HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 9, 2018

RFP CALENDAR

HMA News

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IN FOCUS

ELECTRONIC VISIT VERIFICATION: IMPLICATIONS FOR STATES, PROVIDERS, AND MEDICAID PARTICIPANTS

This week, our *In Focus*, written by HMA Principal Jen Burnett in collaboration with the National Association of States United for Aging and Disabilities (NASUAD), summarizes key considerations and policy decisions that states should consider as they work to implement electronic visit verification (EVV) systems in accordance with the mandate included in the 21st Century Cures Act. The full paper, which is titled *Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants* is available by clicking here.

On January 1, 2019, new federal requirements for EVV go into effect, requiring the use of EVV for Medicaid funded personal care services. EVV technology has been available for more than two decades, but prior to the passage of the CURES Act, EVV was optional for states, providers, and managed care organizations (MCOs). It requires state Medicaid programs to implement EVV for Medicaid-funded personal care services by January 2019, and for Medicaid-funded home health care services by January 2023. This summary highlights the current state of EVV; the new requirements set forth in the CURES Act; the role of the Centers for Medicare & Medicaid Services (CMS); and the approaches states may consider.

EVV: What It Is and How It Is Currently Being Used

EVV technology verifies that home and community-based services are delivered to individuals needing those services. Originally patented in 1996, EVV technology continues to evolve and improve, with multiple vendors available to states, managed care organizations (MCOs), and providers. There are several technologies used for EVV, including:

- Telephone timekeeping with telephony: Requires the use of the individual's telephone at the time of the visit. It can utilize a landline available in their home, or a smartphone/cell phone used by the personal care provider or the individual when a landline is not available.
- Web or phone-based applications using Global Positioning Service (GPS) verification: Relies on a mobile application, which is a GPS-enabled "clock" that indicates when service begins and ends. The worker "clocks in" and "clocks out" using their smartphone or tablet.
- One-time password generator using a key Fixed Object (FOB): Uses a "fixed object," known as a key FOB, which is placed in the home of the individual and is attached to something in the home, like a drawer pull. The FOB generates a one-time password or code when the service provider arrives and when they leave.
- Biometrics: Verifies that the appropriate personal care service worker or home health care worker is the person providing the service using biometric identifiers such as voice recognition, fingerprints, iris or facial scan.

The New Driver Behind EVV: The 21st Century CURES Act

Enacted on December 13, 2016, the CURES Act is considered to be landmark legislation for health care quality improvement through innovation. Section 12006 of the CURES Act requires state Medicaid programs to implement EVV for personal care and home health care, or face reductions in their federal medical assistance percentage (FMAP) beginning in 2019 for personal care services, and in 2023 for home health care services. Drivers behind the EVV mandate in the Cures Act include a projected 26 percent growth in personal care service providers from 2014–2024, due to demographic growth in the population needing these services, but more importantly, because people prefer to receive services in their own homes.

IMPLEMENTING EVV: THE ROLE OF CMS

The CURES Act sets forth specific CMS responsibilities related to EVV. These include:

- Collecting and disseminating best practices to state Medicaid directors, with respect to training individuals who furnish personal care or home health services, as well as family caregivers and participants.
- Tracking state progress and implementation timeframes, and making adjustments to the FMAP paid to states that do not meet compliance deadlines, in accordance with the reductions outlined in Table 1 below:

TABLE 1. SCHEDULE OF FMAP REDUCTIONS FOR NON-COMPLIANCE

YEAR	PERSONAL CARE	HOME HEALTH
2019	.25%	N/A
2020	.25%	N/A
2021	.5%	N/A
2022	.75%	N/A
2023	1%	.25%
2024	1%	.25%
2025	1%	.5%
2026	1%	.75%
2027 & after	1%	1%

- Providing assistance to states and other stakeholders, including surveys and webinars (for links to CMS presentations related to this assistance, see the full report).
- Establishing and managing an Advanced Planning Document process for review and approval/disapproval of state requests for enhanced match when the EVV system is operated by the state (or a contractor) as part of the Medicaid Enterprise System.

Implementing EVV: What States Need to Know

The CURES ACT sets forth state responsibilities and FMAP regarding the implementation of EVV. These include:

- The consequences for not complying with the law: FMAP reductions and timeframes are specified in Table 1 above.
- Specific elements that must be electronically verified, including:
  - The type of service performed;
  - The individual receiving the service;
  - The date of the service;
  - The location of service delivery;
  - The individual providing the service; and
  - The time the service begins and ends.
- Expectations for stakeholder engagement and training: The CURES Act requires states to take into account the considerations of a variety of stakeholders as they plan, design and implement EVV, including providers, participants, family caregivers, people who provide direct care, and other stakeholders.

Implementing EVV: State Program Design and Implementation

A 2017 National Association of Medicaid Directors/CMS survey of states found that there is wide variation in the status of implementation with less than a year to go before the implementation deadline. While not all states responded to the survey, CMS identified five design approaches to EVV implementation and shared them with states/stakeholders in December 2017. CMS identified five design models:

- Provider Choice: The state sets minimum standards for the EVV system and allows each provider to select their own vendor or system to use.
- Managed Care Organization Choice: In states that use MCOs to deliver some or all Medicaid funded personal care services or home health care services, the state could allow MCOs to select their own EVV vendor (akin to the provider choice model). MCO network providers would then use the EVV system mandated by the MCO with which they are contracted.
- State-Procured Vendor: The state competitively procures an EVV vendor that all providers in the state must use.
- State-Developed Solution: The state develops its own EVV system. Similar to the procured vendor model, the system is funded by the state and operates statewide.
- Open Vendor: This model provides both a statewide, state-managed (either procured or state-developed) system which is available to providers or MCOs who wish to use it, but also allows providers and MCOs to select their own EVV vendor.

Jen Burnett can be reached at jburnett@healthmanagement.com.

Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants Paper

HMA Medicaid Roundup

Alaska

Alaska Senate Committee to Review Medicaid Work Requirements Bill. *KTVA* reported on May 1, 2018, that Alaska lawmakers are considering work requirements for Medicaid recipients. Legislation being reviewed by the Alaska Senate Finance Committee calls for able-bodied adult recipients to work a minimum of 20 hours a week or participate in volunteer work, subsistence activities, education, or training. The bill could impact an estimated 25,000 individuals currently enrolled in Medicaid. Read More

California

California Audit Finds Poor Care in Nursing Homes. *The Los Angeles Times* reported on May 3, 2018, that a California state audit found poor care in nursing homes. According to the audit, the California Department of Public Health (CDPH) has not performed necessary inspections or issued timely citations for substandard care, resulting in an increased number of incidents that could cause serious injury or death. The audit also found that CDPH nursing home licensing decisions were inconsistent and lacking in transparency. The audit was ordered by Assemblyman Jim Wood (D-Healdsburg) and Senator Mike McGuire (D-Healdsburg). Read More

Georgia

Governor Vetoes Bill Creating Health Care Council. *Georgia Health News* reported on May 8, 2018, that Georgia Governor Nathan Deal has vetoed a bipartisan bill that would have created a health care council and advisory board aimed at tackling health care access, effectiveness, and cost of care issues in the state. Deal said the bill would create unnecessary additional levels of government. Read More

Florida

Florida Medicaid Secretary Acknowledges Opposition to Reduction in Medicaid Retroactive Eligibility. *Health News Florida* reported on May 9, 2018, that Florida deputy secretary for Medicaid Beth Kidder admitted to federal regulators that there was opposition from some Democratic lawmakers to the state's proposed reduction in Medicaid retroactive eligibility from 90 to 30 days. Kidder's letter to the Centers for Medicare & Medicaid Services comes after Senate Minority Leader Audrey Gibson (D-Jacksonville) slammed the Florida Agency for Health Care for failing to acknowledge any opposition. Read More

Lawmaker Calls for Federal Review of Proposed Reduction in Medicaid Retroactive Eligibility. *Health News Florida* reported on May 8, 2018, that incoming Florida Senate Minority Leader Audrey Gibson (D-Jacksonville) has called for a thorough review by federal regulators of a proposal that would cut Medicaid retroactive eligibility in the state from 90 to 30 days. In a letter to the Centers for Medicare & Medicaid Services, Gibson also criticized the state Medicaid agency for downplaying opposition to the proposal. The Florida Agency for Health Care Administration projects that the change would impact about 39,000 people and save the state $98 million. Read More

Illinois

Illinois to Expand Medicaid Mental Health, Substance Abuse Treatments. *NPR Illinois* reported on May 8, 2018, that federal officials have approved the Better Care Illinois Behavioral Health Initiative, a $2 billion state program that will expand Medicaid mental health and substance abuse treatments in Illinois. The initiative will fund 10 pilot programs beginning as early as July. Read More

Kansas

CMS Rejects Kansas Medicaid Lifetime Limit Waiver Proposal. *The Hill* reported on May 7, 2018, that federal regulators rejected a Kansas waiver request to impose a three-year lifetime limit on Medicaid benefits. Seema Verma, administrator of Centers for Medicare & Medicaid Services Administrator, said that while the Trump administration wants to create a "pathway out of poverty" through initiatives like work requirements, it also wants Medicaid to be available when people need it. As previously reported, a final decision on the waiver had been delayed amid disagreement within the administration. Read More

Kansas Lawmakers Reach Medicaid Compromise. *KCUR* reported on May 3, 2018, that Kansas lawmakers have reached a budget bill comprise that would block Governor Jeff Colyer from implementing Medicaid work requirements and a lifetime cap under the planned KanCare 2.0 waiver renewal. The administration could continue discussions with federal officials about eligibility changes but changes could not be made without the Legislature's approval. Read More

Louisiana

Louisiana Medicaid Cuts Could Force 37,000 Out of Nursing Homes. *CNN* reported on May 9, 2018, that proposed cuts to the Medicaid budget in Louisiana could force 37,000 individuals out of nursing homes and group homes, according to the Louisiana Department of Health. The House-approved budget would cut $538 million from health care services, including four Medicaid programs for the disabled and elderly. One such program is the Medicaid Long Term Care Special Income Level Program, which provides Medicaid coverage to individuals with incomes of $750 to $2,250 a month, accounting for 80 percent of nursing home residents. The Senate has yet to vote on a budget. Read More

Massachusetts

Harvard Pilgrim Health Care, Partners Healthcare in Merger Discussions. *Wbur* reported on May 4, 2018, that Partners Healthcare, the largest Massachusetts hospital network, and Harvard Pilgrim Health Care, the second largest health insurer in the state, began merger talks last year and are close to signing a letter of intent. The deal would be subject to state and federal antitrust reviews. Read More

Minnesota

Minnesota Medicaid Plans Trim Losses in 2017. *Insurancenewsnet.com* reported on May 5, 2018, that Medicaid managed care plans in Minnesota trimmed losses significantly in 2017. An analysis of regulatory fillings among four large not-for-profit plans – Blue Cross Blue Shield of Minnesota, HealthPartners, Medica and UCare – shows a 2017 loss of $53.7 million in the state's Medicaid and MinnesotaCare lines of business, compared to a loss of $344.7 million in 2016. As previously reported, Minnesota not-for-profit plans overall reported net income of $307.9 million in 2017 on revenues of $27.6 billion. A request for proposals for Medicaid and MinnesotaCare in the Twin Cities metro area is anticipated to be released early next year. Read More

New Hampshire

New Hampshire Gains Approval for Medicaid Work Requirements. *The Hill* reported on May 7, 2018, that the Centers for Medicare & Medicaid Services (CMS) has approved a New Hampshire 1115 waiver request allowing the state to implement Medicaid work requirements. Medicaid members ages 19 to 64 must complete 100 hours a month of work, school, or community service to be eligible for benefits. CMS has approved similar requirements in Indiana, Arkansas, and Kentucky. Read More

New Hampshire House Passes Medicaid Expansion Extension With Work Requirements; Governor Supports Legislation. *The Concord Monitor* reported on May 3, 2018, that New Hampshire Governor Chris Sununu supports a state House decision to extend Medicaid expansion for approximately 50,000 individuals, including work requirements. The House made minor changes to the Senate version approved earlier this year. The Senate could now agree to those changes or call for a conference committee. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Attorney General Resigns. *Crain's HealthPulse* reported on May 8, 2018, that New York Attorney General, Eric Schneiderman, has resigned after accusations of physical assault against four women. How this affects Centene Corp.'s plan to acquire Fidelis Care is unclear. Approval by the Attorney General is required before the deal can be finalized; the deal has already received approval from the Department of Health and the Department of Financial Services. Centene had hoped to finalize the transaction in the next few months. The State Solicitor General, Barbara Underwood, has been named as acting Attorney General until the legislature names a new interim Attorney General.

Fidelis Care has already announced its plans for a charitable foundation, to be funded by the proceeds from the sale. The foundation, with assets of $3.2 million, will be known as the Mother Cabrini Health Foundation. It plans to invest in health care and health-related causes, such as the social determinants of health. Read More

New York Citizens Budget Commission Releases Health Home Paper. The Citizens Budget Commission hosted a symposium to share a recently-released paper that reviews the experience of New York's Health Home initiative. Charles Brecher, principal author of the report, noted that New York is now spending over $500 million/year on the health home initiative, but argued that the program is not targeting Medicaid beneficiaries who could most benefit from the program. He noted that the people who could most benefit from the program are also the hardest to reach. The paper lays out a series of options that the Department of Health should consider, including better targeting of priority populations, greater reliance on specialized health home entities that have greater reach within targeted populations, and stronger ties between managed care plans and health homes. A video recording of the symposium, as well as a copy of the report, can be found here.

New York to Begin Managed Long-Term Care Plan Closure Oversight. As part of the 2019 enacted budget, the New York Department of Health will begin monitoring what happens to Medicaid beneficiaries enrolled in managed long-term care (MLTC) plans when they are transferred to a different plan due to closure of their plan. As of April 2018, any MLTC that receives new members as a result of merger or acquisition of another MLTC will be required to file a report with the Department of Health that documents the hours of personal care each enrollee was receiving at the time of the transfer; the hours of personal care each enrollee was receiving one year after the time of the transfer; the percent change in hours of personal care; and in the event the hours of personal care provided have declined, an explanation why the hours have declined with supporting documentation. For plans that have acquired more than 1,000 transferred enrollees, the Department will identify a representative random sample of members to be reviewed. Read More

New York Releases Health Workforce Retraining Initiative Request for Applications. The New York Department of Health is soliciting applications from organizations proposing to train or retrain health industry workers to obtain new positions, meet the new job requirements of existing positions, or otherwise meet the requirements of the changing public health and health care market. Up to $18,320,000 is available under the Request for Applications for a two-year period. Applications are due on June 22, with an anticipated award in October. This funding is in addition to workforce retraining commitments made by Performing Provider Systems as part of the DSRIP program. At the start of DSRIP, PPSs committed to spending $415M over 5 years on workforce transformation; at the DSRIP halfway point, they had spent $247.5M. Read More

New York Distributes Funds for Medicaid Managed Long-Term Care Workforce Investment Program. The New York Department of Health has distributed $58 million under the Medicaid Managed Long-Term Care Workforce Investment Program. The program, part of New York's Medicaid Redesign Team efforts, will allocate up to $245 million to prepare workers for a changing long-term care environment. The Workforce Investment Program aims to identify areas that have a shortage of long-term care workers and expand home care so more people can remain in their communities instead of going to nursing homes or hospitals. The funding is directed to workforce training entities that then enter into contracts with managed long-term care plans to provide trainings. 1199SEIU's Homecare Industry Education Fund received $21.5 million, the single largest award. Read More

New York Attorney General Posts Fidelis Care Petition to Sell Assets to Centene Corporation for Public Comment. The Office of the Attorney General of New York has posted a petition submitted by Fidelis Care regarding the sale of its assets to Centene Corporation for public comment. The acquisition has already been approved by the Department of Health and the Department of Financial Services. The Attorney General's review falls under the state's not-for-profit conversion law, which regulates the transfer of assets from a not-for-profit to a for-profit entity, to assure the public good is being protected. The petition can be found on the website of the Attorney General, https://ag.ny.gov/Fidelis. The Office of the Attorney General will be accepting public comments via e-mail only through May 23rd at Fidelis.Transaction@ag.ny.gov. It will review all public comments prior to making a final decision on the petition.

North Dakota

North Dakota Considers Reinsurance Waiver for Exchange Market. *CQ Health* reported on May 8, 2018, that North Dakota has commissioned a study to evaluate a possible reinsurance waiver aimed at lowering health care Exchange premiums and broadening the insurance pool by attracting young, healthy individuals to the state's individual market. Under the plan, the state would continue to require all essential health benefits and coverage for individuals with pre-existing conditions. Alaska, Minnesota, and Oregon have all obtained reinsurance waivers. Louisiana, Maine, and Wisconsin are currently pursuing such waivers. Read More

Ohio

Ohio Workers' Compensation Analysis Finds Pharmacy Benefit Manager Overcharged Agency. *The Columbus Dispatch* reported on May 4, 2018, that an analysis conducted on behalf of the Ohio Bureau of Workers' Compensation found the program pharmacy benefit manager (PBM), OptumRx, overcharged the agency $5.6 million in 2017. The analysis conducted by Healthplan Data Solutions indicated the PBM was paying pharmacists less to fill prescriptions than they were charging the state. Healthplan Data Solutions has been hired by the Ohio Department of Medicaid to examine pharmacy costs in the Medicaid program. The Medicaid analysis is expected to be completed in June. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania House Passes Bill to Improve Mental Health Emergency Services, Senate Vote Pending. The Pennsylvania House of Representatives unanimously passed House Bill 1997, which provides for the medical assistance deemed eligibility program for inpatient behavioral health services. Patients in crisis would be "deemed eligible" for behavioral health services, automatically enrolled in a local behavioral health managed care organization (BHMCO), and receive these services immediately while their medical assistance application is being reviewed. The intent is to avoid higher emergency room costs and prevent, if possible, these individuals from becoming involved in the criminal justice system. Read More

Texas

HHSC Commissioner Retires Amid Contract Scrutiny. *Dallas News* reported on May 4, 2018, that the executive commissioner for the Texas Health and Human Services Commission, Charles Smith, will retire on May 31, 2018. Former state Sen. Tommy Williams will serve as interim executive commissioner. The announcement comes after the state was forced to cancel managed care contracts for the Children's Health Insurance Program in rural and south Texas because of scoring errors. Read More

Utah

Medicaid Expansion to Appear on Utah Ballot. *U.S. News and World Report* reported on May 4, 2018, that advocacy group Utah Decides Healthcare has gathered enough signatures to place Medicaid expansion on the Utah ballot in November. The program would cover a projected 150,000 individuals and would cost the state approximately $80 million, with the federal government contributing $700 million. The state share would be paid for by an increase in sales tax. Separately, the state has its own proposal for a partial expansion covering 70,000 individuals, which includes work requirements. Read More

Virginia

2 Virginia Exchange Plans Propose Double-Digit 2019 Premium Rate Increases. *The Hill* reported on May 4, 2018, that Virginia Exchange plan CareFirst Blue Cross Blue Shield has requested an average 2019 premium rate increase of 64 percent, while Cigna has requested an increase of 15 percent. Both plans blamed repeal of the individual mandate in part for the price hike. A third plan, Optima, has proposed a 5 percent decrease in 2019 rates, while others have yet to post rate requests for next year. Read More

National

Trump to Request $7 Billion in CHIP Cuts. *Reuters* reported on May 7, 2018, that President Trump will ask Congress for $7 billion in cuts to the Children's Health Insurance Program (CHIP). A senior Trump administration official argued that the reductions would not negatively affect the program, adding that $5 billion of the CHIP cuts would come from an account that is not authorized to be spent under current law. Read More

HHS Proposes Further Delay in 340B Ceiling Regulation. *Modern Healthcare* reported on May 4, 2018, that the U.S. Department of Health and Human Services (HHS) has proposed a year-long delay to a rule that sets drug ceiling prices in the 340B drug discount program to further explore concerns about the program. The program, which was supposed to start July 1, has been delayed four other times already. Read More

FDA Commissioner Considers Changes to Drug Rebate Law. *Modern Healthcare* reported on May 3, 2018, that the Trump administration is considering changes to drug rebate laws in hopes of reducing drug prices. "What if we took on this system directly, by having the federal government re-examine the current safe harbor for drug rebates?" said Scott Gottlieb, M.D, commissioner of the U.S. Food and Drug Administration. Opponents of rebates say the savings accrued by pharmacy benefit managers aren't passed onto consumers. Read More

Industry News

Slavitt Forms Venture Firm to Focus on High Needs Populations. *Modern Healthcare* reported on May 8, 2018, that Town Hall Ventures, a new venture capital firm led by former Centers for Medicare & Medicaid Services Administrator Andy Slavitt, will invest in technology and service companies focused on low-income, high-needs populations. Slavitt sees opportunities among Medicare and Medicaid plans, hospitals, post-acute providers, and others who serve this population. Read More

Simplura Health Group Acquires Keystone In-Home Care. One Equity Partners announced on May 9, 2018, that its portfolio company, Simplura Health Group (formerly All Metro Health Care), has completed the acquisition of Keystone In-Home Care, a Pennsylvania-based provider of customized, in-residence care services for seniors and individuals with disabilities. Keystone will become part of CareGivers America. Financial terms were not disclosed. Simplura currently operates in five states. Read More

COMPANY ANNOUNCEMENTS

MCG Health's Dr. Monique Yohanan to Join Panel Discussion on the Opioid Crisis at 2018 Medicare Advantage Summit

MCG Health Integrates Chronic Care Guidelines into Casenet's TruCare Population Health Management Platform

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/Summer 2018	North Carolina	RFP Release	1,500,000
May 21, 2018	Iowa	Contract Awards	600,000
May 23, 2018	Minnesota Special Needs BasicCare	Proposals Due	53,000 in Program; RFP Covers Subset
May 30, 2018	New Hampshire	RFP Release	160,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 7, 2018	Alabama ICN (MLTSS)	Proposals Due	25,000
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 1, 2018	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 11, 2018	Alabama ICN (MLTSS)	Contract Award	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 1, 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 or Rebid 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 - Partnership Opportunities for Payers, Providers and States: Supportive Housing for High Utilizers on June 7, 1–2 EDT. Read More

New this week on HMA Information Services (HMAIS):

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- DC Medicaid Information Technology Architecture 3.0 State Self-Assessment RFP, May-18
- Vermont Coordination of Benefits RFI, Apr-18
- Virginia MEDALLION 4.0 Managed Care RFP, Notice of Award, and Related Documents, 2017-18
- Washington Medicaid Managed Care Dental RFP, May-18

Medicaid Program Reports and Updates:

- Illinois Medicaid Advisory Committee Meeting Materials, May-18
- North Carolina Medical Care Advisory Committee Meeting Materials, Apr-18
- Virginia Commonwealth Coordinated Care Plus Advisory Committee Meeting Materials, Mar-18
- Nevada Medical Care Advisory Committee Meeting Materials, Apr-18
- Utah Medical Care Advisory Committee Meeting Materials, Apr-18
- Oregon Medicaid Advisory Committee Meeting Materials, Apr-18
- Maryland Medicaid Advisory Committee Meeting Materials, Apr-18

Medicaid Data and Updates:

- South Carolina Medicaid Managed Care Enrollment is Up 1.3%, Apr-18 Data
- South Carolina Medicaid Managed Care Enrollment Share by Plan, Apr-18 Data
- Maryland Medicaid Managed Care Enrollment Share by Plan, Mar-18 Data
- Maryland Medicaid Managed Care Enrollment is Up 2.4%, Mar-18 Data
- Utah Medicaid Managed Care Enrollment is Flat, Apr-18 Data
- Utah Medicaid Managed Care Enrollment Share by Plan, Apr-18 Data
- Arizona Medicaid Managed Care Enrollment Share by Plan, Apr-18 Data
- Arizona Medicaid Managed Care Enrollment is Down 2.9%, Apr-18 Data

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HMA WELCOMES

Heidi Emerson – Senior Consultant
Heidi Emerson joins HMA most recently from Massachusetts Executive Office of Health and Human Services where she served as a contractor, MassHealth. In this role, she supported the development and implementation of the statewide investments program to increase the capacity of Accountable Care Organizations, community partners, and community services agencies to participate in MassHealth's payment and delivery system reform initiatives. She conducted interviews, performed environmental scans and assisted with procurement.

Prior to Massachusetts Executive Office of Health and Human Services (EOHHS), Heidi served as deputy director and manager of state affairs at National Association of Community Health Centers. In these roles, Heidi planned and coordinated state health policy projects with a focus on healthcare workforce, Medicaid, health center-hospital partnerships, and telehealth. She managed a joint project with America's Essential Hospitals and George Washington University to support collaborative efforts between health centers and hospitals at the national and local levels to address state health policy and delivery system transformation issues. She facilitated partnerships between health centers and hospitals within four local communities, and provided a forum for sharing knowledge and discussing common issues across communities. Heidi conducted policy research and provided technical assistance for state primary care associations and health centers, which included the development and facilitation of educational workshops, webinars, meetings, and workgroups. She created a podcast series and wrote issue briefs and blogs on emerging issues and state health policy trends. Heidi helped identify new funding opportunities and develop proposals, and served as liaison to federal agencies, national organizations, and other external stakeholders.

Prior to EOHHS, Heidi served as director of planning at Charles B. Wang Community Health Center. In this role, Heidi managed and supported strategic planning activities of the board of directors and senior staff across the organization. She coordinated across health center leadership and worked with external stakeholders to design projects and write grant proposals for governmental agencies and private foundations. She helped secure over $2 million in funds to support health center projects, including capital projects, quality improvement initiatives, and workforce training programs.

Heidi earned her Master of Public Health in health policy and management and a certificate in health finance and management from Johns Hopkins School of Public Health. She earned her master's degree in molecular genetics from Sackler Institute of Biomedical Sciences and her bachelor's degree in English and biological sciences from Stanford University.

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