HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 10, 2019

RFP CALENDAR

HMA News

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ANNOUNCEMENTSTHIS

IN FOCUS

HMA SUMMARY OF 2020 MEDICARE ADVANTAGE AND PART D FLEXIBILITY FINAL RULE

This week, our *In Focus* reviews the Calendar Year (CY) 2020 Medicare Advantage (MA) and Part D Flexibility Final Rule (Final Rule) issued by the Centers for Medicare & Medicaid Services (CMS) on April 5, 2019. The Final Rule implemented various provisions contained in the Bipartisan Budget Act of 2018 (BBA), which required the expansion of MA telehealth benefits and established new criteria for Dual Eligible Special Needs Plans (D-SNPs) integration requirements and streamlined Medicare and Medicaid grievance and appeals processes. The Final Rule also established rules to improve MA and Part D program quality and accessibility, clarified program integrity policies, and established new rules for the MA and Part D Quality Rating System.

While many of the provisions included in the Final Rule set parameters based on legislative requirements, the Administration maintained its commitment to providing states and plans with flexibility to customize their offerings. Despite numerous comments requesting more standardization of requirements, CMS adopted many of its original proposals and indicated that additional technical support or clarification may be provided through sub-regulatory guidance.

CMS opted not to address its Risk Adjustment Data Validation (RADV) extrapolation proposal in the Final Rule, due to a recent extension of the comment period to April 30, 2019. Instead, CMS indicates it will address the RADV proposal and comments received in subsequent rulemaking.

2020 Medicare Advantage and Part D Flexibility Final Rule Highlights

Expansion of MA telehealth benefits: In accordance with the BBA, beginning in 2020, MA plans will have greater flexibility to cover telehealth benefits. Specifically, MA plans will be permitted categorize "additional telehealth benefits" (telehealth benefits beyond those covered under Medicare Fee-For-Service Part B) as basic benefits rather than supplemental benefits, ensuring concrete reimbursement for these services. MA plans may cover areas of telehealth previously unavailable to most Medicare beneficiaries, such as telehealth visits originating in urban areas or from the enrollee's home. In addition, CMS made final its proposals that plans covering additional telehealth benefits as a basic benefit:

- Have the discretion to determine which services are clinically appropriate for telehealth,
- Must offer comparable telehealth and in-person services,
- May establish differential cost-sharing for telehealth and in-person visits,
- Must ensure telehealth providers serving their enrollees are in-network providers, and
- May not include telehealth capital and infrastructure costs (e.g., information technology hardware and software) in their annual bids.

CMS chose to delay rulemaking on telehealth-related network adequacy requirements and encounter data submission requirements, instead reinforcing that these two requirements remain in place without changes at this time. Finally, CMS chose not to make final a proposal requiring MA plans to identify the individual telehealth services they cover to enrollees in the plans' Evidence of Coverage document.

Adoption of D-SNP Integration Requirements: CMS made final its proposal that, by 2021, D-SNPs would be required to meet **one** of the following three standards for Medicare and Medicaid integration as required by the BBA:

- Qualify as a Fully Integrated Dual Eligible SNP (FIDE SNP), a D-SNP with a capitated contract with the state Medicaid agency to cover comprehensive Medicare and Medicaid services, including long-term services and supports (LTSS) and behavioral health.
- Qualify as a Highly Integrated Dual Eligible SNP (HIDE SNP), a D-SNP that has, or whose parent organization or another entity owned and controlled by the parent organization has, a capitated contract with state Medicaid agency in the state it operates that includes LTSS, behavioral health, or both
- Notify the state Medicaid agency, or entities designated by the state Medicaid agency, when certain high-risk, full-benefit dual eligible

individuals, as determined by the state Medicaid agency, are hospitalized or have a skilled nursing facility admission. CMS clarified in the Final Rule that D-SNPs are permitted to authorize other entities, such as network providers, to notify the state Medicaid agency or designated entity on the D-SNP's behalf, though D-SNPs would retain the responsibility for compliance.

CMS also made final its proposal to impose intermediate sanctions to suspend enrollment if a D-SNP fails to meet one of the above requirements. Determinations regarding whether these sanctions will apply at the plan-level or contract-level will be made on a case-by-case basis. Non-compliant plans will be required to submit a corrective action plan describing how they intend to come into compliance.

CMS received numerous comments requesting additional clarity and direction to facilitate compliance with the integration requirements. CMS indicated the agency anticipates issuing sub-regulatory guidance to further clarify how D-SNPs can coordinate Medicare and Medicaid benefits.

Implementation of Unified Grievances and Appeals Processes for D-SNPs: As mandated by the BBA, CMS made final its proposals to unify Medicare and Medicaid grievance and appeals processes for certain D-SNPs and companion Medicaid managed care plans by 2021. The unification requirements apply only to D-SNPs and affiliated Medicaid managed care plans with "exclusively aligned enrollment", meaning all of the D-SNP enrollees receive Medicaid coverage through the D-SNP or an affiliated Medicaid managed care organization operated by the D-SNP's parent organization. CMS notes that the vast majority of D-SNP enrollment is not exclusively aligned, and therefore, these requirements would only apply to a limited number of plans in 2021. In developing the unified requirements, CMS proposed and made final processes that were most protective of the beneficiary, as directed by the BBA. These include:

- Enrollee assistance: Plans must offer to assist members with Medicaid-related coverage issues and resolution of grievances
- Integrated organization determination: All requests for benefits covered by plans must be subject to the same integrated organization determination process
- Integrated grievances: Plans must accept grievances filed orally or in writing at any time, consistent with Medicaid standards
- Integrated reconsiderations/appeals: Plans are permitted to have only one level of integrated reconsideration for an enrollee; enrollees must file an integrated reconsideration within 60 days of the denial, consistent with MA and Medicaid managed care requirements

Several commenters requested clarity regarding the circumstances under which providers may request organization determinations or integrated reconsiderations on behalf of an enrollee. In the Final Rule, CMS explicitly states that any providers that furnish, or intend to furnish, a service to an enrollee may request an integrated organization determination or an integrated reconsideration but may only request pre-service appeals without the enrollee's consent, and that they must provide notice to the enrollee of that request.

***Updates to MA and Part D Plan (PDP) Quality Rating System*:** Following an effort to improve the transparency of the Star Rating methodology and advance notice to plans in the CY 2019 Final Rule, the 2020 Final Rule updates specifications for three measures: 1) Controlling High Blood Pressure (Part C) (effective for 2022 Star Ratings); 2) Medicare Plan Finder (MPF) Price Accuracy (Part D) (effective for 2022 Star Ratings); and 3) Plan All-Cause Readmissions (Part C) (effective for 2023 Star Ratings). As required in regulation, the Controlling High Blood Pressure and the Plan All-Cause Readmissions measures will have a weight of 1 in the first year after being reintroduced back into the Star Ratings. CMS also finalized its proposal to exclude from the Improvement Measures calculation any measure that receives a measure-level Star Rating reduction for data integrity concerns for the current or prior year.

The Final Rule adopts enhancements to the cut-point methodology for measures effective for the 2022 Star Ratings, including implementation of a guardrail. The guardrail will provide some stability by capping the amount by which cut points will increase or decrease from year to year (no more than 5 percent). However, CMS declined to establish pre-determined cut points (such as pre-determined 4-star thresholds) in advance of the measurement period despite industry feedback.

With some changes, CMS made final its proposed methodology for calculating Star Ratings to account for extreme and uncontrollable circumstances, such as hurricanes and other natural disasters. This will apply to the 2020 measurement period and the 2022 Star Ratings. CMS received many comments related to the issue of socioeconomic status (SES) and Star Ratings, but indicated this issue was outside the scope of this regulation. Instead, CMS described ongoing efforts for identifying and addressing impact of social risk factors on quality measurement outcomes.

***Refinements to Preclusion List Requirements*.** In the 2019 Final Rule CMS eliminated the requirement that all prescribers and suppliers of services enroll in Medicare but announced that the agency would prohibit payment for Part D drugs and MA services prescribed or furnished by providers included on a "preclusion list". The preclusion list includes providers whose Medicare enrollment has been revoked as well as providers who present program integrity concerns. MA plans and PDP Sponsors are required to reject claims from providers on the preclusion list and implemented certain beneficiary protections, such as enabling access to a provisional drug supply. In the 2020 Final Rule, CMS continues to make refinements to its preclusion list policy, such as modifying the provider appeals process and requiring beneficiary notification. However, CMS declined to delay the effective date of the preclusion list. To avoid duplicative administrative processes, CMS also codified that a similar provider exclusion list created by the Office of Inspector General (OIG) will take precedence over CMS's preclusion list.

***Expansion of PDP Access to Part A and B Data*.** CMS made final its proposal to give PDP Sponsors access to enrollee Part A and B claims data for purposes of optimizing therapeutic outcomes, improving care coordination, engaging in fraud and abuse or compliance activities, and supporting other health care operations. Data will be available on a quarterly basis, upon a PDP Sponsor's request, provided in a standardized format. These data will include seven types of claims: inpatient, outpatient, carrier, durable medical equipment, hospice, home health, and skilled nursing facility. These data will not include Part C or D data, or HCC or RxHCC risk scores.

HMA continues to analyze these provisions and others included in the Final Rule. For more information or questions about HMA's Medicare Practice, please contact Mary Hsieh or Jon Blum.

Link to 2020 Medicare Advantage and Part D Flexibility Final Rule

HMA Medicaid Roundup

Alaska

House Committee Cuts Medicaid Spending, Imposes New Restrictions. *The Anchorage Daily News* reported on April 5, 2019, that Alaska's House Finance Committee reduced the budget for the state's Medicaid program by $58 million – less than the $249 million proposed by Governor Mike Dunleavy. The approved cuts include limits on retroactive Medicaid payment requests from providers and new restrictions on physical, occupational, and speech therapy. Read More

Alaska Pushes Ahead with Medicaid Block Grant Proposal. *KTOO* reported on April 3, 2019, that Alaska hopes to be the first state to receive Medicaid funding through a block grant. The initiative is backed by Alaska Governor Mike Dunleavy at the urging of Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma. Dunleavy also asked for the support of President Trump in a letter in March. Read More

Arizona

Health System Set to Reopen Hospital in Maryvale. *The Arizona Republic* reported on April 7, 2019, that Arizona's Maricopa Integrated Health System (MIHS) is scheduled to reopen its centrally located safety net hospital in Maryvale later this month. Funds for the renovation came from a voter-approved measure and MIHS. The hospital has been closed since 2017. Read More

Florida

Florida Announces Plan to Cancel Proposed Cuts for Providers Treating Children with Autism. *The South Florida Sun-Sentinel* reported on April 4, 2019, that the Florida Agency for Health Care Administration (AHCA) is halting plans that would have resulted in significant rate reductions to health care providers treating children with autism. Mary Mayhew, the newly appointed secretary of the AHCA, delayed the changes to the behavioral analysis program after holding a public meeting with advocates. AHCA also announced a Medicaid waiver, that if approved, would allow the state to provide affordable housing as part of its Medicaid program. Read More

Idaho

Idaho Enacts Medicaid Expansion, Seeks Work Requirement. *Modern Healthcare* reported on April 9, 2019, that Idaho Governor Brad Little signed into law a bill expanding Medicaid to an estimated 90,000 low-income individuals in the state. The bill also seeks a federal waiver for Medicaid work requirements and a waiver to allow certain Medicaid eligibles the option of receiving coverage on the state's health insurance Exchange. Read More

Kansas

Medicaid Expansion Dispute Delays Annual Budget Approval. *The Associated Press* reported on April 8, 2019, that a legislative dispute over Medicaid expansion has delayed approval of the fiscal 2020 Kansas state budget until May. Medicaid expansion is one of the remaining issues in budget negotiations between the House and Senate. Republican leaders seek a scaled-back expansion plan, compared to the one supported by Democratic Governor Laura Kelly. Republican leaders plan to designate a special committee to study alternatives. Read More

Lawmakers Consider Increasing Medicaid Dental Reimbursement Rates. *The Kansas City Star* reported on April 8, 2019, that Kansas lawmakers are considering an increase in Medicaid dental reimbursement rates in an effort to bring more dentists into the program. However, the increase being proposed is far less than what was lobbied for by the Kansas Dental Association. Less than one-third of the state's 1,400 dentists accept Medicaid, and rates haven't increased since 2001. Read More

Kentucky

Kentucky Cancels BrightSpring Health Services' Contract, Provider Certification. *The Louisville Courier Journal* reported on March 25, 2019, that the Kentucky Department for Behavioral, Developmental, and Intellectual Disabilities is canceling BrightSpring Health Services' management contract and provider certification for serving adults with intellectual disabilities. BrightSpring expects to lay off a total of 218 people, including 125 employees from the Bingham Gardens state-run center for adults with disabilities, and 93 employees from Community Alternatives Kentucky of Somerset. The state awarded Bluegrass the managed care contract for Bingham Gardens, effective February 14. BrightSpring is cooperating with the state while it decides whether to appeal the provider certification termination for Somerset. Read More

Louisiana

Louisiana Medicaid Is Under Scrutiny Over Improper Enrollments. *The Daily Advertiser/USA Today* reported on April 9, 2019, that Republican lawmakers in Louisiana renewed their attacks on how the state is managing its Medicaid program. The Louisiana Department of Health acknowledged during a House Appropriations Committee that thousands of individuals had received Medicaid coverage despite failing to meet income requirements. The state has been systematically removing these ineligible individuals from the Medicaid rolls. Read More

Maine

Maine Receives CMS Approval for Medicaid Expansion; Nearly 17,000 Individuals Are Already Enrolled. *WAGM* reported on April 4, 2019, that the Centers for Medicare & Medicaid Services (CMS) has approved Maine's state plan amendments for its voter-approved Medicaid expansion program. Governor Janet Mills issued an executive order last year to begin implementation of the program in January 2019. Nearly 17,000 individuals have been enrolled since January, with the state retroactively processing applications back to July 2018. Read More

Minnesota

BCBS-Minnesota Reports $47 million in Operating Earnings for Medicaid, MNCare Lines in 2018. *The Star Tribune* reported on April 9, 2019, that Blue Cross Blue Shield of Minnesota had operating earnings of $47 million in 2018 on its Prepaid Medical Assistance (Medicaid) and MinnesotaCare lines of business, after the state increased payment rates to health plans. The company's individual line of business also saw improvement. For the prior two years, operating losses for Medicaid and MNCare lines topped $200 million. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Nurses Avoid Strike, Reach Tentative Agreement with Hospitals. Members of the New York State Nurses Association (NYSNA) announced on April 9, 2019, a four-year tentative agreement with Mount Sinai Health System, New York-Presbyterian, and Montefiore Health System. The agreement, which expires December 31, 2022, includes language that would mandate hospital nurse-to-patient ratios, resulting in the hiring of 1,450 additional nurses. The tentative agreement now goes to full vote by NYSNA members. Read More

CMS Approves New York Children's Home and Community Based Service Waiver. On April 1, 2019, the Centers for Medicare & Medicaid Services (CMS) approved two waiver amendments as part of New York's Children's Medicaid System Transformation. The 1915(c) waiver amendment consolidates six previous 1915(c) waivers into a single waiver, so all children are eligible for the same set of benefits. The 1115 waiver amendment incorporates certain Medicaid State Plan behavioral health services into the Medicaid managed care benefit and adds home and community-based services authorized under the concurrent 1915(c) Children's Waiver in the managed care benefit package. The state's Children's Medicaid System Transformation is aimed at simplifying the delivery system for high needs children currently served under a number of different waiver programs, expanding care management, and adding new Home and Community Based Services to the Medicaid benefit. Read More

New York Foundation to Distribute $150 Million in Grants to Improve Health. The Mother Cabrini Foundation will be distributing up to $150 million in grants this year to organizations across New York State to "improve the health and well-being of vulnerable New Yorkers, bolster the health outcomes of diverse communities, eliminate barriers to care and bridge gaps in health services." The foundation was established last year as a result of the acquisition of Fidelis Care by Centene Corporation, and has assets of $3.2 billion. At the time, the foundation submitted a draft program guide to the Charities Bureau as part of its review of the transaction. They named a Board of Directors, but since then have had no visibility. Mother Cabrini recently launched a web site that names the executive staff, including Monsignor Gregory Mustaciuolo, formerly Vicar General and Chancellor of the Archdiocese of New York as CEO and Deborah Konopko, a former Pataki Administration official, as COO. For its 2019 funding priorities the foundation has identified a number of vulnerable populations:

- low income individuals and families;
- older adults;
- immigrants and migrant workers;
- formerly incarcerated individuals;
- persons with special needs;
- veterans;
- young children, pregnant women and new moms; and
- youth and young adults

Further information about how to apply for grants will be available mid-April. Read More

North Carolina

House Republicans Reintroduce Medicaid Expansion Bill. *The Winston-Salem Journal* reported on April 9, 2019, that a group of North Carolina House Republicans led by Rep. Donny Lambeth (R-Forsyth) have reintroduced a Medicaid expansion bill, including work requirements, monthly premiums, and a tax on health plans and providers to cover the state's 10 percent share of the cost. The bill is now called NC Health Care for Working Families, but it mirrors Lambeth's previous Carolina Cares expansion measure, which stalled in committee because of lack of Republican support. Read More

North Dakota

House Panel Rejects Proposal to Shift Medicaid Expansion from Managed Care to Fee-for-Service. *The Bismarck Tribune* reported on April 9, 2019, that a North Dakota House committee rejected a proposal to transition the state's Medicaid expansion program from managed care to fee-for-service. The proposal from Governor Doug Burgum also would have cut provider reimbursement rates. Sanford Health Plan holds the contract to manage the state's expansion population. Read More

Pennsylvania

Court Rules UPMC-Highmark Consent Decree to End June 30. *The Pittsburgh Post-Gazette* reported on April 3, 2019, that Pennsylvania Commonwealth Court Judge Robert Simpson ruled that the UPMC-Highmark consent decree will come to an end June 30 as planned. Pennsylvania Attorney General, Josh Shapiro, has already said he will issue an appeal. Shapiro's office petitioned the court in February to force UPMC to extend the consent decrees but was initially denied the request. The original termination date of June 30 was decided last summer, when the State Supreme Court settled a dispute between Highmark and UPMC over whether Highmark Medicare Advantage members would lose access to UPMC doctors and hospitals. Read More

Texas

Legislative Agency Reports Medicaid Quality Problems. *The Texas Tribune* reported on April 8, 2019, that a series of biannual reports from the Texas Legislative Budget Board revealed that state-funded mental health services were reaching less than 20 percent of eligible individuals and that 70 percent of newborns weren't able to receive timely health screenings. The reports, which were made public for the first time, are designed to guide legislation by outlining inefficiencies in state government. Read More

West Virginia

Family Health Will Not Renew Medicaid Contract. *West Virginia Metro News* reported on April 5, 2019, that West Virginia Family Health (WVFH) will not be renewing its Medicaid managed care contract with the state. WVFH, which is owned by Highmark Health, is working with the state and the Bureau for Medical Services to help transition an estimated 60,000 WVFH members. The contract is set to expire on June 30. Read More

National

Hospitals, Insurers Urge CMS to Amend Proposed Medicare Part D, Medicaid Managed Care Drug Rebate Rule. *Modern Healthcare* reported on April 8, 2019, that hospitals and insurers are urging the Centers for Medicare & Medicaid Services (CMS) to amend a proposed rule, which would institute a safe harbor for point-of-sale discounts in place of safe harbors for Medicare Part D and Medicaid managed care drug rebates. America's Health Insurance Plans recommended that the rule should also require drug makers to disclose research and development costs and to explain prices and price increase. The American Hospital Association called for incentives for drug makers to lower list prices. The proposed rule would go into effect January 1, 2020, which insurers and hospitals say is too soon to adjust to pricing. Read More

CMMI Director Considers Bundled Payments for Post-Acute Care. *Modern Healthcare* reported on April 8, 2019, that Adam Boehler, director of the Center for Medicare & Medicaid Innovation (CMMI), is seeking hospital input on potential bundled payment models for post-acute care. Boehler told attendees at the American Hospital Association annual meeting that he is considering bundled payment, noting a flood of industry interest. Boehler declined to provider a timeline, but noted that nothing is imminent. Read More

Trump Administration to Release ACA Replacement Proposal. *The Hill* reported on April 7, 2019, that the Trump administration will "fairly shortly" release a proposed replacement for the Affordable Care Act (ACA), according to acting White House chief of staff Mick Mulvaney. Health and Human Services Secretary Alex Azar and administrator of the Centers for Medicare & Medicaid Services (CMS) Seema Verma met with other administration officials over the weekend to discuss possible proposals. This follows last week's news that the Senate would not work on a comprehensive health care package to replace the ACA before the 2020 election. Read More

Medicaid Expansion Linked to Fewer Cardiovascular Deaths, Study Suggests. *CNN* reported on April 5, 2019, that counties in states that expanded Medicaid had fewer cardiovascular-related deaths annually compared to states that didn't expand Medicaid, according to a study presented at the American Heart Association's Scientific Sessions. The study, which is based on mortality data for adults ages 45 to 64, found that cardiovascular-related deaths rose from 141.9 to 142 per 100,000 in expansion states from 2010 to 2016. Over the same period, cardiovascular-related deaths in non-expansion states rose from 176.1 to 180,6 per 100,000. Read More

Medicaid HCBS Enrollment Hits 4.6 Million in 2017, Kaiser Study Says. The Kaiser Family Foundation reported on April 4, 2019, that about 4.6 million Medicaid enrollees received Medicaid home and community-based services (HCBS) in 2017, with joint federal and state spending totaling $82.7 billion. Data in the Kaiser study includes Medicaid HCBS provided through home health, personal care, Community First Choice (CFC), and Section 1915 (i), 1915 (c) and 1115 waivers. Read More

MACPAC Meeting Is Scheduled for April 11-12. The Medicaid and CHIP Payment and Access Commission (MACPAC) announced on April 8, 2019, that its next meeting will be held April 11-12. Topics to be discussed are:

- Prescription Drug Policy: Grace Period and Cap on Rebates
- Treatment of Third-Party Payment
- Medicaid Program Integrity
- Therapeutic Foster Care
- Utilization Management of Medication-Assisted Treatment
- Medicaid in Puerto Rico
- Interoperability in Federal Health Care Programs
- Evaluation of Integrated Care. Read More

Industry News

CareSource Awards PBM Contract to Express Scripts. *The Akron Beacon Journal/The Columbus Dispatch* reported on April 9, 2019, that Express Scripts has won a contract to provide pharmacy benefit management services to CareSource, the largest Medicaid managed care plan in Ohio, effective January 1, 2020. The arrangement stresses transparency, a custom pharmacy network, and value-based programs, including the leveraging of Express Scripts' "claims management technology to power pharmacy innovation." CareSource's existing contract with CVS Caremark expires December 31, 2019. Read More

Great Point Partners Finalizes Recapitalization of Little Spurs Pediatric Urgent Care. Great Point Partners announced on April 4, 2019, that it has finalized a growth recapitalization of pediatric urgent care service provider Little Spurs Pediatric Urgent Care, which operates 12 clinics in Texas. Little Spurs treats children with acute illnesses and injuries in an urgent care setting. Read More

Community Health Centers Are More Financially Stable Following Medicaid Expansion, Study Finds. *U.S News & World Report* reported on April 4, 2019, that community health centers operating in states with Medicaid expansion programs are more financially stable than those in non-expansion states, according to a survey from The Commonwealth Fund. The survey of nearly 700 health center officials points to increases in the number of insured patients in expansion states as a key factor in the improved financial results. Centers in expansions states also reported greater ability to provide affordable coverage, expand services, and upgrade facilities than centers in non-expansion states. Read More

Health Quest, Western Connecticut Health Network Merge to Form Nuvance Health. *Crain's New York Business* reported on April 3, 2019, that Health Quest, a Dutchess County, New York-based hospital system, and Danbury-based Western Connecticut Health Network have completed their previously announced merger. The combined seven-hospital not-for-profit system, now called Nuvance Health, has projected annual revenues of $2.4 billion. Merger plans were announced in March 2018. Read More

Clear Spring Health to Acquire CCAI. Clear Spring Health announced on April 4, 2019, that it has struck an agreement to acquire and re-capitalize Community Care Alliance of Illinois (CCAI) out of rehabilitation. CCAI is a not-for-profit managed care organization contracted to offer Medicare benefits. The deal is pending regulatory approval. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Ohio	RFP Release	2,360,000
2019	Hawaii	RFP Release	360,000
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
April 29, 2019	Louisiana	Proposals Due	1,500,000
May 17, 2019	Minnesota MA Families and Children; MinnesotaCare	Proposals Due	679,000
May 17, 2019	Minnesota Senior Health Options; Senior Care Plus	Proposals Due	55,000
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 1, 2019	Idaho Medicaid Plus (Dual) -Bonner, Kootenai, Nez Perce Counties	Implementation	
June 28, 2019	Texas STAR+PLUS	Contract Start Date	530,000
June 28, 2019	Louisiana	Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
July 1, 2019	Washington Integrated Managed Care - North Sound (Island, San Juan, Skagit, Snohomish, and Whatcom Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
July 9, 2019	Oregon CCO 2.0	Awards	840,000
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
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
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
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	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
January 1, 2020	Washington Integrated Managed Care - Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum Counties); Salish (Clallam, Jefferson, and Kitsap Counties); Thurston-Mason (Mason and Thurston Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
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
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	315,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	960,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	148,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	265,500
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

COMPANY

MCG Health's Dr. William Rifkin to Speak at 2019 ACMA National Conference

HMA News

Upcoming Webinars:
April 16, 2019 - Rethinking Behavioral Health Crisis Systems: Saving Lives, Saving Resources. Register here

April 17, 2019 - Activating Local Communities to Successfully Address Opioid Addiction and Recovery. Register here

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- California Medicaid Managed Care Enrollment is Down 0.7%, Mar-19 Data
- Georgia Medicaid Management Care Enrollment is Up 1.5%, Apr-19
- Kentucky Medicaid Managed Care Enrollment is Flat, Apr-19 Data
- Kentucky Medicaid Managed Care Enrollment is Flat, Mar-19 Data
- Louisiana Medicaid Managed Care Enrollment is Up 1.6%, Feb-19 Data
- Michigan Medicaid Managed Care Enrollment is Up 0.5%, Mar-19 Data
- Minnesota Medicaid Managed Care Enrollment is Down 4.0%, Mar-19 Data
- West Virginia Medicaid Managed Care Enrollment is Down 1.4%, Apr-19 Data
- California Dual Demo Enrollment is Down 2.4%, Mar-19 Data
- Michigan Dual Demo Enrollment is Down 2.8%, Mar-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Alabama Independent Disproportionate Share Hospital (DSH) Audit RFP and Amendment, Apr-19
- Idaho Medicaid Plus Plan Model Contract, 2018
- Idaho Medicare Medicaid Coordinated Plan Model Contract, 2019
- Nevada Women's Health Connection (WHC) Program RFP, Apr-19
- Virginia Focused Stakeholder Engagement for Medicaid Expansion Efforts RFP and Award, Apr-19

Medicaid Program Reports, Data and Updates:

- Arkansas Governor's Proposed Budget, FY 2019-2021
- Arkansas Works 1115 Waiver Amendment and Related Documents, 2016-18
- Arizona AHCCCS Works 1115 Waiver Amendment Request and Related Documents, Jan-19
- California Medicaid Managed Care Sanctions for Failure to Meet Minimum Performance Levels, Oct-18
- California Medi-Cal Managed Care Performance Dashboard, Mar-19
- Connecticut Improving Behavioral Health Outcomes for HUSKY Members Presentation, 2018
- DC DCHF Mayor's Proposed Budget, FY 2020
- Hawaii Quest Integration 1115 Waiver Renewal Approval, Application and Other Related Documents, Oct-18
- Indiana Medicaid Managed Care Demographics by Age, Aid Category, and Program, 2016-18, Feb-19

- Kansas KanCare 2.0 1115 Waiver Renewal Approval, Application and Other Related Documents, Dec-18
- Maine Medicaid Expansion State Plan Amendments with Approvals, Apr-19
- Michigan Medicaid Health Plan External Quality Review Report, 2014-17
- North Carolina Medicaid LME-MCO Financials, CY 2018
- Pennsylvania DHS Opioids and Opioid Dependency Agents Utilization Update, Sep-18
- Rhode Island Long Term Care Services and Finance Performance Report, Apr-19
- South Carolina Senate Finance Committee Medicaid Budget Request Slides, SFY 2020
- Texas Legislative Budget Board Medicaid Reports, 2019
- Utah Medicaid Expansion FAQs and Comparison Chart, Feb-19
- Utah Medical Care Advisory Committee Meeting Materials, Mar-19

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