HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 20, 2019

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

THIS WEEK

IN FOCUS

MA RELEASES ONE CARE DUAL DEMONSTRATION 2.0 REQUEST FOR RESPONSES

This week, our *In Focus* reviews the Massachusetts One Care Dual Demonstration 2.0 request for responses (RFR), released by the Massachusetts Executive Office of Health and Human Services (EOHHS). One Care will cover Medicare and Medicaid dual eligible adults with disabilities ages 21 through 64 and includes medical, behavioral, Long-term Services and Supports (LTSS), community supports, and care management services statewide.

One Care

One Care launched in 2013 as an 1115 duals demonstration waiver (both a capitated model demonstration under the Financial Alignment Initiative and a state demonstration to integrate care for dual eligible individuals). The current program serves approximately 22,500 members through Tufts Health Plan and Commonwealth Care Alliance. One Care will focus on integrated care management and care coordination through an Interdisciplinary Care Team (ICT). Plans will have flexibility to innovate around care delivery and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost traditional services. Goals will focus on the following:

- Integrated Care Management
  - Employ best practices in complex care management, practice-based care management, and flexible community-based supports;
  - Improve linkages for ICTs to effectively communicate and coordinate care at the enrollee's direction;
  - Further engage and empower enrollees in leading or self-directing their care, including through engagement with their ICTs and care planning processes; and
  - Engage providers through the care model to partner with One Care Plans using innovative approaches.
- Innovative Provider Contracting and Purchasing
  - Leverage value-based purchasing approaches that incorporate quality benchmarks and/or specific outcomes in the payment models (i.e. quantitatively valuing quality and outcome improvements);
  - Develop population-health based preventive approaches and proactive strategies to shift utilization from acute and other facility settings to community settings;
  - Design alternative care approaches to reduce and avoid unnecessary acute, emergency, and hospital-based care; and
  - Design and invest in alternative care approaches that prevent, avoid, delay, and reduce unnecessary nursing facility admissions and care, including returning Enrollees from nursing facilities to the community.
- Community Living and Engagement
  - Support individuals with disabilities to live independently in the community;
  - Deepen support for individuals with Intellectual or Developmental Disabilities (ID/D) and Autism Spectrum Disorder (ASD) and their families;
  - Facilitate effective communication access and address accessibility; and
  - Partner with community-based experts to develop effective strategies to promote community living, and rebalancing, and to engage enrollees.
- Outcomes, Social Determinants, and Health Disparities
  - Improve Enrollee outcomes and quality of life;
  - Address social determinants of health;
  - Identify and address health disparities and inequities; and
  - Strategically partner with housing Providers, including to more effectively support chronically homeless populations.

- Eligibility and Enrollment
  - Proactively address eligibility churn, including through deemed continued eligibility;
  - Drive self-selected enrollment;
  - Find and meaningfully engage individuals who may be hard to locate; and
  - Improve Enrollee engagement and satisfaction to reduce voluntary disenrollments.

Eligible Populations

One Care plans will serve dual eligible beneficiaries who are:

- Adults with physical disabilities;
- Adults with Intellectual or Developmental Disabilities (ID/D)
- Adults with Serious Mental Illness (SMI)
- Adults with Substance Use Disorders (SUD)
- Adults with disabilities who have multiple chronic illnesses or functional or cognitive limitations
- Adults with disabilities who are homeless

Awards

EOHHS expects to award contracts to three plans but may award up to five. Plans can bid in as few as one or as many as all 14 counties, and in full or in partial counties. Subsequently, they can be awarded in all, some, or none of their proposed counties or partial counties. EOHHS also intends to enter into a two-way contract with each selected One Care Plan for additional services. Plans must include an Innovation Plan in their response.

Current Market

One Care serves approximately 22,500 individuals in nine counties. The current One Care contracts were extended though December 31, 2019. Enrollment is through a voluntary opt-out process. In 2017, Massachusetts spent an estimated $546.9 million on Medicaid and Medicare services for One Care enrollees.

Massachusetts Dual Eligible Enrollment by Plan, 2015-17, October 2018

	2015	2016	2017	Oct-18
Commonwealth Care Alliance	**10,216**	**11,771**	**15,506**	**19,434**
% of total	*83.2%*	*82.1%*	*83.8%*	*86.3%*
Network Health (Tufts Health Plan)	**2,069**	**2,560**	**2,996**	**3,084**
% of total	*16.8%*	*8.1%*	*8.6%*	*8.5%*
Total Enrollment	**12,285**	**14,331**	**18,502**	**22,518**
+/- between reporting periods		*2,046*	*4,171*	*4,016*
% chg. between reporting periods		*16.7%*	*29.1%*	*21.7%*
Total Eligible	100,293	104,415	101,980	99,087
Opt-Outs	28,747	31,589	34,731	36,448
% of Total Eligible	*28.7%*	*30.3%*	*34.1%*	*36.8%*

Source: MassHealth, HMA

Timeline

The One Care RFR was issued February 11, 2019. Responses are due May 24, 2019, with awards announced in the early fall of 2019. Implementation will begin January 1, 2021, with contracts effective for five years through December 31, 2025, with five optional renewal years.

RFP Activity	Date
RFR Issued	February 11, 2019
Letters of Intent Due	April 30, 2019
Responses Due	May 24, 2019
Awards	Early Fall 2019
Contracts Signed	Late Spring/Summer 2020
Implementation	January 1, 2021

Link to One Care RFR

HMA Medicaid Roundup

Alaska

Alaska Economy Would Suffer from Repeal of Medicaid Expansion, Report Finds. *The Anchorage Daily News* reported on February 13, 2019, that the Alaska economy would lose 3,690 jobs following a repeal of the state's Medicaid expansion program, according to a study commissioned by the Alaska State Hospital and Nursing Home Association. The report, prepared by Halcyon Consulting, estimates that 1,800 of those jobs would come from providers, including hospitals, physician practices, and outpatient facilities. Read More

Arkansas

Arkansas Medicaid Billing Changes Limit Mental Health Care. *The Arkansas Democrat Gazette* reported on February 17, 2019, that Arkansas's Medicaid beneficiaries are struggling to receive mental health services because of changes to the state's Medicaid billing rules. The changes, effective July, reduce what providers can bill Medicaid for outpatient behavioral services, disallow certain same day services, and prevent Medicare-Medicaid duals from using Medicaid as secondary insurance. Providers in the state have been forced to let employees go, limit the number of Medicaid patients they see, and reduce services because of the new rules. Read More

Arkansas Reports Additional 10,000 Individuals Fail to Comply With Medicaid Work Requirements. *CQ Health* reported on February 15, 2019, that 10,258 individuals failed to meet Arkansas' Medicaid work requirements in January 2019, more than double the number that did not comply in December 2018. More than 18,000 lost Medicaid coverage in 2018. Adults without dependent children are required to report they are working, looking for a job, or going to school for 80 hours per month for three straight months. Read More

Connecticut

Legislators Consider Public Health Insurance Option. *The CT Mirror* reported on February 14, 2019, that two Connecticut House committee leaders held a hearing to consider a state public insurance option. Representatives Sean Scanlon (D-Guilford) and Senator Matt Lesser (D-Middletown), who co-chair the House Insurance and Real Estate Committee, focused on a public option aimed at small businesses and individuals who don't qualify for Affordable Care Act subsidies. Read More

Florida

Senator Proposes Bill Allowing Lyft, Uber To Provide NEMT Services. *The Florida Phoenix* reported on February 20, 2019, that Florida Senator Jeff Brandes (R-St. Petersburg) has proposed a bill that would allow transportation companies, like Uber and Lyft, to participate in the state's Medicaid non-emergency medical transportation (NEMT) program. The bill also includes a provision that would allow ambulances to cross county lines to transport non-emergency Medicaid patients during a rideshare trip. Read More

House Republicans Push for Health Care Regulatory Changes. *The Palm Beach Post* reported on February 15, 2019, that Florida House Republicans are advancing proposals aimed at relaxing health care regulations. Among the proposals are reducing or eliminating the certificate of need laws, promoting the use of telemedicine, relaxing scope-of-practice regulations for physician assistants and nurses, and easing ambulatory care restrictions. House Speaker Jose Oliva (R-Miami) is pushing for these changes in hopes of advancing competition in healthcare. Read More

House Subcommittee To Again Consider Expanding Autonomy Of Nurse Practitioners. *Health News Florida* reported on February 14, 2019, that the Florida House Health Care Quality Subcommittee is reconsidering whether to allow registered nurse practitioners to operate independently of physicians. In recent years, the Florida Senate has expressed reluctance to revamp regulations for nurse practitioners after opposition from physicians and concerns that the measure wouldn't solve the problem of increasing rural access to health care. The state has 29,100 advanced registered nurse practitioners, according to the Florida Department of Health. Read More

Florida Faces Rising Inmate Health Care Costs, Budget Shortfalls. *FLAPOL* reported on February 13, 2019, that inmate health care costs in Florida are rising because of mental health services, high rates of hepatitis C, and an aging prison population, according to Tom Reimers, health director at the state Department of Corrections (DOC). Budget shortfalls have led the DOC to slash programs for substance abuse and mental health. Read More

Georgia

Senate Committee Clears Medicaid Expansion Bill. *Georgia Health News* reported on February 19, 2019, that the Georgia Senate Health and Human Services Committee passed a bill that would allow the state to pursue partial Medicaid expansion up to 100 percent of poverty through a federal waiver. The Patient's First Act is expected to cost $135 million more and cover 240,000 fewer people than the full expansion up to 138 percent of poverty, according to the Georgia Budget and Policy Institute. Read More

Senate Introduces Federal Health Waiver Legislation. *The Atlanta Journal-Constitution* reported on February 13, 2019, that Georgia Senate Republicans introduced the Patient's First Act, which would allow the state to pursue partial Medicaid expansion through a federal waiver. The bill, sponsored by Senator Blake Tillery (R – Vidalia), gives Governor Brian Kemp leeway to pursue a variety of approaches to broadening coverage. In addition to a partial expansion of up to 100 percent of poverty, for example, options might include stabilizing premiums on the Affordable Care Act Exchanges. Kemp has indicated that the state will not pursue full expansion of 138 percent of poverty, which would add a projected 500,000 individuals to the state's Medicaid program. Read More

Idaho

Idaho Submits Medicaid Expansion Plan for Federal Review. *KXLY* reported on February 16, 2019, that Idaho has sent a Medicaid expansion plan to federal regulators for approval. Review of the program by the Centers for Medicare & Medicaid Services (CMS) could take several months, according to a spokeswoman for the Idaho Department of Health and Welfare. The state agency is accepting public comments on the plan until March 22. Read More

Iowa

Senate Democrats Propose Moving Managed LTC Members Back to Fee-for-Service. *The Sioux City Journal* reported on February 15, 2019, that Iowa Senators Amanda Ragan (D-Mason City) and Liz Mathis (D-Hiawatha) proposed a bill that would move managed long-term care patients back to fee-for-service Medicaid. The proposal would also require independent case management, independent patient assessment, and an external review process for claims denials, among other provisions. Iowa established the state's Medicaid managed care program in 2015. Read More

Kansas

Kansas Considers Changes to Medicaid Applications Process. *The Kansas City Star* reported on February 18, 2019, that Kansas is considering ways to better streamline the Medicaid application process, including minimizing the role of the state's applications clearinghouse contractor. Earlier this year, Kansas Governor Laura Kelly proposed hiring 300 additional state workers to take over certain Medicaid application processing functions and wants to reopen bidding for the rest. Maximus is the state's Medicaid applications clearinghouse. Read More

Kentucky

Kentucky Releases Report on Medicaid Pharmacy Benefit Program. *ABC 36 News* reported on February 19, 2019, that Kentucky has released a report examining the role and impact of Medicaid Pharmacy Benefit Managers (PBMs) and offering recommendations to help create transparency, control prices, and improve care from pharmacies. The report, titled "Medicaid Pharmacy Pricing: Opening the Black Box," was developed with data made available under state legislation passed in 2018 to increase transparency in the Medicaid PBM program. Read More

Kentucky Medicaid Plan Passport Health Files Lawsuit Over Rate Cuts. *The Courier Journal* reported on February 18, 2019, that Kentucky Medicaid managed care organization Passport Health Plan has filed a lawsuit against the state over rate cuts that took effect last year. Passport has stated that the cuts may put the company out of business, especially a 4.1 percent cut in Jefferson County where the company does most of its business. Passport has 315,000 members in the state. Read More

Massachusetts

Massachusetts Releases One Care Request for Responses. On February 11, 2019, the Massachusetts Executive Office of Health and Human Services (EOHHS) released the One Care Dual Demonstration 2.0 request for responses (RFR). The program covers dual eligible adults with disabilities ages 21 through 64 and includes medical, behavioral, Long-term Services and Supports (LTSS), additional community supports, and care management services statewide. EOHHS expects to award contracts to three plans, but no more than five. Implementation will begin January 1, 2021, with contracts effective for five years through December 31, 2025, with five optional renewal years. EOHHS also intends to enter into a two-way contract with each selected One Care Plan for additional services. Read More

Missouri

Medicaid Drops 70,000 Individuals in 2018, Mostly Children. *The Kansas City Star* reported on February 18, 2019, that the Missouri Medicaid program dropped 70,000 eligible individuals in 2018, of which almost 57,000 were children, following newly reinstituted eligibility reviews. The state, meanwhile, cites an improved economy among the factors for declining enrollment. Read More

Nebraska

Nebraska Still Lacks Firm Timetable for Implementing Voter-Approved Medicaid Expansion. *The Idaho Statesman/Associated Press* reported on February 17, 2019, that Nebraska is still working on a establishing a timeline for when beneficiaries would begin receiving coverage under the state's voter-approved Medicaid expansion program. Matthew Van Patton, director of Nebraska Medicaid and Long-Term Care, has indicated that the agency is working to upgrade computers, hire additional employees and complete contract negotiations with managed care organizations before coverage can begin. An estimated 90,000 adults will be eligible for expansion coverage. Read More

New Hampshire

New Hampshire Announces Medicaid Managed Care Awards. The New Hampshire Department of Health and Human Services (DHHS) announced on February 15, 2019, that AmeriHealth Caritas, Boston Medical Center Health Plan, and Centene/Granite State Health Plan have won the state's Medicaid Care Management (MCM) contract awards. WellCare also bid but did not win. The MCM program will provide full-risk, fully capitated Medicaid managed care services to approximately 181,000 beneficiaries from July 1, 2019, through June 30, 2024. This is the first time that DHHS has re-procured the MCM program since it began in December 2013. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Governor Cuomo Announces Budget Amendments. New York Governor Andrew Cuomo announced changes to the fiscal year 2020 Executive Budget Financial Plan, including re-estimates and amendments. Estimated tax receipts have been revised downward due to weaker personal income tax collections in December 2018 and January 2019. The downward revisions to receipts are offset by reductions in estimated General Fund disbursements and use of available resources. Governor Cuomo attributed the decline in tax collections to federal changes in the deductibility of state and local taxes. The budget amendments include a proposed $550 million cut to the Medicaid budget (which is doubled to over $1 billion when the federal share of Medicaid is included). Three actions were announced:

- Elimination of recently announced Transformation Fund investments, including the 2 percent inpatient hospital and 1.5 percent nursing home increases effective November 1, 2018
- Reduction of Indigent Care Payments for voluntary hospitals, including an across-the board cut of $275 million beginning in 2019, and beginning in 2020 a cap of $10,000 per year for hospitals located in New York City, Westchester County, or Long Island that either individually or collectively as part of a co-established system had a 2017 operating margin of at least 2.98 percent and a minimum of $68 million in operating income
- An across-the-board 0.8 percent reduction in Medicaid provider reimbursement.

The Governor also announced that he was reconvening the Medicaid Redesign Team (MRT) to conduct a comprehensive evaluation of the Medicaid program and offer recommendations to further stabilize the long-term fiscal condition of the Medicaid Global Cap. The MRT will consider a number of topics including addressing the needs of vulnerable populations, responding to the current Federal landscape, evaluating options to enhance affordable health insurance coverage and access, sustaining the future of New York's long-term care system and stabilizing fiscally distressed health care providers. Read More

New York Drug Utilization Review Board Seeks Discounts on Arthritis Drug. *Politico New York* reported on February 14, 2019, that New York's Drug Utilization Review Board (DURB) has called on the Department of Health to seek further discounts on the arthritis drug Remicade, recommending that the Medicaid program pay no more than what it does for the lowest-cost copycat version of the biologic. Under the state's Medicaid Drug Cap, DURB has the power to demand additional rebates for some of the program's costliest drugs. Read More

New York Releases Indigent Care Report. The New York Department of Health has released a report prepared by the Indigent Care Pool Workgroup. The multi-stakeholder workgroup, established in last year's budget, was tasked with reviewing the current methodology for distribution of Indigent Care Pool (ICP) funding. The ICP is part of the larger Disproportionate Share Pool (DSH) funding. New York distributes $3.6 billion in DSH payments, of which the ICP is $795 million. ICP funding has been criticized for spreading funds across a large number of hospitals rather than targeting hospitals that provide the most care to the uninsured and experience the greatest financial distress. New York is also concerned about the looming federal cuts to DSH, and a review of the ICP was in part designed to develop a strategy for absorbing those cuts. The workgroup established a series of criteria for evaluating different approaches but ended up unable to arrive at a consensus on what a funding methodology should look like. Read More

North Carolina

North Carolina Releases Scoring of Medicaid Managed Care Bids. The North Carolina Department of Health and Human Services (DHHS) released the scoring for its recent Prepaid Health Plan Services contract awards, with WellCare receiving 736 points out of 1025. United garnered 728 points, BCBS of North Carolina 712, AmeriHealth Caritas 707, and Centene 628. Aetna (705 points), My Health by Health Providers (630 points), and Optima Health/Sentara (573) did not receive contracts. See data package below for the scoring table. Read More

Type of Contract	Rank	Health Plan	Weighted Total Score	Percentage of Total Possible Points
Statewide	1	WellCare Health Plans	736.19304	71.824%
Statewide	2	UnitedHealthcare	727.76474	71.001%
Statewide	3	BCBSNC - Healthy Blue	712.22431	69.485%
Statewide	4	AmeriHealth Caritas	706.66204	68.943%
Statewide	5	Aetna	704.60144	68.742%
Statewide	6	My Health by Health Providers	629.7128	61.435%
Either	7	Carolina Complete Health/Centene	628.39969	61.307%
Regional	8	Optima Health	573.48539	55.950%
		Total Possible Points	1025	
		Total Possible if All Scores Meet Expectations (60%)	615	

Source: North Carolina Department of Health and Human Services

North Carolina Audit Finds Medicaid LME/MCO Contracts Should Limit Allowable Profits, Costs of Behavioral Health Services. *North Carolina Health News* reported on February 15, 2019, that the North Carolina Department of Health and Human Services (DHHS) failed to include terms to "define or recover excess Local Management Entities/Managed Care Organizations (LME/MCOs) savings" in the state's seven behavioral health MCO contracts, according to a report from the Office of the State Auditor. The report recommends that state contracts include language that is precise enough to contain all federally required provisions. Following the state's managed care transition, more than 2.1 million Medicaid beneficiaries, including those with severe mental, developmental and substance abuse problems, will receive both physical and behavioral health coverage. Read More

Ohio

Ohio Seeks $16 Million Repayment From Former BWC Pharmacy Benefit Manager. *The Columbus Dispatch* reported on February 19, 2019, that Ohio Attorney General Dave Yost is seeking a $16 million repayment from OptumRx for pharmacy benefit manager (PBM) services provided to the Bureau of Workers' Compensation (BWC). OptumRx's contract was previously terminated by BWC as a result of findings from an analysis of prescription drug spending. A letter from BWC to OptumRx outlined overcharges attributable to failure to adhere to agreed discounts on generic drugs. Read More

Ohio Medicare Accepts Providers' Corrective Plans. *NBC4 Columbus* reported on February 12, 2019, that the Centers for Medicare & Medicaid Services (CMS) has approved the Plans of Correction for Mount Carmel West and Mount Carmel St. Ann's hospitals after they were found to be noncompliant with Medicare standards for pharmaceutical services. The Ohio Department of Health has been directed to conduct follow-up surveys and inspections to ensure that the hospitals are implementing their plans. Read More

Oklahoma

Senate Committee Approves Bill To Expand Medicaid Through Insurance Exchange. *The Oklahoman* reported on February 19, 2019, that an Oklahoma Senate committee advanced a bill, authored by Senator Greg McCortney (R-Ada), to expand Medicaid through the state's Insure Oklahoma insurance exchange. The bill would provide premiums subsidies to individuals eligible for Medicaid expansion and who meet work requirements, with coverage provided by a commercial health plan. Read More

Oregon

House Passes Medicaid Funding Package. *The Portland Business Journal* reported on February 19, 2019, that Oregon Governor Kate Brown's $265 million Medicaid funding package is moving to the state Senate for consideration after passing in the House. The bill, which aims to fill a $900 million Medicaid budget hole, raises the hospital assessment from 5.3 percent to 6 percent, and increases the premium tax on insurers and managed care organizations. Yet to advance are the Governor's proposed employer tax and an increased tobacco tax. Read More

Oregon Receives 11 Updates to Letters of Intent for CCO 2.0 Contracts. The Oregon Health Authority announced on February 20, 2019, that it had received 11 updates to letters of intent from organizations seeking to apply for the 2020-24 coordinated care organization (CCO) contracts. Four organizations have withdrawn their letters of intent from the Portland metro area (CareOregon, Kaiser Foundation Health Plan of the Northwest, Moda Health Plan, and PacificSource Community Solutions – Portland). Trillium Community Health Plan expanded its intended service area. Providence Health Assurance and PacificSource Community Solutions have removed counties from their service areas. Four additional organizations made technical changes. Each organization was required to list the counties they intend to serve, and based on the letters received, every county would have at least one CCO. Applications are due April 22, 2019, with contracts beginning January 1, 2020. Only applicants that submitted a letter of intent are eligible to submit a complete application. Read More

Note, the Oregon Health Authority initially announced receipt of 10 updated letters of intent on February 19, 2019, omitting Trillium Community Health Plan's letter because of a clerical processing error.

Texas

Texas Settles Medicaid Fraud Lawsuit for $236 Million. *The Houston Chronicle* reported on February 19, 2019, that Texas has settled a Medicaid fraud lawsuit for $236 million. The case involved billing for unnecessary dental and orthodontic work by Texas dentists serving low-income children. State contracted Conduent Business Services, which had handled pre-approval of the dental procedures, did not admit wrongdoing. Read More

Utah

Utah Advocates Are Concerned Over Recently Passed Medicaid Per Capita Cap. *Kaiser Health News* reported on February 14, 2019, that health care advocates in Utah are concerned over recently passed legislation that would allow the state to institute a per capita cap on Medicaid spending. The measure was included in a bill aimed at replacing the state's voter-approved Medicaid expansion with a more limited partial expansion up to 100 percent of the federal poverty level. The bill was signed by Governor Gary Herbert on February 11 and will be submitted to the Centers for Medicare & Medicaid Services (CMS) for approval. If CMS does not approve, the bill requires the state to fully expand Medicaid in 2020. Read More

Wisconsin

Wisconsin Releases Family Care Partnership RFP for Selected Service Areas. The Wisconsin Department of Health Services on February 20, 2019, released a request for proposal (RFP) for geographic service areas nine, 10, and 13 of the state's Family Care Partnership, a Medicaid managed long-term care program for low-income frail, elderly and adult individuals with developmental, intellectual, or physical disabilities. Proposals are due on April 12, 2019, with implementation expected to begin January 2020. Wisconsin began procuring the Family Care contracts in phases in 2016 as part of an effort to make the program available in every county in the state. The RFP and additional documents can be found here.

National

Medicaid Expansion Voter Initiatives May Face Obstacles. *The Wall Street Journal* reported on February 17, 2019, that Republican lawmakers in states like Florida and Missouri are considering legislation that would make state Medicaid expansion voter initiatives more difficult to pass. Changes may include charging fees, mandating more petition signatures, or requiring more votes to pass. Both Florida and Missouri are likely targets for Medicaid expansion initiatives. Read More

House Democrats Are Cleared to Defend ACA in Court. *Politico* reported on February 14, 2019, that a federal appeals court has granted a House Democrats' petition to intervene in defense of the Affordable Care Act (ACA) in a case questioning the constitutionality of the law. Last year, a federal Judge in Texas struck down the ACA, ruling that the law was rendered invalid after Congress eliminated the penalty for not having health insurance. The 5th Circuit of Appeals also approved requests from Colorado, Iowa, Michigan and Nevada to join the defense. Read More

CMS Demonstration to Incentivize Ambulance Providers to Use Urgent Care, Telehealth. *CQ Health* reported on February 14, 2019, that the Center for Medicare & Medicaid Services has launched a new emergency transportation demonstration known as Emergency Triage, Treat, and Transport (ET3), which will pay first responders when they transport Medicare fee-for-service patients to urgent care or use telehealth. The program is aimed at reducing incentives among ambulance providers to bring patients to emergency rooms. ET3 is a five-year, voluntary demonstration that will likely begin in 2020. Read More

House, Senate Democrats Introduce Medicare Buy-in Legislation. *Politico* reported on February 13, 2019, that House and Senate Democrats have introduced legislation to allow individuals between 50 and 65 years old to buy into Medicare using the same tax credits and cost sharing subsidies available on the Affordable Care Act Exchanges. Premiums would go into a buy-in fund separate from traditional Medicare. The legislation is co-sponsored by Senators Tammy Baldwin (D-WI) and Debbie Stabenow (D-MI) and Representatives Brian Higgins (D-NY) and Joe Courtney (D-CT). Read More

Industry News

4 Health Plans Win Rulings in Effort to Recover Cost-Sharing Reduction Payments. *Modern Healthcare* reported on February 15, 2019, that judges at the U.S. Court of Federal Claims ruled in favor of four health plans seeking to recover unpaid insurance Exchange cost-sharing reduction (CSR) payments from the federal government. Judge Margaret Sweeney ruled in favor of Maine Community Health Options, which is owed an estimated $5.7 million in CSR payments; Community Health Choice, which is owed $11.2 million for 2017; and Common Ground Healthcare Cooperative, which is owed $12 million to $13 million for 2017 and $60 million for 2018. Judge Thomas Wheeler ruled that the federal government owes L.A. Care Health Plan approximately $6 million in 2017 CSR payments. Montana Health Co-op and Sanford Health Plan won similar CSR rulings last year. The Montana Health case has been appealed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
2019	Louisiana	RFP Release	1,500,000
April 1, 2019	Idaho Medicaid Plus (Dual) - Bonneville, Bingham, Bannock Counties	Implementation	3,329
April 12, 2019	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Proposals Due	
April 22, 2019	Oregon CCO 2.0	Applications Due	840,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
July 9, 2019	Oregon CCO 2.0	Awards	840,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

HMA WELCOMES

Linda Shields – Principal
Linda Shields has more than 25 years of uniquely diversified strategic and operational healthcare experience in both the private and public sectors.

Her breadth of experience in the payer, provider, employer and regulatory arenas, crossing commercial and public settings, provides Linda with a broad, strategic and operational understanding of the emerging market trends, challenges, opportunities and solutions.

Before joining HMA, Linda worked as vice president of states and payers for The Lewin Group where she led the effort for managed care strategy and operations, healthcare delivery transformation, quality and performance driven outcomes, regulatory compliance, and operational improvement and effectiveness. She served in the capacity of project director, subject matter expert and task lead for multiple engagements with state and federal governments, managed care organizations, foundations and providers.

She has also worked in the private sector with commercial insurers, self and fully-insured national and international employer groups, and Taft Hartley Funds on care delivery strategy and operations, benefit design, targeted care management programs, coalition building, value-based payment, contracting, provider networks and data driven innovations.

Linda has extensive experience working with Medicare, Medicaid, dual eligibles, federal demonstrations and waivers, grants, public and private sector health plans, labor unions, physician associations, integrated delivery systems, administrative services only plans, national and international employers, and the pharmaceutical industry.

She is a registered nurse and has a bachelor's degree in nursing from The College of New Jersey.

HMA News

Upcoming Webinars:
February 28, 2019 - Military Competency Among Health Care Providers: Best Practices for Screening, Treating and Coordinating Care of Veterans. Register here

March 1, 2019 – Successful Prevention Strategies to Address the Opioid Crisis. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Michigan Dual Demo Enrollment is Down 0.8%, Jan-19 Data
- Ohio Dual Demo Enrollment is Up 4.0%, Feb-19 Data
- Rhode Island Dual Demo Enrollment is 15,382, Feb-19 Data
- South Carolina Dual Demo Enrollment is Up 29.4%, Jan-19 Data
- Texas Dual Demo Enrollment is 41,653, Feb-19 Data
- Arizona Medicaid Managed Care Enrollment is Flat, Feb-19 Data
- Colorado RAE Enrollment is 1.2 Million, Jan-19 Data
- Puerto Rico Medicaid Managed Care Enrollment is Up 2.3%, Sep-18
- South Carolina Medicaid Managed Care Enrollment is Up 1.0%, Feb-19 Data
- Utah Medicaid Managed Care Enrollment is Flat, Feb-19 Data

Public Documents:
Medicaid RFPs, RFIs, and Contracts:

- Arizona Regional Behavioral Health Authority (RBHA) Services Transfer RFI, Feb-19
- DC MMIS Core System and Supporting Services RFP, Feb-19
- Kentucky Medicaid Managed Care Contracts, SFY 2019
- Massachusetts One Care RFR, Feb-19
- North Carolina Prepaid Health Plan Services RFP, Proposals, Scoring, and Related Documents, 2018-19
- New Hampshire Granite Workforce Case Management Services Pilot Project RFA and Scoring, 2018-19
- New Hampshire Medicaid Care Management Services RFP, Scoring Summary, and Awards, 2018-19
- New York OASAS RFAs Addressing Opioid Crisis, Feb-19
- Oregon Final CCO 2.0 RFA, Attachments, and Updated Letters of Intent, Feb-19
- Utah Medicaid Auditing and Accounting RFP and Attachments, Feb-19
- Vermont Optical Benefits to Medicaid Beneficiaries RFP, Feb-19
- Wisconsin MCO for the Delivery of Managed LTC in Selected Service Areas in GSR 7 and 8 RFP, Proposals, Scoring, and Contracts, Jan-19
- Wisconsin MCO for the Delivery of Managed LTC in Selected Service Areas in GSR 8 and 12 RFP, Jan-19

Medicaid Program Reports, Data and Updates:

- U.S. Medicaid, CHIP Enrollment at 72.6 Million, Nov-18 Data
- Florida Governor's Proposed Budget, FY 2019-20
- Iowa Medicaid Managed Care Quality Assurance System Report, 2018
- Maryland HealthChoice CAHPS Report, 2018
- Massachusetts 2018 Annual Health Care Cost Trends Report, Feb-19
- NASBO Fiscal Survey of the States, 2017-18
- New Jersey Family Care Enrollment by Age, Eligibility Group, and County, 2016-18
- New Mexico Centennial Care 2.0 Approved Renewal and Other Related Documents, Dec-18
- New Mexico Centennial Care Public Event Presentations, Feb-19
- New Mexico Medicaid Advisory Committee and Subcommittee Meeting Materials, Jan-19
- Ohio Medicaid to Rebid Managed Care Contracts, Feb-19 Opportunity Assessment
- Pennsylvania Behavioral Health Managed Care External Quality Review Reports, 2016-17
- South Carolina Medical Care Advisory Committee Meeting Materials, Feb-19
- Tennessee Medicaid Managed Care Enrollment by Age, Gender, County, 2015-18, Jan-19
- Texas Governor's Proposed Budget, FY 2020-21
- Virginia Managed Care Operational Report, SFY 2018

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.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; Los Angeles, California; New York, New York; Philadelphia, Pennsylvania; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

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.