding. States spend about $10 billion a year on services for more than 330,000 individuals. Read More

States Consider Their Own Individual Mandates. *The Wall Street Journal* reported on February 4, 2018, that at least nine states and the District of Columbia are considering their own version of the individual health insurance mandate: California, Connecticut, Hawaii, Maryland, Rhode Island, Washington, Minnesota, New Jersey, Vermont, and the District of Columbia. The state mandate would attempt to replace the recently repealed federal individual mandate. Read More

CMS Contracts with IntegriGuard to Verify Special Exchange Enrollment Eligibility. *Modern Healthcare* reported on February 2, 2018, that the Centers for Medicare & Medicaid Services (CMS) has awarded IntegriGuard an $18 million contract to verify individual eligibility for special federal Exchange enrollment, which occurs outside of the standard open-enrollment period. According to CMS, approximately 650,000 people signed up for special enrollment in 2017. Special enrollment is available to people who lose health coverage, move, get married, have a baby, or experience another qualifying life event. Read More

House Republicans Are Open to ACA Exchange Plan Reinsurance Measure. *The Hill* reported on February 1, 2018, that House Republicans are open to a proposal from Rep. Ryan Costello (R-PA) to stabilize the Affordable Care Act Exchange market for 2019 and 2020. The measure would fund Exchange plan reinsurance to help lower premiums. Rep. Cathy McMorris Rodgers (R-WA), the fourth-ranking Republican in House leadership, is a co-sponsor of the bill. House Energy and Commerce Committee Chairman Greg Walden (R-OR) also supports the measure. Read More

Republicans Abandon ACA Repeal and Replace for Now. *Politico* reported on February 1, 2018, that Republicans have abandoned efforts to repeal and replace the Affordable Care Act, at least for this year. Instead some Republicans are joining bipartisan efforts to shore up the Exchanges, including a potential reinsurance initiative. Read More

CMS to Release Rural Health Strategy for Providers. *Modern Healthcare* reported on February 6, 2018, that the Centers for Medicare & Medicaid Services (CMS) will release a technical blueprint for how the federal government plans to help rural health care providers implement telehealth, telemedicine, and information outreach. CMS Administrator Seema Verma announced the plan at the National Rural Health Association's Policy Institute in Washington, DC. Rural providers, which rely heavily on Medicaid and Medicare, continue to struggle financially. Read More

Industry News

HCA Acquires Memorial Health in Georgia. The *Savannah Morning News* reported on February 1, 2018, that the Hospital Corporation of America (HCA) acquired Savannah, Georgia-based Memorial Health for an estimated $456 million. The transaction includes Memorial University Medical Center, Dwaine & Cynthia Children's Hospital, Mercer University School of Medicine Savannah Campus, and the Curtis and Elizabeth Anderson Cancer Institute. HCA veteran Shayne George will serve as chief executive of Memorial Health. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2018 (Delayed from 2017)	Alaska Coordinated Care Demonstration	Contract Awards	TBD
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
February 27, 2018	Iowa	Contract Awards	600,000
March 2018	Alabama ICN (MLTSS)	RFP Release	25,000
March 1, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
April or May 2018	Alabama ICN (MLTSS)	Contract Award	25,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 6, 2018	Texas STAR and CHIP	RFP Release	3,342,530
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
July 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September 2018	North Carolina	Contract awards	1,500,000
September 26, 2018	Texas STAR and CHIP	Evaluation Period Ends	3,342,530
October 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA News

Upcoming Webinar - Innovations in Medicaid Managed Long-Term Services and Supports: How Health Plans are Providing Support to Family Caregivers (February 28, 1 – 2 EST). Join Health Management Associates and the AARP Public Policy Institute as we discuss the findings of the new report on Emerging Innovations in Managed Long-Term Services and Supports (LTSS) for Family Caregivers. The report shows that health plans are increasingly recognizing and supporting family caregivers for individuals with LTSS needs. The webinar will also feature the real-world experiences of Anthem Inc., a health plan that is helping family caregivers in LTSS settings. The emerging innovations report is part of the joint Long-Term Services and Supports State Scorecard series and supported by The Commonwealth Fund, The SCAN Foundation, and the AARP Foundation. Read More

How Interagency, Cross-Sector Collaboration Can Improve Care for CSHCN: Lessons from Six State Initiatives. Families and care providers know that children and youth with special health care needs (CYSHCN) are best served through a coordinated approach across the myriad programs, agencies, and levels of government that touch them. However, states face structural, operational, financial, regulatory, and cultural challenges to breaking down traditional silos to achieve interagency, cross-sector collaboration. Read more

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