HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 28, 2018

RFP Calendar

HMA News

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THIS WEEK

IN FOCUS

NEW YORK MEDICAID REDESIGN: ROLES AND RESPONSIBILITIES

This week, our *In Focus* section, written by HMA Principal Denise Soffel, reviews New York's *Medicaid Redesign Team Structural Roadmap: Roles and Responsibilities in a Value Based Payment World,* released by the state's Department of Health on March 19, 2018.

New York is committed to the transformation of its health care delivery system. Its Delivery System Reform Incentive Payment (DSRIP) program envisions a significant shift to community-based care, a more integrated delivery system, and a shift to value-based payment. A new document, released in draft form for public comment, lays out an ambitious objective: "New York seeks to make health care a team sport. The State seeks to forever banish the traditional silos that made care navigation for patients difficult and in some cases impossible." (p. 13)

The draft document provides a structural roadmap of roles and responsibilities of various entities in a value-based payment environment. The document identifies a "middle layer" of actors that operate between the state as payer and the actual providers of care. This layer includes managed care plans, managed long-term care (MLTC) plans, health homes, performing provider systems (PPSs) currently participating in the DSRIP program, ACOs and IPAs, as well as patient-centered medical homes. These actors are seen as critical to ensuring cost-effective, high-quality care. The Structural Roadmap intends to define the various roles that middle level entities play in a value-based delivery system, where integrated networks replace disconnected service silos.

The draft includes a chart that describes the functions of each of the layers that run between the state and the on-the-ground providers of care. Functions are categorized as either patient support or provider support.

Layer	Patient Support Functions	Provider Support Functions
MCOs	Manage Enrollment, Out-of-Network Benefits, Member Communication	Risk Management, Data Analysis, Provider Accountability, Utilization Review
Performing Provider Systems	Population Health Management	Provider Actionable Data, Facilitate provider Partnerships
IPAs/ACOs	Access to Integrated Care	Shared Services, Critical Contracting Mass
Health Homes	Support in Care Navigation	Hands-on Care Management
BH/LTC/Specialty providers	Specialized Care	Subject Matter Expertise
PCMH	Primary Care Quarterback	

Medicaid Managed Care Organizations

The Structural Roadmap envisions a smaller role for mainstream managed care organizations (MCOs) in the future. New York has relied on MCOs to provide care within the Medicaid program since its initial waiver was approved in 1996. Initially MCOs had a leading role in providing care coordination and case management to their members; in addition to capitation payments, they have received quality incentive bonus payments based on extensive performance metrics. Health homes now have primary responsibility for care management, based on a belief that they are better able to meet the needs of the highest-cost, highest-need Medicaid beneficiaries, who require a more intensive, comprehensive approach to care management than plans are able to provide. The Structural Roadmap identifies policies that will encourage MCOs to work more closely with their health home partners, including moving payment for health home services into the capitation rate and developing a Health Home Quality Performance and Management program, which will give MCOs health-home-specific performance data.

According to the Structural Roadmap, MCOs will remain involved in enrollment and member services, network development, and quality and utilization management. MCOs "will begin to delegate some risk, network development, and care management activities to increasingly sophisticated networks of providers that have been purposefully designed to better manage population health under VBP arrangements." (p.2)

Since the DSRIP program began, much of the responsibility for identifying and responding to community health needs has shifted from MCOs to the 25 PPSs across the state, which have developed local networks of partners working collaboratively to "reform service delivery, address community health needs and reduce avoidable hospitalizations." (p. 7) MCOs are expected to partner with PPSs to support value-based purchasing (VBP) arrangements, especially with data-sharing related to patient management, tracking, and quality improvement.

Managed Long Term Care

As described in the Structural Roadmap, MLTC plans will continue to have a significant role in providing care management to Medicaid beneficiaries requiring long term services and supports. They will also be involved in developing VBP initiatives by establishing relationships with and between providers and facilitating data sharing. The Structural Roadmap envisions MLTC plans playing a leading role in encouraging LTC providers to move to VBP arrangements and sharing best practices in care delivery, contracting, and quality measures.

Health Homes

Health Homes will be required to take full responsibility for care management for high-need beneficiaries. Given that MCOs can selectively contract with health homes, the health homes face competitive pressure to prioritize the quality of the care management services they provide through improved supervision and management of the care management agencies providing care on the ground. Health home care managers are responsible for closing all gaps in care needs of their members, assuring that members get the services they need, and that the services are coordinated effectively. Health homes also need to improve partnerships with MCOs in order to conduct successful outreach, aligning real time data and predictive risk modeling to better prioritize and target outreach activities. Health homes will be required to support MCO value-based purchasing goals by moving to value-based arrangements with progressive risk over time. In fact, health homes are required to enter into VBP arrangements with upside-only risk (at a minimum) by January 2019. It is unclear how care management needs for Medicaid beneficiaries who are not health home-eligible or who choose not to enroll in a health home will be met.

Performing Provider Systems

PPSs are beginning the fourth year of the five-year DSRIP program. They are expected by now to have developed deep population health management activities, including data management, patient tracking, practice redesign, community engagement, provider connectivity, and service integration (although the capacity of the PPSs varies across the state). PPSs are now in the process of developing a sustainability plan that describes how they will support on-going VBP implementation once DSRIP has ended. (Note that should a PPS decide not to continue post-DSRIP, it must describe how it will transfer its infrastructure to others in the community so as not to lose population health functional capacity). PPSs have the responsibility to develop a plan for working with MCOs, as well as with provider entities such as accountable care organizations, independent practice associations, and patient-centered medical homes, to maintain a population health facilitator function. It remains unclear whether all 25 PPSs will be able or willing to continue operations without ongoing funding once DSRIP ends in March 2020.

The state expects MCO and PPS partnerships will deepen to support providers as VBP rolls out. There will be an emphasis on data sharing as PPSs develop better real-time patient management, tracking, and quality improvement capabilities. These partnerships will also aid MCOs in improving quality and efficiency scores that affect payment.

Accountable Care Organizations and Independent Practice Associations

Providers are increasingly forming arrangements to facilitate providing accountable, value-based care, providing better population health management, and lowering cost. These organizations, which are occurring both horizontally and vertically, provide an asset to VBP contracting by allowing providers to take on risk contracting. MCOs are already working with these organizations; those relationships are likely to accelerate as behavioral health, specialty care, and long term care services become integrated into provider organizations.

Behavioral Health Care Collaboratives

Behavioral Health Care Collaboratives (BHCCs) are newly-established entities that establish provider networks that span various behavioral health silos, including mental health and alcohol and substance-use services. BHCCs are designed to integrate care across the entire spectrum of physical and behavioral health services. BHCCs are intended to help prepare providers for VBP by facilitating shared infrastructure and administrative capacity, as well as collective quality management. They should also encourage VBP payers, whether MCOs or providers, to partner with the BHCCs. BHCCs are receiving funding to build data-collection and data-analytic capacity, facilitating their participation in VBP.

Patient Centered Medical Home/Advanced Primary Care

New York began providing financial incentives to primary care practices that achieved National Committee for Quality Assurance (NCQA) recognition starting in 2010. Medicaid will begin a process this year that will reduce, and eventually eliminate, PCMH incentive payments for practices that opt not to participate in VBP arrangements with (at least) upside-only risk. Longer term, the state intends to limit PCMH incentive payments to practices that meet quality and efficiency targets.

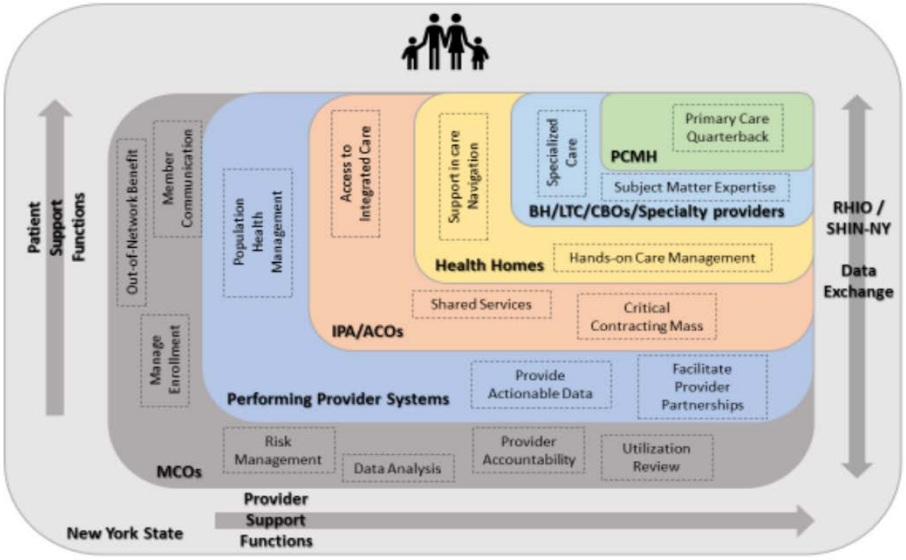
SHIN-NY Support for DSRIP and VBP

New York has invested significantly in the development of the Statewide Health Information Network for New. It is meant to provide the health information exchange infrastructure necessary to support health care transformation initiatives. Eight Qualified Entities (QE) across the state are meant to support the exchange of electronic health record information. The state has been working with the QEs to help PPSs with data management and information exchange. QEs are supporting providers, PPSs and MCOs by making clinical data available for care management and quality measurement. QEs are also helping with consent management, which can be a major barrier to effectively implementing VBP. "Focusing on high-quality and easily available EHR information will support real-time, actionable, high-performing population health management." (p. 12)

Missing from the Structural Roadmap is a discussion of social determinants of health and the role of community-based organizations (CBOs) in addressing those needs. The importance of addressing social determinants has been a central theme of New York's health reform efforts.

Care Delivery Layers

The following infographic is meant to display activities within the layer responsible for each activity, categorized as patient support (vertically) or provider support (horizontally)



The state is seeking public comment on the Structural Roadmap by April 2. Comments should be sent to VBP@health.ny.gov.

Link to Medicaid Redesign Team Structural Roadmap: Roles and Responsibilities in a Value Based Payment World

HMA Medicaid Roundup

California

California Enrolled 450,000 Ineligible Medicaid Expansion Members, OIG Report Says. *Kaiser Health News* reported on March 27, 2018, that California mistakenly enrolled more than 450,000 Medicaid expansion members who may not have been eligible for the program, according to a report by the Office of Inspector General (OIG). The cost of covering these members was $1.15 billion, of which 90 percent involved federal funds. The analysis was based on a sample of 150 expansion enrollees. Read More

Florida

Governor Scott Signs Bills Requiring Backup Generators at Nursing Homes, Assisted Living Facilities. *Health News Florida* reported on March 27, 2018, that Florida Governor Rick Scott signed two bills (HB 7099 and SB 7028), requiring nursing homes and assisted-living facilities to have backup generators and fuel supplies. The legislation comes after residents died in a nursing home in Broward County following Hurricane Irma. Read More

Illinois

Illinois Fails to Recoup $76 Million in Overpayments to Medicaid MCOs. *U.S. News/Associated Press* reported on March 24, 2018, that Illinois failed to recoup $76 million in overpayments to Medicaid managed care plans, according to two state audits. The audits also found that an additional $71 million was paid for Medicaid services without checking if members were still eligible. There is currently a backlog of 74,649 requests for social services that hadn't been evaluated in the required 45 days, with the oldest request dating back to 2014. Read More

Iowa

Senate Approves Bill to Improve Mental Health System. *The Des Moines Register* reported on March 21, 2018, that the Iowa Senate approved a bill to expand and improve mental health and substance abuse disorder services for state residents. The measure includes the addition of six regional access centers that would offer short-term assistance to individuals experiencing a mental health crises and the expansion of treatment teams to monitor and assess Iowans with serious mental illness. The legislation, which already passed the state House, now moves to Governor Kim Reynolds desk. Read More

Mississippi

Legislature Agrees to Reauthorize Medicaid, Passes Budget. *The Clarion Ledger* reported on March 26, 2018, that the Mississippi House and Senate reached a compromise on proposed changes to the state Medicaid technical amendments bill, paving the way for reauthorization of the state Medicaid program and approval of a $917.5 million Medicaid budget. As previously reported, the House had refused to approve the budget unless the Senate approved the technical amendments bill. The compromise maintains a requirement that managed care plans pay provider rates set by the legislature; however, it omits a proposal requiring the state to contract with provider-sponsored plan Mississippi True for a portion of the state Medicaid managed care business. Read More

Minnesota

Minnesota Reinsurance Program Reduces Exchange Premiums 15 Percent, Report Says. The Star Tribune reported on March 21, 2018, that a Minnesota reinsurance program resulted in significant reductions in premium rates for 2018 Exchange plans, according to an Urban Institute study. For example, the study found that the average monthly premium rate fell 15 percent among adult non-smokers for the lowest-cost Silver plan. The reinsurance program was launched in 2017. Read More

Nebraska

Judge Puts Skyline Nursing Facilities, Assisted Living Facilities in Receivership. The Nebraska Department of Health & Human Services (DHHS) announced on March 23, 2018, that it has placed 21 nursing facilities and 10 assisted living facilities owned by Cottonwood Healthcare/Skyline in receivership to protect the health and safety of residents. The Nebraska Department of Health and Human Services had requested that the facilities be placed in receivership after Skyline was unable to meet payroll. Klaasmeyer & Associates will oversee operations of the facilities. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey DOH and DHS Commissioners Seek to Modernize Healthcare System. *NJ Spotlight* reported on March 26, 2018, that Acting Commissioner Carole Johnson of the New Jersey Department of Human Services (DHS) and Dr. Shereef Elnahal, Acting Commissioner of the Department of Health (DOH), are seeking to modernize New Jersey's healthcare system to provide better data, improve access to care, and reduce disparities. At a New Jersey Policy Perspective conference, both commissioners identified key goals, such as reducing racial disparities in maternal health, infant mortality, and other health outcomes; improving integration of behavioral health and medical care; and addressing operational gaps inhibiting residents from getting Medicaid coverage. They highlighted regulatory changes already made to improve Medicaid payment for family-planning services, Hepatitis C treatments, and diabetes preventions. The Department of Health is also creating a statewide system to identify patients to facilitate the linkage of electronic health records across hospitals. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York to Release Social Determinants of Health RFI. The New York Department of Health is launching a new initiative designed to identify innovative new or existing ideas for how to effectively address the Social Determinants of Health (SDH) for Medicaid members across New York. The state plans to launch a Request for Innovation (RFI) initiative that will solicit proposals from community-based organizations (CBOs) not only from across New York, but also throughout the country, and potentially around the world. The initiative's primary goal is to help healthcare providers, managed care organizations, and DSRIP Performing Provider Systems (PPS) as they seek creative ways to address SDH needs of the members they serve. This RFI will help all those entities identify new strategies that could be deployed successfully to assist them in their important population health work.

The Department of Health plans to release the RFI requirements on May 1, 2018. The state plans to name a team of national experts to evaluate the proposals. Proposals will be due to the department June 1, 2018; winners will be announced by July 15. Proposals will be evaluated based on the following criteria:

- Potential Return on Investment
- Scalability
- Evidence-based practices
- Relevance to the Medicaid population
- Speed to market (how quickly the strategy could be launched)

Winners will have an opportunity to present their ideas directly to PPS, MCOs and VBP contractors at a conference that DOH will host in August. Read More

New York Governor Cuomo Proposes Budget Strategy to Take Medicaid Health Plan Reserve Funds. *Politico* reported on March 26, 2018, that New York Governor Cuomo has proposed a new strategy for raising money to support health care initiatives. Under the proposal, any Public Health Plan, a managed care plan whose products are limited to Medicaid and other publicly financed coverage (including Child Health Plus and the Essential Plan) whose reserves rise above 150 percent of the minimum contingent reserve fund would have that excess confiscated by the state. The money would be placed in a public asset fund to be used for community health reinvestment. The minimum contingent reserve is equal to 7.5 percent of a company's net premium income. According to *Politico*, only two plans currently meet that level – Fidelis Care, operated by the Catholic church, and MetroPlus, operated by the NYC Health + Hospitals.

Centene has announced its plan to acquire Fidelis Care, a proposal that is undergoing state review. Governor Cuomo's original budget proposal included establishing a Health Care Shortfall Fund, to be financed by assets generated by conversions, acquisitions, or related transactions in which not-for-profit health insurers convert to corporations organized for profit, which could affect the Fidelis Care-Centene deal. Fidelis Care representatives reiterated last week that if the state proceeded to claim those assets, they would abandon the deal with Centene. Read More

Ohio

Ohio Medicaid Mobility Transformation Plans Announced. The Ohio Department of Medicaid released a white paper on March 21, 2018, outlining its strategy to transform the state's current county-based non-emergency medical transportation (NEMT) system to a state-based brokerage model. Ohio intends to contract with one or more transportation brokers to develop and maintain a provider network, verify Medicaid eligibility for NEMT services, determine and authorize the mode of transportation, and dispatch an appropriate vehicle. Read More

Pennsylvania

Senate Confirms Four Cabinet Members. On March 20, 2018, the Pennsylvania Senate unanimously confirmed four members of Governor Tom Wolf's cabinet. All four were acting department heads prior to their confirmation. Confirmed in their positions were Department of Health Secretary, Dr. Rachel Levine; Department of Human Services Secretary, Teresa Miller; Department of Drug and Alcohol Programs Secretary, Jennifer Smith; and Insurance Commissioner, Jessica Altman. Read More

Pennsylvania Medical Assistance Advisory Committee (MAAC) March 22 Meeting Provides Budget Updates.

Office of Medical Assistance Programs (OMAP) Budget Briefing

OMAP Deputy Secretary Sally Kozak presented the proposed budget. The total Medical Assistance (MA) budget proposed is $19.9 billion, broken down into $15.9 billion for capitation, $2.6 billion for fee for service, $800 million for Medicare Part D, $400 million for other, and $200 million for the Medical Assistance Transportation Program (MATP). This section of the budget does not include long term living or the Children's Health Insurance Program (CHIP). Kozak outlined OMAP's 2018-19 priorities: addressing value based purchasing, social determinants of health, Medicaid management information system procurement, continued program modernizations, and consolidating the Department of Health (DOH) and the Department of Human Services (DHS) into the Department of Health and Human Services. Read More

Office of Long Term Living (OLTL) Budget Briefing

OLTL Deputy Secretary Kevin Hancock presented the proposed budget. The total OLTL budget for 2018-19 is $8.47 billion including state, federal, and other funding. Hancock explained the breakdown as follows: $3.2 billion for Community HealthChoices (CHC), $2.8 billion for long-term care, $1 billion for home and community based services, and the remainder for managed long-term care, services to persons with disabilities, and attendant care. Hancock also emphasized that the 2018-2019 budget reflects a full year of operation of CHC in the Southwest zone, as well as implementation funds for CHC in the Southeast. Read More

Office of Mental Health and Substance Abuse Services (OMHSAS) Budget Briefing

OMHSAS Chief of Staff Allison Frantz presented the proposed budget, which totals $5.147 billion. The largest portion is Medicaid at $3.991 billion, including behavioral health fee-for-service and HealthChoices behavioral health, and additional funding requests. Frantz noted a projected $3.9 billion in HealthChoices Behavioral Health Managed Care funding. Read More

Office of Developmental Programs (ODP) Budget Briefing

ODP Deputy Secretary Nancy Thaler presented the proposed budget. The ODP total budget for 2018-19 is $4.1 billion, including $2.01 billion in state funds. Thaler said that ODP represents approximately 16% of the state portion of the 2018-19 DHHS budget, and the proposal includes the consolidation into DHHS. Thaler outlined specific 2018-19 initiatives as follows: $4.1 million to expand services for 100 individuals on the emergency wait list through the Consolidated Waiver, $10.2 million to expand services for 800 individuals on the wait list through the Community Living and P/FDS Waivers and 800 individuals in the Community Living and P/FDS waiver, $688,000 to expand services for 40 additional adults with autism on the waiting list through the Adult Community Autism Program. Read More

Tennessee

Community Health Systems to Sell Three Hospitals to West Tennessee Healthcare. Tennessee-based Community Health Systems announced on March 27, 2018, that it has entered into a definitive agreement to sell three hospitals from its Tennova Healthcare operation to West Tennessee Healthcare. The transaction, which is expected to close in the second quarter of 2018, includes hospitals in Dyersburg, Jackson, and Martin. Read More

Texas

Sendero Health Plans to Exit Texas STAR Medicaid, CHIP. *My Statesman* reported on March 23, 2018, that Sendero Health Plans is exiting the Texas STAR Medicaid and Children's Health Insurance Program (CHIP), citing projected 2018 losses. Approximately 18,000 members will need to select a new plan in April. These members account for 40 percent of Sendero's total membership. Read More

Utah

Utah Enacts Partial Medicaid Expansion; CMS Approval Pending. The *Salt Lake Tribune* reported on March 27, 2018, that Utah Governor Gary Herbert signed a bill authorizing partial expansion of Medicaid coverage to 70,000 low income residents. The legislation, which includes work requirements, requires approval by the Centers for Medicare & Medicaid Services. A separate Utah ballot initiative for November 2018 would expand Medicaid coverage to 150,000 additional people. Read More

Washington

Washington Fines Exchange Plan Over Provider Access Issue. *Bloomberg* reported on March 22, 2018 that Washington state has fined Centene Corp. for failing to comply with an agreement to improve provider access for Exchange plan members. Centene continues to work to address the provider access problem. Read More

National

NAMD Published Medicaid 1115 Waiver Issue Brief. The National Association of Medicaid Directors (NAMD) on March 19, 2018, published an Issue Brief titled, Medicaid Section 1115 Waiver Trends in an Era of State Flexibility. New Section 1115 waivers have already been approved to test four concepts: work/community engagement, incentives for healthy behaviors, premiums, and alternative treatment of substance use disorders.

The NAMD Issue Brief focuses on seven additional strategies that have not been approved to date but that states are pursuing or may pursue in coming months. These include:

1. Testing Strategies to Modernize the Medicaid Pharmacy Benefit
2. Establishing a Robust Continuum of Care for those with Serious Mental Illness
3. Creating a Continuum of Coverage and Stabilizing the Marketplace
4. Seeking Stronger Alignment and Authentic Partnership with Medicare
5. Advancing Alternative Payment Models for Safety-net Providers
6. Testing Medicaid's Role in Addressing the Social Determinants of Health
7. Testing Time Limits for Medicaid Coverage

Some of these concepts have been fleshed out to the extent that actual waiver applications have been submitted. For example, Massachusetts is seeking CMS approval for a closed formulary, and North Carolina has requested a waiver to include acute behavioral health care in an Institution for Mental Diseases. Several states are seeking changes in coverage of healthy adults with incomes above 100 percent of the federal poverty level, and others are contemplating lifetime limits of 48 to 60 months for Medicaid coverage of certain adults. Read More

State, Local Agencies, SAMHSA Seek to Lift Moratorium on Methadone Vans. *Governing* reported on March 26, 2018, that some state and local agencies are seeking to lift a moratorium on mobile methadone vans, making access to opioid treatments easier. The Substance Abuse and Mental Health Services Administration (SAMHSA) also wants the ban to be lifted. SAMHSA states that of the 2 million people addicted to opioids in the United States, only one in five receive treatment. The vans were banned in 2007 by the U.S. Drug Enforcement Administration over concerns about potential diversion of the medication. Read More

States May Seek 1332 Waivers in Effort to Curb Exchange Premiums After Stabilization Package Fails to Pass. *Modern Healthcare* reported on March 23, 2018, that states will need to find ways to curb 2019 Affordable Care Act (ACA) Exchange plan premiums after a stabilization package failed to pass in Congress. State officials and policy analysts agree that setting up reinsurance funds under Section 1332 waivers may be the best option. The waivers would need to be approved by the end of April, with insurers to begin filing their proposed rates as early as May. The Trump administration is still expected to release its final rule on Exchange benefit and payment parameters, originally scheduled for February. Read More

CMS Proposal Would Roll Back Certain Medicaid Access to Care Monitoring Requirements. *CQ Health* reported on March 22, 2018, that the Centers for Medicare & Medicaid Services released a proposed rule that would roll back certain Medicaid access-to-care monitoring requirements. Under the proposed rule, states with at least 85 percent Medicaid managed care penetration would no longer be required to monitor the impact of provider rate cuts on access to care for fee-for-service members provided that the rate cuts are under four percent per year or six percent over two consecutive years. A separate rule applies to monitoring access for Medicaid managed care members. The change would impact 17 states. Read More

HHS Gets Funds for Opioid Abuse Programs, But Not Exchange Stabilization. *Modern Healthcare* reported on March 21, 2018, that Congress released an omnibus spending bill that appropriates $88 billion for the U.S. Department of Health and Human Services, including $3.6 billion in funding for opioid abuse programs. However, the two-year spending measure doesn't include funding for cost-sharing reduction payments or reinsurance to help stabilize the Affordable Care Act Exchanges. Read More Funding for opioid treatment includes $1 billion for state grants. Read More

Industry News

CareSource Names New CEO. The *Dayton Daily News* reported on March 28, 2018, that CareSource has named Erhardt Preitauer as chief executive, replacing Pam Morris, who is retiring. Preitauer was most recently senior vice president of government programs at Horizon Blue Cross Blue Shield and head of the company's Medicaid plan. Read More

Ascension to Sell St. Vincent's Medical Center to Hartford Healthcare. *Modern Healthcare* reported on March 27, 2018, that Ascension has signed a letter of intent to sell Connecticut-based St. Vincent's Medical Center to Hartford HealthCare. Financial terms have not yet been disclosed. Read More

Ascension May Shift Focus to Outpatient Care, Telemedicine. *Modern Healthcare* reported on March 22, 2018, that Catholic health system Ascension is in the midst of a restructuring that could reduce its hospital footprint in favor of increased focus on outpatient care and telemedicine. Chief executive Anthony Tersigni stated the new strategic direction is a result of low reimbursement rates from payers, regulatory complexity, and skyrocketing pharmaceutical costs. Ascension expects to save $57 million annually after restructuring. Read More

HCA Healthcare to Acquire Mission Health. *Citizen Times* reported on March 21, 2018, that HCA Healthcare has signed a letter of intent to acquire North Carolina-based Mission Health. HCA operates 177 hospitals and 119 surgery centers in 20 states based out of Nashville, Tennnessee. The transaction is subject to the negotiation of a definitive agreement and applicable regulatory approval. Mission health currently operates seven hospitals in 18 western counties of North Carolina. Read More

Palm Medical Centers Acquires Angel Medical Center. MBF Healthcare Partners announced on March 21, 2018, that portfolio company Strategic Health Services, LLC/Palm Medical Centers, has acquired Alpha Ortho-Care, Inc., a Florida-based primary care practice doing business as Angel Medical Center. Financial terms were not disclosed. 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
Spring 2018	North Carolina	RFP Release	1,500,000
April 2018	Alabama ICN (MLTSS)	RFP Release	25,000
April 2018	New Hampshire	RFP Release	160,000
April 6, 2018	Texas STAR and CHIP	RFP Release	3,342,530
April 6, 2018	Puerto Rico	Proposals Due	~1,300,000
April 11, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Proposals Due	~1,600
April 24, 2018	Iowa	Contract Awards	600,000
April 27, 2018	Florida Children's Medical Services	Responses Due	50,000
April 12, 2018	Washington FIMC (Remaining Counties)	Proposals Due	~1,600,000
May 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
May 22, 2018	Washington FIMC (Remaining Counties)	Contract Awards	~1,600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
June 2018	Alabama ICN (MLTSS)	Contract Award	25,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	North Carolina	Proposals Due	1,500,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
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	Puerto Rico	Implementation	~1,300,000
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	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
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 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
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	Washington FIMC (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA News

Upcoming Webinar - Technology Refresh: Assessing, Updating Health Insurance Exchange Platforms to Improve Marketplace Functionality and Enhance the User Experience on April 11, 1-2 EDT. Read More

HMA WELCOMES

Ryan Mooney – Senior Consultant, Austin Texas

Ryan Mooney has extensive legal, regulatory, and policy experience with an emphasis on federal laws and rules pertaining to the Federally-facilitated Exchanges, state-based Exchanges on the Federal Platform, and Medicare. He has the expertise to assist states, insurance companies, hospitals, and other private healthcare entities in navigating the ever-changing health reform landscape.

Ryan joins HMA from the Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO) where he served as the lead regulatory professional for the Enrollment Division of the Marketplace Eligibility and Enrollment Group. In this role, Ryan developed and wrote regulations, policies, and sub-regulatory guidance, and provided technical assistance to Congress for new legislation related to Federally-facilitated Exchange enrollment, insurance premium billing and payment, enrollment fraud, implementation of statutory grace periods for non-payment of premium, special enrollment periods, and the interaction of Medicare and Medicaid with Exchange-based Qualified Health Plans. Ryan also developed and wrote the enrollment-related sections of the Marketplace's regulatory submissions, including the annual Department of Health and Human Services (HHS) Notices of Benefit and Payment Parameters and rules promulgated on an ad hoc basis. Ryan routinely briefed top leadership at CMS on complex regulatory and policy matters and met regularly with healthcare industry leaders to discuss implementation and improvement of regulations and policies.

Prior to CMS, Ryan was a management analyst at the Health Resources and Services Administration (HRSA), Bureau of Health Workforce (BHW). He provided legal and technical consultation concerning program integrity, compliance, and effectiveness to senior leadership and made recommendations related to breach of contract actions for non-compliant National Health Service Corps clinicians.

Ryan earned his JD from The George Washington University School of Law and his bachelor's degree in European history at Washington and Lee University. He is licensed to practice law in Texas, California, Virginia, and the District of Columbia.

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; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
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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.