HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

CMS SECTION 1115 MEDICAID DEMONSTRATION EVALUATION REQUIREMENTS

Implications for Designing Consumerism & Personal Responsibility Waivers

This week, our *In Focus* section highlights HMA Medicaid Market Solutions' (MMS) efforts to support state flexibility in designing and implementing Section 1115 Demonstration Waivers promoting member engagement and personal responsibility. Over the coming weeks, HMA MMS will present a

series of articles providing in-depth analyses of the many facets of these new Medicaid models. This week, we examine the implications for designing consumerism and personal responsibility waivers.

BACKGROUND

Section 1115 demonstration waivers allow states to request the Secretary of Health and Human Services to "waive" certain federal Medicaid requirements to implement state-specific policy approaches to serve Medicaid populations.[1] Recently, states have used these waivers to advance consumerism and personal responsibility policies, such as mandatory premium payments and community engagement requirements. The Centers for Medicare and Medicaid Services (CMS) requires that all states evaluate their waivers. The evaluation must be conducted by an independent third-party evaluator. Evaluation components of 1115 waivers are set and reported at five key points in the demonstration process:[2]

Initial Application: Section 1115 demonstration applications must include the goals and objectives of the waiver, including a general description of how the state intends to evaluate whether the goals and objectives are met.

Application Approval: During the CMS review, negotiation, and approval of section 1115 demonstrations, detailed evaluation components are outlined and included within the special terms and conditions (STCs), which accompany each approved waiver.

Evaluation Design: After a waiver is approved, states are required to submit a comprehensive evaluation plan, which describes how each requirement with the STCs will be assessed.

Demonstration Renewal: Generally, states must submit an evaluation describing findings to date, as part applications to renew or extend their demonstration.

Demonstration End: States are required to submit a final evaluation plan upon the conclusion of each section 1115 demonstration.

NEW DEVELOPMENTS IN 1115 EVALUATION

In February of this year, the U.S. Government Accountability Office (GAO) published an analysis of state evaluations of Section 1115 Medicaid Demonstrations. The publication, titled "Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures", found that state 1115 evaluations were in need of considerable improvement. The report stated lack of standardization prevented the evaluation of critical program elements and dissemination of results. Even when findings were released, methodological limitations—such as small sample sizes and the lack of comparison groups—prevented the evaluations from being useful.

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[1] Centers for Medicare and Medicaid Services (CMS). About Section 1115 Demonstrations. Available at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html. Accessed August 2, 2018.

[2] United States Government Accountability Office. Medicaid Demonstrations. Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. Available at https://www.gao.gov/assets/690/689506.pdf. Accessed August 2, 2018.

The GAO report concludes with three formal recommendations for CMS:[3]

The Administrator of CMS should establish written procedures for implementing the agency's policy that requires all states to submit a final evaluation report after the end of each demonstration cycle, regardless of renewal status.

The Administrator of CMS should issue written criteria for when CMS will allow limited evaluation of a demonstration or a portion of a demonstration, including defining conditions, such as what it means for a demonstration to be longstanding or noncomplex, as applicable.

The Administrator of CMS should establish and implement a policy for publicly releasing findings from federal evaluations of demonstrations, including findings from rapid cycle, interim, and final reports; and this policy should include standards for timely release.

As a result of the GAO report, states should expect more stringent standards for Section 1115 Medicaid Demonstration evaluations. In its written response to the GAO report, the Department of Health and Human Services (HHS) referenced recent actions to enhance the quality of 1115 evaluations, such as including specific evaluation requirements and timelines within demonstration STCs and requiring states to adhere to the prevailing standards of academic rigor in their evaluation reports (e.g., controlling for confounding variables).[4] The HHS response also cited a recent CMS informational bulletin which highlights the agency's work to develop standardized evaluation templates to support the alignment and comparison of 1115 evaluations.

INCREASED EXPECTATIONS FROM 1115 EVALUATION

CMS is increasing expectations of state 1115 evaluations. Comparison of STCs for Indiana's previous and most recent Healthy Indiana Plan 1115 demonstrations reveals more stringent evaluation requirements, including two additional addendums outlining specific components of the evaluation.

The first addendum describes the required elements of the evaluation plan including the following:

A description of how demonstration goals translate into measurable targets for improvement

The use of driver diagrams to visually aid readers in understanding the rationale for program policies and outcomes

The identification of the specific statistical testing (e.g., t-tests, chi-square, odds ratio, ANOVA, regression, etc.) for each measure

[3] U.S. Government Accountability Office. Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. Available at https://www.gao.gov/products/GAO-18-220. Accessed September 13, 2018.

[4] U.S. Department of Health and Human Services (HHS). GAO Report on Medicaid Demonstration Evaluations—Appendix II: Comments from the Department of Health and Human Services. Available at https://www.gao.gov/assets/690/689506.pdf. Accessed September 25, 2018.

A discussion of how evaluation methodologies including "difference-in-differences" and propensity score analyses may be used to adjust for variances in comparison populations over time

The addendum includes an additional mandate that the state post its evaluation plan to its website.

Indiana's second STC addendum outlines the structure for completing the formal evaluation reports for the demonstration. It requires the state to:

Discuss how the demonstration interacts with other aspects of the state's Medicaid program

Assess the implications of the evaluation's findings at both the state and national levels

Describe lessons learned from the demonstration

Make strategy recommendations for other states interested in implementing a similar approach, as well as other related requirements

CMS is also enhancing evaluation efforts at the federal level. The agency has contracted for separate federal evaluations of 1115 waivers and recently released several reports that describe preliminary findings from its national assessment of section 1115 evaluations.

One report focused on member engagement strategies detailed that although engagement in one state (Indiana) was relatively high (i.e., 90 percent of members made monthly payments to partake in enhanced "HIP Plus" benefits), less than half of the members in the remaining demonstrations participated in incentivized behaviors. The report suggested a need for ongoing member education if demonstrations are to be successful with member engagement.

Another report compared monthly payment requirements across demonstrations finding that the proportion of members who are required or encouraged to make monthly payments vary considerably (e.g., 25% in Michigan versus 100% in Indiana). The report also found that the consequences of failing to comply with required payments varied considerably - being subject to copayments (Iowa), tax return garnishment (Michigan) and disenrollment from programs (Iowa, Indiana, and Montana).

A third report described health plan enrollment continuity among members enrolled in demonstrations that provide premium assistance for members to purchase coverage from the Health Insurance Marketplace. The report highlighted the potential for a high rate of enrollment continuity among demonstrations with complete public and private health plan overlap (Arkansas and New Hampshire), while outlining the possibility of considerable enrollment discontinuity where health plan overlap was not absolute (Iowa). The report identified strategies to encourage or mandate health plan participation in both the public and private sectors as a means of maximizing health plan enrollment continuity for members who transition between eligibility for Medicaid and the Marketplace.

The federal analysis and publication of the results of states' 1115 evaluations demonstrates the increasing accountability and scrutiny of state evaluations. States should be prepared to incorporate CMS' recommendations and best practices within their demonstration designs. States should expect that Section 1115 Medicaid demonstration applications, which include strategies identified as ineffective or problematic within the CMS evaluation reports, may face a more difficult road toward federal approval.

CONSIDERATIONS FOR CURRENT & UPCOMING EVALUATION EFFORTS

In addition to meeting CMS requirements, the evaluation should provide value to the program itself. It is important to consider specific data needed to improve identification of demonstration outcomes and to inform state policy decision making. The following elements are essential for designing effective program evaluations:

Plan in Advance: Evaluation should be built into the waiver application, long before it is approved. In addition, states should incorporate recommended strategies from CMS' evaluation of similar demonstrations into their evaluation design.

Budget: Comprehensive evaluations can be expensive. CMS requires states to appoint independent evaluators but does not provide additional evaluation funding outside of administrative funding. Research and plan for associated costs prior to waiver approval.

Data Availability & Quality: Where will the data to perform the evaluation come from? Does the data structure allow for the analyses proposed in the evaluation? Most evaluations will comprise a mix of both quantitative (e.g., claims) and qualitative (e.g., surveys) data. Depending on the availability and quality of quantitative data, additional investment in the acquisition of qualitative data may be needed.

Ongoing Monitoring & Evaluation: CMS reserves the right to request ad hoc reports to assess the success of Section 1115 Medicaid Demonstrations, outside of the reports listed within each waiver's STCs. Planning to have regular monitoring and ongoing reporting capabilities will enable the ability to support additional requests from federal contractors, and allows states to course correct, as needed.

For more information, please contact Vice President Gaylee Morgan GMorgan@healthmanagement.com, or Senior Consultants Desmond Banks dbanks@hmamedicaidmarketsolutions.com and Kaitlyn Feiock kfeiock@hmamedicaidmarketsolutions.com.

HMA Medicaid Roundup

Arkansas

Arkansas Drops 4,100 More Medicaid Beneficiaries for Failing to Meet Work Requirements. *Modern Healthcare* reported on October 15, 2018, that Arkansas dropped another 4,100 Medicaid beneficiaries this month for not meeting work requirements, on top of 4,300 last month. The requirements apply to about 76,000 Medicaid beneficiaries in the state. According to a Kaiser Family Foundation report, many beneficiaries are not aware of the requirements, don't understand what's required, or are stymied by the online reporting process. Read More

California

Medicaid Members Joining Health Net to Have Access to UC Davis Primary Care Services. *California Healthline* reported on October 10, 2018, that up to 5,000 California Medicaid members shifting coverage from UnitedHealth to Health Net in Sacramento County will have access to primary care and other medical services from UC Davis Health. UnitedHealth, which has had a network arrangement with UC Davis, announced two months ago that it is leaving the Sacramento Medicaid market. Health Net hasn't had a primary care network arrangement with UC Davis for three years. Read More

Florida

Florida Medicaid Effort to Reduce Fraud in Autism ABA Treatment Leads to Coverage Denials, Delays for Many Kids. *Health News Florida* reported on October 11, 2018, that 3,800 children with autism in Florida were either partially or fully denied coverage of Applied Behavioral Analysis (ABA) treatment, following a statewide initiative to fight Medicaid billing fraud. In March, the Florida Agency for Healthcare Administration began requiring autism patients already approved for ABA treatment to reapply for coverage every six months through a new contractor, eQHealth Solutions. Some therapists complain that patients are waiting months for approval or being denied coverage. Read More

Georgia

Medicaid Expansion Is At Center of State Gubernatorial Race. *CNBC* reported on October 16, 2018, that Medicaid expansion is at the center of Georgia's tight gubernatorial race. Leading the polls is Brian Kemp, a two-term Republican secretary of state and opponent of Medicaid expansion. Stacey Abrams, a former Democratic state legislator, favors expansion. According to an analysis by the Robert Wood Johnson Foundation, approximately 500,000 Georgians would be insured under Medicaid expansion. Read More

Idaho

Idaho Remains Unsure About Potential Cost of Medicaid Expansion. *The Idaho Statesman* reported on October 14, 2018, that Idaho remains unsure about the potential cost of a Medicaid expansion measure on the November ballot, having received six varying projections from the actuarial firm the state hired to study the issue. Over a period of about a month this summer, Milliman released projections ranging from 10-year costs of $105 million (the most recent projection) to 10-year savings of nearly $200 million. The difference can be attributed in part to varying data on how many people would likely sign up — with initial projections using Census data and more recent projections using real-time data provided by the state. Read More

Iowa

Medicaid Officials Are Concerned Over Critical Incidents Among Managed LTSS Members. *The Gazette* reported on October 10, 2018, that Iowa Medicaid managed long-term services and supports plans are experiencing a high number of critical incidents among the 5000 members enrolled under the state's Home and Community Based Services waiver. Self-reported data showed that UnitedHealthcare had 18,145 critical incidents as of June, while Amerigroup had 5,655 critical incidents. In both cases the number of critical incidents were only slightly higher than the prior three-month period. Officials from the Iowa Department of Human Services, who discussed the results in a recent meeting, also raised concerns that Medicaid members weren't receiving adequate care coordination. Read More

Nebraska

Medicaid Expansion Would Benefit State Economy, Study Finds. *The Omaha World-Herald* reported on October 15, 2018, that Medicaid expansion in Nebraska would generate an estimated 11,000 jobs and approximately $1.3 billion in new economic activity, according to an analysis commissioned by the Nebraska Hospital Association. The analysis, which included findings from 33 expansion states, also found that expansion would benefit rural hospitals facing financial struggles. Nebraska voters will decide in a November ballot measure whether the state should expand Medicaid, which would impact 90,000 individuals in the state. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Amendments to the New Jersey Medicaid MCO D-SNP contract. New Jersey's Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) recently posted the July 2017 amendments to the Medicaid MCO D-SNP contract. HMA compared the latest contract amendments with the previous contract version from July 2016. Many of the changes seem consistent with continued efforts to align State and Federal requirements in the Medicaid MCO contract with D-SNPs.

Below we highlight key changes to the amended contract. A more detailed list of changes is available on the HMA IS website.

Services

- The following In Lieu of Services (ILOS) may be covered by MCO.
  - Over the counter medication
  - Residential treatment in an institution for Mental Disease (IMD) for a covered BH/SUD services – must not exceed 15 resident days in one month of treatment
  - Treatment in a long term acute care facility
  - Residential modifications
  - Assistance with finding or keeping housing (not including rent)
- Adds Institution for Mental Diseases (IMD) as an ILOS for all benefits packages. Includes tracking and reporting requirements for an inpatient stay in an IMD for psychiatric or substance use disorder care in public or private institutions.
- *NJ MIPPA WRAP agreement:*
  - Requires MCO to provide mental health and substance abuse disorder services to all enrollees in need including members receiving MLTSS. Outlines process for payment and coordination of inpatient hospital services.
  - Adds coverage for inpatient psychiatric institution services up to 15 days for individuals 21-65 years old for NJ MIPPA D-SNP Wrap only.

Providers

- Clarifies that MCO is not required to contract with more providers than necessary to meet needs of members
- Adds provider network factors that MCOs must take into consideration

Federal compliance

- Replaces sections on Medical Loss Ratio (MLR) Standard, report, and compliance remittance with federal rules regarding calculation and report of MLR.
- Requires compliance with federal HCBS regulations by March 17, 2019.

Grievances and Appeals

- Requires MCOs to provide enrollees 60 days to file appeals from time of notice, reduced from 90 days. Increases time frame for fair hearings from 20 to 120 days.

Tracking, Reporting, and Review

- Adds an annual report describing drug utilization review activities to state.
- Adds reporting requirements of pharmacy encounter and drug utilization data for the drug rebate process.
- Requires MCO to notify DMAHS within 90 days of reduction in reimbursement rate for personal care assistant/home-based services (and other services) with written assurance access and quality will not be reduced.

Financial provisions

- Removes Medical Loss Ratio compliance section.
- Establishes the NJ Medicaid Access to Physician Services program, which sets minimum rates in a new fee schedule for services provided by qualified providers. This program is funded by increase in non-dual capitation rates in acute care and MLTSS and has quarterly reporting requirements.
- Increases premium rates for NJ Medicare Advantage Dual Eligible Special Needs Plan.

Dates	Previous Premium Rate (PMPM)	New Premium Rate (PMPM)
SFY17a/CY16 July -December 2016	$463.35	$494.50
SFY17b/CY17 Jan – June 2017	$463.35	$494.50
SFY18a/CY17 July-December 2017	$494.50	$493.49

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Announces New Program to Help New Yorkers Access Insurance Coverage for Substance Abuse and Mental Health Disorders. New York announced on October 9, 2018, that it is establishing a Behavioral Health Ombuds Program intended to educate families and individuals on their insurance rights and provide assistance when they are denied coverage. The new Ombuds Program, called Community Health Access to Addiction and Mental Healthcare Project (CHAMP) is being overseen by three agencies – the Office of Alcoholism and Substance Abuse Services, the Office of Mental Health and the Department of Financial Services. It will educate individuals, families, and health care providers on their legal rights to coverage, help them access treatment and services, and investigate and resolve complaints regarding denial of health insurance coverage. A general mailbox (Ombuds@oasas.ny.gov) and a hotline number (888-614-5400) have been established for questions about the program. The 2018-19 Budget included $1.5 million to establish the new Ombuds Program in partnership with three community-based organizations: the Community Service Society, the Legal Action Center and the New York State Council for Community Behavioral Healthcare. Read More

New York Department of Health Plans Value Based Payment Webinar. As New York continues its transition to a more value-based payment (VBP) system it is sharing "lessons learned" by early adopters. In September 2016, New York implemented a two-year VBP Pilot program designed to create momentum for the transition from fee–for–service to a value-based payment environment. Six provider organizations and eight managed care organizations are piloting three different types of value based payment arrangements: Health and Recovery Plan (HARP) Subpopulation, Integrated Primary Care (IPC), and Total Care for the General Population (TCGP). On Wednesday, October 30, 2018, from 2:00-3:30, the Department of Health will be hosting the third in a series of Early Lessons Learned Webinars from VBP Pilot participants. This webinar will feature a joint presentation from SOMOS Community Care and Northern Manhattan Improvement Corporation (NMIC).

To register for the webinar click here

Four Plans to Exit New York Fully Integrated Duals Advantage Program. Four additional plans participating in New York's duals demonstration, the Fully Integrated Duals Advantage (FIDA) program, are closing as of January 1st. The four plans, AgeWell NY, GuildNet Gold, MetroPlus and VillageCare Max, have a total enrollment of 893 members. Enrollment in FIDA continues to decline, with 3,797 members in the 8-county demonstration region as of August 2018. Out of the original 23 plans participating in FIDA, only six remain in the program. New York has not yet announced what its plans are for when the demonstration ends in December 2019, although it remains committed to fully integrated managed care approaches for the dually eligible population.

Ohio

Poll Finds Most Ohioans Have Favorable View of Medicaid. *The Cincinnati Enquirer* reported on October 9, 2018 that Ohio Medicaid is viewed favorably by seven out of 10 Ohioans, which is consistent with the Kaiser Family Foundation's report that 74% of Americans have a favorable opinion of Medicaid. The Ohio Health Issues Poll was conducted by the health-education nonprofit Interact for Health and surveyed 816 Ohio adults. The poll also found that 9 out of ten adults have insurance in Ohio, which is again, consistent with the national estimates. The survey data will be valuable in helping advocates and state leaders assess Medicaid, as well as inform future program changes. Read More

Pennsylvania

Insurers Discontinue Prior Authorization for Substance Abuse Treatment. *Modern Healthcare* reported on October 12, 2018, that seven Pennsylvania insurers have agreed to remove prior authorization requirements for substance abuse treatment in Pennsylvania. The insurers, Aetna, Capital BlueCross, Geisinger, Highmark, Independence Blue Cross, UPMC, and UnitedHealthcare, reached an agreement with the Commonwealth of Pennsylvania to remove the coverage restrictions and include a broader range of medications to treat substance use disorders on the lowest cost-sharing tier. The move aligns prior authorization limits applicable to large commercial plans for medication-assisted treatment (MAT) access with those already used by both the state's Medicaid fee-for-service and managed-care programs. The agreement includes individual, small group and large group plans, but not self-funded health plans, which are regulated by the federal government. Read More

Tennessee

Medicaid Applicants Get Day in Court in Lawsuit Over Application Delays, Denials. *Fox 17 News* reported on October 11, 2018, that a class action lawsuit concerning Tennessee Medicaid application delays and denials went to trial this month. The suit, filed in U.S. District Court in Tennessee four years ago by The Southern Poverty Law Center, claims that the state has been violating federal law by requiring individuals to apply for Medicaid through the Affordable Care Act Exchange. Thousands of Medicaid eligibles have been impacted by the delays and denials, the lawsuit says. Read More

Texas

Texas Reports 'Significant Progress' In Acute Care Services, LTSS System Redesign for IDD Population. The Texas Health and Human Services Commission (HCSC) released a report suggesting "significant progress" as well as "opportunities for systemic improvement" in the state's redesign and implementation of a new acute and long-term care services and supports (LTSS) system for individuals with intellectual or developmental disabilities (IDD). The report detailed the transition of acute services in STAR+PLUS, STAR Kids, and STAR Health for 19,204 individuals with IDD to a capitated, managed care delivery system. HHSC hopes to increase community support services in an effort to prevent institutionalization of individuals with IDD and promote independence. Read More

Virginia

Virginia Holds Statewide Information Sessions For Providers In Preparation For Medicaid Expansion. *The Winchester Star* reported on October 11, 2018, that the Virginia Department of Medical Assistance Services is holding statewide information sessions for medical providers to discuss changes in coverage in preparation for the state's Medicaid expansion, which takes effect January 1, 2019. Expansion will apply to up to 400,000 individuals, including childless adults, individuals with disabilities and families with incomes up to 138 percent of the poverty level. Coverage will include primary and specialty care, behavioral health and preventive services. Read More

Wisconsin

Governor Delays Medicaid Work Requirements Ahead of Election. *Politico* reported on October 16, 2018, that Wisconsin Governor Scott Walker has delayed implementing Medicaid work requirements ahead of the November election, federal officials say. Wisconsin in a non-expansion state. Polls show that Walker is tied with or behind Democratic candidate Tony Evers, who supports expansion. In addition to work requirements, Wisconsin also received federal approval to ask beneficiaries about illegal drug use and to require beneficiaries to pay toward their care. Read More

National

Former Maine Health Commissioner Is Appointed Federal Medicaid Director. *The Associated Press* reported on October 15, 2018, that President Trump has appointed former Maine health commissioner Mary Mayhew as deputy administrator and director of the federal Center for Medicaid and CHIP Services. As commissioner of the Maine Department of Health and Human Services under Governor Paul LePage, Mayhew was a staunch opponent of Medicaid expansion. Read More

Low-Income Individuals in Non-Expansion States Forego Care, Study Says. *The Associated Press* reported on October 15, 2018, that low-income individuals in states that did not expand Medicaid are more likely to forgo necessary medical care than their peers in expansion states, according to a Government Accountability Office report. Nearly 20 percent of low-income individuals in non-expansion states have forgone necessary care within the past 12 months, compared to 9.4 percent in expansion states, the study says. Medicaid expansion remains a high-profile issue in states for November. Read More

ACA Premiums to Drop 1.5 Percent In 2019. The Centers for Medicare & Medicaid Services (CMS) announced on October 11, 2018, that average premiums for benchmark silver plans on the Affordable Care Act Exchanges will drop 1.5% in 2019, compared to a rate increase of 37 percent in 2018. The largest decline is in Tennessee, where rates will fall 26 percent. An additional 23 qualified health plans are participating in the Exchanges in 2019, and 29 existing plans are expanding into additional counties. Read More

Medicaid Innovation Accelerator Program Hosts National Learning Webinar. The Medicaid Innovation Accelerator Program's (IAP's) Community-Integration through Long-Term Service and Supports (CI-LTSS) Program Area is hosting a national learning webinar, "Using Data to Identify Housing Needs and Target Supports, on Wednesday, November 7, 2018 from 2:00 PM-3:30 pm ET. During this webinar, speakers will discuss methods for using multiple types of data, including Medicaid, Homelessness Management Information Systems and others, to identify needs and prioritize housing supports for their target populations. National subject matter experts will provide a framework for cross-systems data analyses and targeting, including tips for getting started with this work. Experts from three IAP states that have completed cross-systems data matches and are using the results to prioritize and/or expand housing resources in their states will discuss their analytical approach and findings, lessons learned, and next steps. *HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates.* To participate in this webinar, register here.

Industry News

Centene Wins Bernalillo County, NM, Correctional Medical Services Contract. Centene announced on October 15, 2018, that its subsidiary, Centurion Detention Health Services, was awarded a four year contract by New Mexico's Bernalillo County Commission to provide comprehensive health care services to detainees of Metropolitan Detention Center in Albuquerque, New Mexico, effective January 2019. Centurion will provide an array of services including medical, dental, psychiatric, and optometric services. Read More

Community Health Systems Announces Agreement to Sell Mary Black Health System. Community Health Systems announced on October 11, 2018, a definitive agreement to sell South Carolina-based Mary Black Health System, including two hospitals, physician clinics and outpatient services, to Spartanburg Regional Healthcare System. The transaction, which is part of a planned divestiture announced earlier this year, is expected to close in the fourth quarter of 2018. Read More

Abry Partners Invests in Lighthouse Autism Center. Lighthouse Autism Center, which operates applied behavioral analysis therapy centers in Michigan and Indiana, announced on October 11, 2018, that it had received an investment from Boston-based private equity firm Abry Partners. The transaction closed in October; financial terms weren't disclosed. Abry also has investments in US Dermatology Partners, FastMed Urgent Care and North American Dental Group, LLC. Read More

Amedisys to Acquire Hospice Company for $340 Million. *Modern Healthcare* reported on October 10, 2018, that home health provider Amedisys Inc. has signed a definitive agreement to acquire Compassionate Care Hospice for $340 million. The deal, which is expected to close in February 2019, will make Amedisys the nation's third-largest hospice care provider, with 136 centers in 34 states. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 1, 2018	Virginia Medallion 4.0 - Charlottesville/Western	Implementation	88,486
November 1, 2018	Puerto Rico	Implementation	~1,300,000
November - December 2018	Massachusetts One Care (Duals Demo)	RFP Release	150,000
December 1, 2018	Virginia Medallion 4.0 - Roanoke/Alleghany	Implementation	72,827
December 1, 2018	Virginia Medallion 4.0 - Southwest	Implementation	46,558
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
2019	Hawaii	RFP Release	360,000
January 1, 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (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) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract 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
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

COMPANY ANNOUNCEMENTS

MCG Health and ZeOmega Offer Integrated Solution to Expedite Prior Authorizations

HMA News

Suzanne Daub – Principal, Philadelphia

Suzanne Daub is a leading expert and nationally recognized trainer in integrated healthcare who knows how to help clients design, scale and evaluate behavioral integration into primary care and wellness culture. She is an energetic coach who believes building quality integrated systems of care means committing deeply to the people who deliver the work and empowering service users. Suzanne is best known for her creative leadership, which inspires those who serve vulnerable populations to embrace responsibility for transforming the way healthcare is delivered. She is passionate about a "no wrong door" approach to integrated care and works across systems to ensure that individuals and families get whole-person, recovery-oriented services regardless of where they seek help.

Suzanne has more than 30 years of experience in direct patient care, program administration and managed care. For 18 years, she served as director of behavioral health at a multisite Federally Qualified Health Center (FQHC) in Philadelphia where she integrated care using the Behavioral Health Consultation (BHC) model. Suzanne co-founded the largest network of primary care behavioral health providers in the country and was recognized by the Pennsylvania Association of Community Health Centers with the Innovations Award.

As the extreme health disparities among people with serious mental illness came to light, Suzanne brought her integrated care skills to community mental health organizations across the country as a senior integrated care consultant for the National Council for Behavioral Health.

Immediately prior to joining HMA, she was the senior director of Integrated Care Initiatives for UPMC/Community Care Behavioral Health, Pennsylvania's largest Medicaid Behavioral Health managed care organization. Suzanne led the scaling of behavioral health homes to 65 organizations serving adolescents, adults and individuals receiving opioid treatment.

Chuck Weis – Principal, Chicago

Charles Weis is a high impact and versatile financial executive with extensive experience driving capital, financial and business strategies while mitigating risk in a change-intensive healthcare environment.

As a principal with HMA, he is poised to help clients work toward financial stability, increase organizational growth, improve business and financial structures, and achieve integrated information systems.

Charles is a transformational leader whose sound financial guidance, business acumen and vision have been instrumental in positioning businesses for success through complex financings, growth strategies, strategic alliances and business turnarounds.

Prior to joining HMA, he was executive vice president, senior advisor and CFO of Sinai Health System in Chicago. As a senior healthcare financial executive, he developed and ran an integrated system which delivers a full range of high-quality outpatient and inpatient services as well as many innovative community-based health, research, and social service programs. In this role, he provided significant input for the system's strategic, business, and financial plan which helped the health system flourish.

Dr. Barry Jacobs – Principal, Philadelphia

Dr. Barry J. Jacobs is a noted clinical psychologist and family therapist whose passion for enhancing support for family caregivers led him to author several books and dozens of articles on the topic as well as present and speak nationally and internationally to organizations, associations and providers.

His areas of expertise include behavioral health integration, complex care management, enhancing family caregiver engagement and supports, practice transformation, team-based care and provider wellness. He brings this wealth of knowledge, along with decades of clinical practice experience to individuals, couples and families, to HMA.

Before joining HMA, he was the Director of Behavioral Sciences for the Crozer-Keystone Family Medicine Residency Program where he oversaw family medicine residents performing interviewing techniques, basic mental healthcare skills, and assessments of family influence on health. He also led an interprofessional team in his health system's complex care management program for high-utilizing frail elderly patients, as well as for younger Medicaid patients with complex social problems.

He is the co-author of AARP Meditations for Caregivers—Practical, Emotional and Spiritual Support for You and Your Family and the author of The Emotional Survival Guide for Caregivers—Looking After Yourself and Your Family While Helping an Aging Parent as well as co-editor of the e-book, Collaborative Perspectives—A Selection of CFHA's Best Blogs From 2009-2015.

Lauren Ohata – Senior Consultant, Los Angeles

Lauren Ohata is a highly versatile and strategic leader with experience implementing and supporting policy development and execution across the public and private sectors. She is passionate about effective public policy and serving her community.

She has been on the forefront of leading Affordable Care Act (ACA) and Exchange program implementation nationwide from the start of the first open enrollment period.

In addition to policy development and implementation, Lauren also worked with partners and the public to provide communication and education to ACA Navigators, consumers and health plans. She also worked to develop resolutions to key policy issues aligning leadership across the Department of Health and Human Services, the White House, IRS, Department of Labor and other federal agencies.

Her leadership within the Centers for Medicare and Medicaid Services (CMS) included serving as the chief of staff to the director of the Center for Consumer Information and Insurance Oversight where she facilitated understanding of policy issues with top level leadership and acted on behalf of the director.

Hayley Skinner – Senior Consultant, Albany

Hayley Skinner is a leader in healthcare analytics who has experience partnering with organizations to define and produce data sets and information in support of achieving their healthcare transformation goals.

With advanced degrees in both epidemiology and public health, Hayley joined HMA from ProHealth Physicians, a division of OptumCare, where she helped guide analytic strategy in support of optimizing patient outcomes and organizational performance under their value-based care contracts. As medical group analytic lead, Hayley was responsible for identifying drivers of utilization trends and partnering with clinical leadership to identify actionable opportunities to improve performance. She also served as subject matter expert during the integration of previously siloed data sets and co-lead across the implementation of a population health management platform.

Previously, Hayley led a team of analysts responsible for supporting the analytic needs of the network contracting team with a non- profit health plan which operates Medicaid, family health, commercial, and child health plans. Hayley also served as a dedicated advisor and associate director; two roles that allowed her the opportunity to serve as strategic partner to delivery system leadership nationwide as they sought best practice insights on improving quality and efficiency of care.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Colorado RAE Enrollment is 1.2 Million, Sep-18 Data
- Florida Department of Elder Affairs Summary of Programs and Services, 2017-18
- Iowa Medicaid Managed Care Enrollment is Up 4.8%, Sep-18 Data
- Indiana Medicaid Managed Care Enrollment is Down 4.0%, Sep-18 Data
- Michigan Dual Demo Enrollment is Down 5.5%, Sep-18 Data
- New York Dual Demo Enrollment is Down 14.3%, Sep-18 Data
- Ohio Dual Demo Enrollment is Up 5.9%, Oct-18 Data
- Rhode Island Dual Demo Enrollment is 15,129, Oct-18 Data
- Texas Dual Demo Enrollment at 40,725, Oct-18 Data
- Utah Medicaid Managed Care Enrollment is Down 3.9%, Oct-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arkansas Prior Authorization Reviews, Retrospective Reviews and Medical Reviews/Consults IFB, Oct-18
- Alaska Behavioral Health Administrative Service Organization (ASO) RFP, Sep-18
- Alaska Electronic Visit Verification RFI, Oct-18
- New Jersey D-SNP Contracts, 2016-17
- South Dakota Pharmacy Point of Sale System Contract, 2016
- Indiana Hoosier Care Connect ABD RFP, Contract and Related Documents, 2014-16
- Michigan Medicaid Pharmacy Benefits Manager (PBM) Contract, 2017
- Massachusetts Pharmacy Benefit Manager Services (PBM) Contract, Recommendation and Amendments, Jun-18
- Virginia Commonwealth Coordinated Care Plus MLTSS MCO Contracts, 2017-18

Medicaid Program Reports, Data and Updates:

- Alaska Medicaid Data Book, SFY 2016-17
- Alaska Medicaid Redesign Presentation, Oct-18
- California Department of Managed Health Care Timely Access Reports, 2015-16
- CMS Key Provisions of Legislation Extending Federal Funding for the Children's Health Insurance Program, Oct-18
- Florida Department of Elder Affairs Summary of Programs and Services, 2017-18
- Georgia Care Management Organizations External Quality Review Report and CMO Compliance Reports, 2017-18
- Hawaii Medicaid Fee-For-Service Hospice Rates, Sep-18
- Massachusetts Draft MassHealth Managed Care Quality Strategy Report, Sep-18
- Medicaid Managed Care Activity for People with Intellectual/Developmental Disabilities Map, Oct-18
- Minnesota Case Management Redesign Plan For 2018-19, Mar-18
- Minnesota DHS Expenditure Forecast, Feb-18
- Minnesota Medical Assistance and MinnesotaCare Eligible Persons and Person Months, CY 2017
- Nebraska Long Term Care Redesign Committee Minutes, Sep-18
- New Mexico Centennial Care Public Event Presentation, Sep-18
- New York MLTC External Quality Review Report, 2017
- Oregon CCO 2.0 Report and Update Materials, Oct-18
- Rhode Island Medical Care Advisory Committee Meeting Materials, Sep-18
- SD Enacted Budget, SFY 2019
- U.S. Medicaid, CHIP Enrollment at 73.2 Million, Jul-18 Data
- Washington Medicaid Dental Provider Utilization Summary, FY 2013-17
- Washington Medicaid Dental Services Cost and Utilization Summary, FY 2007-17

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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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