

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... October 23, 2019



In Focus



HMA Roundup



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IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the 19th annual Medicaid Budget Survey conducted by The Kaiser Family Foundation (KFF) and Health Management Associates (HMA). Survey results were released on October 18, 2019, in two new reports: *A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020* and *Medicaid Enrollment & Spending Growth: FY 2019 & 2020*. The report was prepared by [Kathleen Gifford](#) and [Aimee](#)

Lashbrook from HMA; Eileen Ellis and Mike Nardone; and by Elizabeth Hinton, Robin Rudowitz, Maria Diaz, and Marina Tian from the Kaiser Family Foundation. The survey was conducted in collaboration with the National Association of Medicaid Directors.

This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2019 and FY 2020, highlighting policy changes implemented in state Medicaid programs in FY 2019 and those planned for implementation in FY 2020. The conclusions are based on information provided by the nation's state Medicaid Directors.

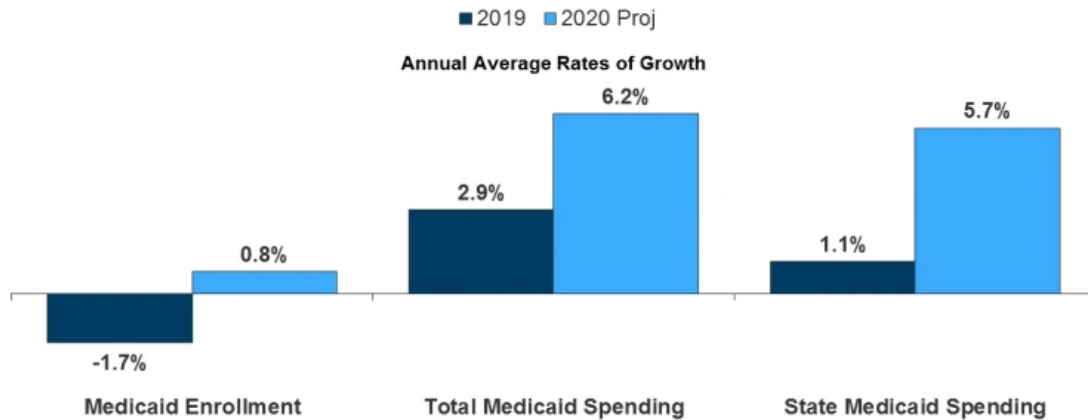
Key Report Highlights

In the following sections, we highlight a few of the major findings from the reports. This is a fraction of what is covered in the 50-state survey reports, which include significant detail and findings on policy changes and initiatives related to eligibility and enrollment, managed care, long-term services and supports (LTSS), provider payment rates, and covered benefits (including prescription drug policies). The reports also look at the key issues and challenges now facing Medicaid programs.

Medicaid Enrollment and Spending Growth

Enrollment declined in FY 2019 (-1.7 percent) due to changes in renewal processes, new functionality of upgraded eligibility systems, and enhanced verifications and data matching efforts. Enrollment peaked in FY 2015 as a result of the Affordable Care Act. Growth in FY 2020 is predicted to be 0.8 percent. Total Medicaid spending growth slowed to 2.9 percent in FY 2019 because of enrollment declines. It is projected to return to a more typical growth of 6.2 percent in FY 2020 due to higher costs for prescription drugs, provider rate increases, and higher costs for the elderly and individuals with disabilities from increased utilization of LTSS. Total Medicaid spending growth outpaced state spending growth in FY 2019 despite an increase in the state contributions for Medicaid expansion under the Affordable Care Act. This was attributed to some expansion states using provider taxes and other savings to finance expansion. States predict that state spending growth will be similarly lower than total spending growth in FY 2020.

Figure 1 – Medicaid Enrollment and Spending Growth, FY 2019 and FY 2020 (Projected)



SOURCE: Enrollment growth for FY 2019 is based on KFF analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports. Other growth rates are from the KFF survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2019.

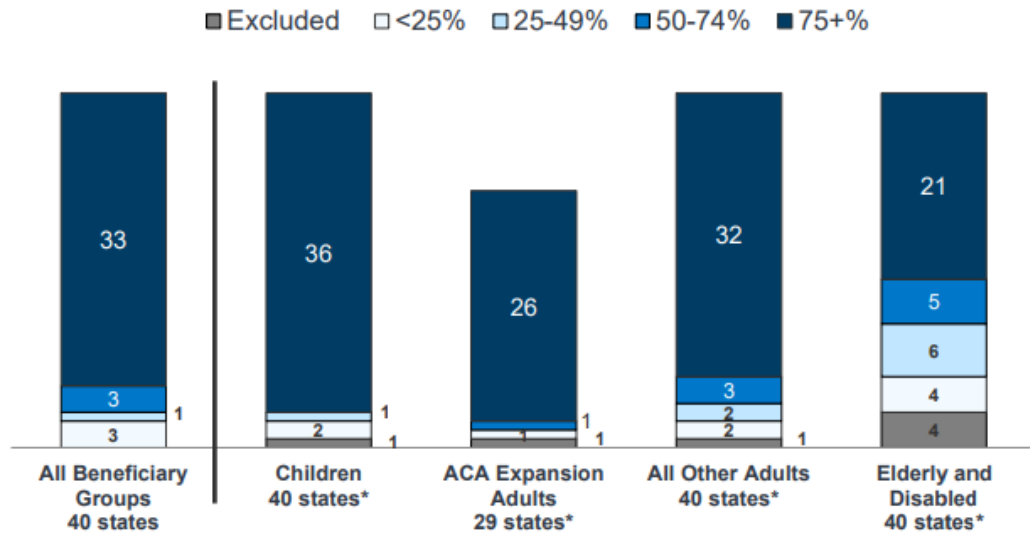
Medicaid Eligibility Standard Changes

- Maine and Virginia implemented Medicaid expansion in FY 2019.
- Idaho, Nebraska, and Utah adopted Medicaid expansion through November 2018 ballot initiatives. Idaho is seeking changes through a 1332 waiver, with plans to implement expansion in FY 2020. Nebraska and Utah are also pursuing waivers, which led to implementation delays.
- Kansas, Missouri, and North Carolina are actively debating Medicaid expansion.
- Other eligibility expansions for six states in FY 2019 and 19 states in FY 2020 (planned) include expanding coverage for pregnant and postpartum women, covering children with disabilities/complex needs, increasing income limit for parents/caretakers, and restoring retroactive coverage.
- Eligibility restrictions implemented in FY 2019 (by seven states) or planned for implementation in FY 2020 (in six states) through Section 1115 waivers target broader Medicaid populations including expansion adults and parents/caretakers and could result in enrollment declines. Most restrictions were for work requirements.
- Work requirements litigation is underway in several states. Additionally, six non-expansion states have pending work requirements waiver requests.
- Other eligibility restrictions include conditioning eligibility on premium payment, waiving reasonable promptness, and conditioning eligibility on completion of a health risk assessment.

Medicaid Managed Care Initiatives

- A total of 40 states (including DC) contract with risk-based managed care organizations (MCOs) to serve their Medicaid enrollees. As of July 2019, 33 states reported that 75 percent or more of their Medicaid beneficiaries were enrolled in MCOs. Children and adults, particularly those enrolled through the ACA Medicaid expansion, are much more likely to be enrolled in an MCO than elderly Medicaid beneficiaries or individuals with disabilities.

Figure 2 - MCO Penetration Rates for Select Groups of Medicaid Beneficiaries, as of July 1, 2019



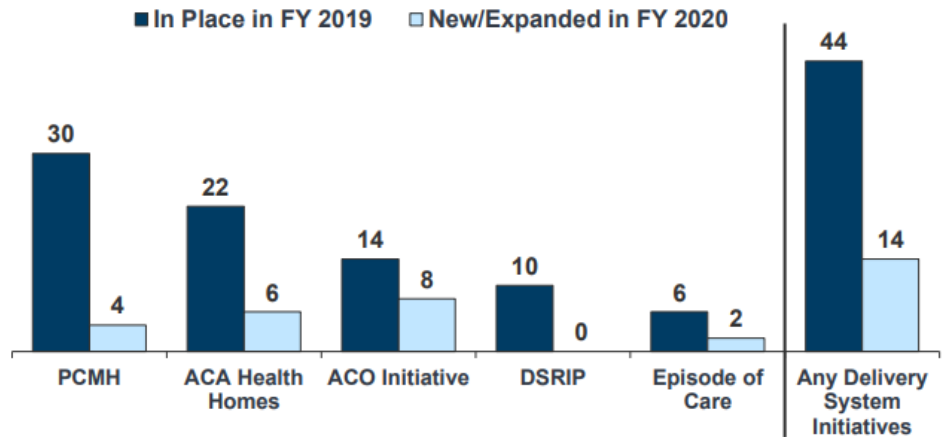
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

- Arkansas reported implementing managed care program for the first time in FY 2019. The Provider-led Arkansas Shared Savings Entities (PASSEs) program serves Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities (I/DD) service needs. Only five percent of Medicaid enrollees are in the program.
- North Carolina will implement risk-based, capitated managed care contracts for the first time to cover approximately 1.6 million enrollees in FY 2020, with mandatory enrollment for most population groups.
- Alaska reported that it will no longer implement an MCO arrangement in FY 2020, which would have served one geographic area (Anchorage and the Mat-Su Valley).
- Because of nearly full MCO saturation in most MCO states, only six states in FY 2019 and eight states in FY 2020 reported actions to increase MCO enrollment, with the majority looking to add new population groups.
- In FY 2019, Mississippi, New Jersey, New York, and Virginia reported actions to carve behavioral health services into their MCO contracts, and in FY 2020, Kentucky, Nebraska, West Virginia, and Wisconsin reported plans to add substance use disorder (SUD) waiver services to their MCO contracts.
- In FY 2019, eight states had contracts that required MCOs to participate in a state-directed VBP initiative and 12 states required MCOs to develop a VBP strategy within state-specified guidelines. In FY 2020, seven states planned to participate in a state-directed VBP initiative, and five states required MCOs to develop a VBP strategy within state-specified guidelines.
- Thirty-five states are planning to leverage Medicaid MCO contracts to promote at least one strategy to address social determinants of health in FY 2020.

Emerging Delivery System and Payment Reforms

- Forty-four states had one or more delivery system or payment reform initiatives in place in FY 2019, including patient-centered medical homes (PCMHs), ACA Health Homes, accountable care organizations (ACOs), episode of care payments, or delivery system reform incentive programs (DSRIPs). PCMH and health home initiatives were the most common in FY 2019.

Figure 3 - State Delivery System Reform Activity, FYs 2019-2020

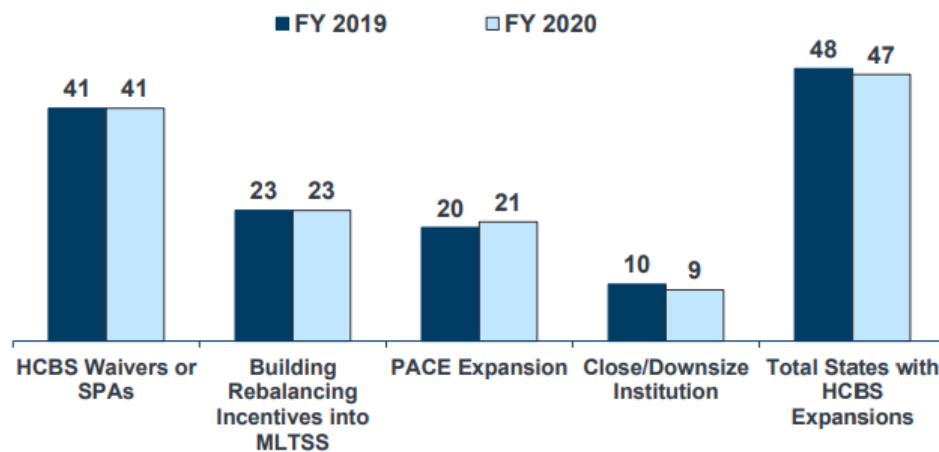


SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

Long-Term Services and Supports Reforms

- Nearly every state reported actions to expand the number of people served in home and community-based settings in both years (48 states in FY 2019 and 47 states in FY 2020).

Figure 4 - State Long-Term Care Actions to Serve More Individuals in Community Settings, FYs 2019-2020



SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

- Housing supports remains an important part of state LTSS benefits, with 37 states offering housing related supports. Congress provided a short-

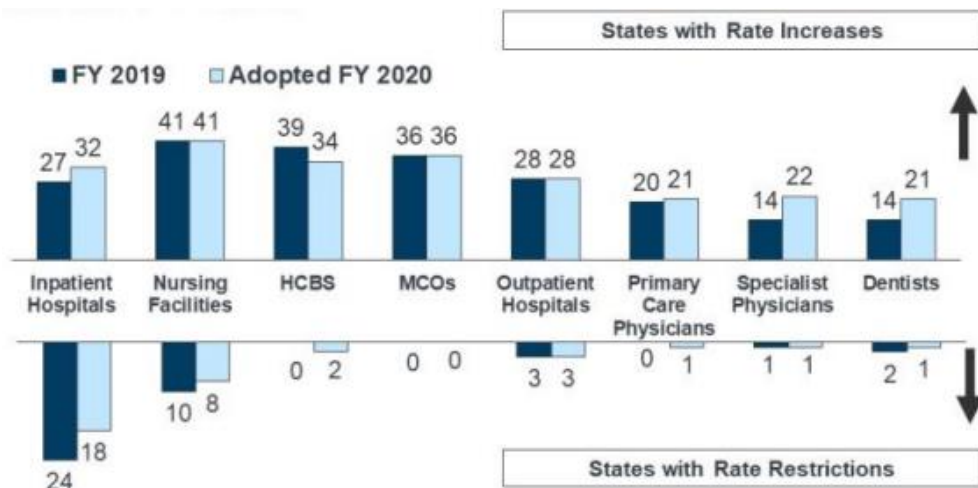
term extension to the Money Follows the Person (MFP) program, however, due to the uncertain future of the program, some initiatives may be at risk.

- In an effort to retain LTSS workers, approximately half the states reported raising wages for direct care workers in FY 2019 and FY 2020.
- Twenty-seven states reported using one or more MLTSS models, as of July 1, 2019, with nine offering an MCO-based Financial Alignment Initiative (FAI). Pennsylvania introduced MLTSS in FY 2018, with a plan to complete statewide expansion in FY 2020. Idaho, Illinois, and Tennessee reported geographic or population expansions for FY 2020.

Provider Rates and Taxes

- Nearly half of MCO states (17 states) require MCO payment changes for some or all types of providers to be consistent with percentage or level of changes made in comparable fee-for-service (FFS) rates. Nineteen states reported that their MCO contracts include rate floors for some provider types, and seven states reported they had minimum MCO payment requirements for all types of Medicaid providers.

Figure 5 - Provider Rate Changes Implemented in FY 2019 and Adopted for FY 2020



SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

- In FY 2019, 34 states, including DC, had three or more provider taxes in place. Thirty-two states have at least one provider tax that is at or above 5.5 percent of net patient revenues (close to the maximum safe harbor threshold of 6 percent). Therefore, federal action to lower that threshold as proposed in the past would have financial implications for many states. Alaska was the only state with no provider taxes.
- California became the eighth state to implement an ambulance tax in FY 2019.
- For FY 2020, 17 states reported planned increases to one or more provider taxes, while six states reported planned decreases.

Benefits and Copayments

- The number of states reporting new benefits and benefit enhancements continues to significantly outpace the number of states reporting benefit

cuts and restrictions. Twenty-three states expanded or enhanced covered benefits in FY 2019, and 28 states plan to add or enhance benefits in FY 2020. The most common benefit enhancements reported were for mental health/SUD services (including waiver of the IMD exclusion for SUD treatment).

- Five states reported new or increased copayment requirements for FY 2019 or FY 2020, including for non-emergency use of a hospital emergency department (ED) and for pharmacy services. Meanwhile 11 states reported policies to eliminate or reduce a cost-sharing requirement.

Pharmacy and Opioid Strategies

- All states reported FFS pharmacy management strategies to reduce opioid harm in FY 2019 and 32 states plan to take further action in FY 2020. Of the states that used MCOs to deliver pharmacy benefits, 29 reported that they required MCOs to follow some or all of their FFS pharmacy management policies for opioids.
- States continue to increase access to Medication Assisted Treatment (MAT) for opioid use disorder, and 44 states reported coverage of methadone in FY 2019.
- States also continue to focus on controlling prescription drug costs. In FY 2019, 24 states reported implementing or expanding at least one initiative to contain costs, and in FY 2020, 26 states plan to do so. Strategies include addressing PBM transparency, spread pricing in managed care, innovative purchasing arrangements, placing prior authorization, among others.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top priorities, issues, and challenges for FY 2020 and beyond, Medicaid directors listed the following:

- Delivery system and payment reforms
- Information technology (IT) systems projects, including Medicaid Management Information Systems (MMIS) procurements and eligibility system upgrades and replacements and implementation of health information exchanges (HIEs)
- Medicaid budget and fiscal challenges
- Section 1115 demonstration waivers, waiver amendments, or waiver renewals
- Preparing for an aging population
- Exploring potential state-based coverage expansion options beyond Medicaid
- Medicaid block grant options

Links to Kaiser/HMA 50-State Survey Reports

[States Focus on Quality and Outcomes Amid Waiver Changes Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020](#)

[Medicaid Enrollment & Spending Growth: FY 2019 & 2020](#)



HMA MEDICAID ROUNDUP

Arizona

Arizona Delays Medicaid Work Requirement Implementation. *Modern Healthcare* reported on October 18, 2019, that Arizona will postpone the implementation of Medicaid work requirements, which were scheduled to take effect January 2020. In a letter sent to the Centers for Medicare & Medicaid Services (CMS), Arizona cited ongoing lawsuits challenging the requirements in other states. Other proposed changes like premiums and cost sharing will also be delayed. Work requirements in the state would impact about 120,000 low-income, non-disabled adults. [Read More](#)

Florida

House Committee to Review Health Care Spending. *Health News Florida* reported on October 17, 2019, that the Florida Health Care Appropriations committee will review health care spending across six state agencies to ensure it is being done “efficiently, effectively, wisely, and appropriately,” according to chairwoman MaryLynn Magar (R-Tequesta). The panel will identify up to \$624 million – or 5 percent of general revenues going towards health care spending – for reprioritization. Magar said the exercise doesn’t necessarily mean \$624 million will be cut. [Read More](#)

Indiana

Indiana Releases Medicaid ABD RFP. On October 18, 2019, the Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) released the state’s Medicaid Managed Care Services for Aged, Blind, and Disabled (ABD) Medicaid Beneficiaries (Hoosier Care Connect) request for proposals (RFP). Proposals are due January 6, 2020, with award announcements expected on April 30, 2020. Hoosier Care Connect serves approximately 90,000 ABD individuals. Incumbent health plans are Anthem and MHS/Centene, with contract options through March 31, 2020. New contracts will run for four years, with two optional one-year renewals. [Read More](#)

Indiana Releases Managed Foster Care RFI. On October 18, 2019, the Indiana Department of Child Services (DCS) and the Family and Social Services Administration (FSSA) released a request for information (RFI) for a potential managed foster care program. Responses to the RFI are due no later than December 13. Any future request for proposals (RFP) will be open to state contracted managed care entities “to leverage existing networks and operations” in the state.

Kansas

Senate Majority Leader Introduces Medicaid Expansion Plan. *KSHB* reported on October 21, 2019, that Kansas Senate Majority Leader Jim Denning (R-Overland Park) has introduced legislation that would fund Medicaid expansion to 138 percent of the federal poverty level. However, the proposal would first require the state to request federal approval to further subsidize premiums on the Affordable Care Act Exchange for people above poverty through tax hikes on cigarettes and vaping products. The plan would not implement work requirements, a policy component that many state Republicans see as crucial. [Read More](#)

Kansas Health Plans to Rebate \$27 Million to Members. *KCUR* reported on October 17, 2019, that Kansas health plans will rebate more than \$27 million in premiums to members related to minimum medical loss ratio requirements. Sunflower, a subsidiary of Centene, will rebate more than \$25 million to 19,000 individual plan members. Other plans had smaller rebates related to group lines. [Read More](#)

Michigan

Michigan Cancels Medicaid Physical, Behavioral Health Integration Pilots. The Michigan Department of Health and Human Services (MDHHS) announced on October 21, 2019, that it has canceled the implementation of three pilots designed to improve the integration of physical and specialty behavioral health for Medicaid beneficiaries. Pilot participants were unable to reach an agreement on costs and a proposed automatic statewide rollout of the program. The pilots were announced in March 2018, with implementation scheduled for October 2020. [Read More](#)

Nursing Facilities Face Proposed Medicaid Reimbursement Cuts. *Skilled Nursing News/Crain's Detroit Business* reported on October 20, 2019, that skilled nursing facilities in Michigan would face significant Medicaid reimbursement cuts under a proposed policy. The proposal, which would take effect November 1, would alter the cost-based model to cap costs and rates at the 65th percentile, down from the 80th percentile currently. Public comments are due November 4, with cuts effective retroactively. [Read More](#)

Mississippi

UnitedHealth to Drop Alabama Hospitals from Mississippi Medicaid Network. *WKRG* reported on October 23, 2019, that UnitedHealthcare will drop the USA Health system in Alabama from its Mississippi Medicaid managed care network, effective January 2020. The move will largely impact Medicaid members in southern Mississippi who seek care in Mobile, AL. However, patients currently being served by USA Health will continue to have access. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

New York Approves Expansion of Medicaid HIV Special Needs Plan Beyond NYC. *Crain's Health Pulse* reported on October 23, 2019, that the New York Department of Health has approved the Visiting Nurse Service of New York's (VNS Choice) expansion of its Medicaid HIV special needs plan (SNP) into Nassau and Westchester counties. HIV SNPs are available for Medicaid-eligible individuals who have HIV/AIDS, identify as transgender or are homeless. Prior to this, New York's three HIV SNPs, Amida Care, Metro Plus SNP and VNS Choice, had only provided coverage in New York City. In addition to covering all Medicaid benefits, HIV SNPs also provide care coordination, treatment adherence, and HIV prevention and risk reduction education. HIV SNPs began in 2001; approximately 14,000 individuals are currently enrolled in an HIV SNP. Since New York established its Health and Recovery Plans in 2016, the HIV SNPs have been allowed to enroll HARP-eligible individuals into their plans. [Read More](#)

New York Expected to Pass Out-of-Network "Surprise" Hospital Bill. *Crain's New York* reported on October 18, 2019, that legislation meant to protect New Yorkers from unexpected surprise bills from hospital emergency department visits would give insurers the ability to pay hospitals outside their networks what they consider reasonable for emergency care, rather than what the hospital charged. New York's current patient protection law shields patients from having to pay a bill when they are taken to an emergency department at a hospital outside their network; insurers must cover those costs no matter how much the hospital charges. The new legislation would allow insurers to initiate an independent dispute resolution process, allowing an arbitrator to decide whether the hospital's charge or insurer's payment is appropriate. The hospital industry has opposed the bill, which they say coerces hospitals into joining insurance networks, reducing their bargaining power. A compromise has been reached that says insurers must provide the hospital with at least 25 percent more than the amount the health care plan paid in its most recent in-network contract before taking any bill to arbitration. The fight over emergency department billing was in fact a proxy for the much larger fight over leverage at the negotiating table between hospitals and insurance companies. [Read More](#)

New York Approves Centene Acquisition of WellCare Subsidiaries. Centene Corp. and WellCare Health Plans, Inc. announced on October 22, 2019, that New York regulators have approved Centene's pending acquisition of WellCare subsidiaries in the state. The companies expect to complete the transaction in the first half of 2020. [Read More](#)

Ohio

Drug Distributors Settle Opioid Lawsuit Filed by Ohio Counties. *The New York Times* reported on October 21, 2019, that drug distributors McKesson, Cardinal Health and AmerisourceBergen and drug manufacturer Teva have settled opioid litigation brought by two Ohio counties for \$260 million. The distributors will pay \$215 million, while Teva is expected to pay \$20 million in cash and donate \$25 million worth in addiction treatment drugs. Talks concerning a universal settlement of litigation involving cities, counties, and states around the nation are ongoing. [Read More](#)

Oklahoma

Oklahoma Medicaid Expansion Advocates to Submit Signatures for 2020 Ballot Initiative. *The Tulsa World* reported on October 23, 2019, that healthcare advocates in Oklahoma will submit nearly 178,000 signatures to state officials to put Medicaid expansion on the ballot in 2020. Expansion would reach individuals up to 138 percent of poverty. [Read More](#)

Oklahoma Expands SoonerCare Virtual Pharmacist Program Statewide. On October 23, 2019, the Oklahoma Health Care Authority announced the statewide expansion of a virtual pharmacist pilot program designed to generate personalized treatment plans for SoonerCare members with high-cost, chronic conditions. The program utilizes technology from Arine. [Read More](#)

Pennsylvania

HMA Roundup - Julie George ([Email Julie](#))

Pennsylvania Exchange Plans Rates to Rise 4 Percent. *The Pittsburgh Post-Gazette* reported on October 17, 2019, that Pennsylvania Insurance Commissioner Jessica Altman released the state-approved rates, which show that consumers statewide should see an average 4 percent rate increase for individual market plans and 9.7 percent increase for small group plans. Commissioner Altman said legislation signed by Governor Tom Wolf earlier this year creating a state-based exchange for Pennsylvania could lower premiums 5-10 percent. The Exchange and reinsurance program should be available January 1, 2021. [Read More](#)

Tennessee

Tennessee Medicaid Block Grant Proposal Is Met with Disapproval at Town Hall. *The Daily Memphian* reported on October 16, 2019, that Tennesseans voiced strong opposition to the state's \$7.9 billion Medicaid block grant proposal during a hearing in Memphis. The response was similar in other hearings across the state. Tennessee will submit its block grant proposal for federal approval in November. [Read More](#)

Texas

Texas to Award Medicaid Dental MCO Contracts to DentaQuest, MCNA, UnitedHealth. On October 14, 2019, the Texas Health and Human Services Commission announced its intent to award dental managed care contracts to DentaQuest USA Insurance Company, Inc., MCNA Insurance Company, and UnitedHealthcare. The program provides dental services to more than 3 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. Implementation will begin September 1, 2020, and contracts will run through August 31, 2023, with five optional one-year extensions. [Read More](#)

Washington

Washington Insurer Is Accused of Medicare Fraud in Whistleblower Lawsuit. *Kaiser Health News* reported on October 18, 2019, that not-for-profit health plan Group Health Cooperative of Seattle, WA, has been accused in a federal whistleblower lawsuit of overcharging Medicare about \$8 million for services billed in 2010. The Justice Department, which hasn't yet taken over the case, said in June that it was investigating the allegations. [Read More](#)

National

ACA Plan Premiums to Fall by 4 Percent in 2020. *CQ News* reported on October 22, 2019, that average premiums for Exchange plans will decrease by 4 percent in 2020, according to the Department of Health and Human Services. State reinsurance programs helped drive down rates. The number of plans offering products on the federal Exchange will increase by 20 in 2020. Average premiums fell 1 percent in 2019. [Read More](#)

Judge Pushes For Last-Minute Opioid Settlement Ahead of Trial. *The New York Times* reported on October 18, 2019, that U.S. District Judge Dan Polster is pushing for a last-minute settlement of lawsuits related to the opioid epidemic before the case goes to trial next week. Scheduled to appear today at Polster's request are chief executives of drug distributors AmerisourceBergen, Cardinal Health, and McKesson; executives from Teva Pharmaceutical Industries and Walgreens; state attorneys general; and officials from other state and local governments. [Read More](#)

House Democrats Push to Strengthen Drug Pricing Bill. *The Hill* reported on October 16, 2019, that House Democrats are seeking to strengthen a bill aimed at lowering drug prices. The revised bill, which authorizes the Secretary of Health and Human Services to negotiate lower prices for up to 250 drugs, would require a minimum of 35 drugs to be negotiated, up from 25 originally. The measure, which is expected to pass the House, impacts individuals in Medicare and commercial plans. [Read More](#)



INDUSTRY NEWS

UPMC CFO Retiring at Year's End. *The Pittsburgh Post-Gazette* reported on October 17, 2019, that UPMC Executive Vice President and Chief Financial Officer Rob DeMichiei is retiring in December 2019. DeMichiei has served as chief financial officer for 15 years. Ed Karlovich, who is chief financial officer for the system's health services division and has been with UPMC for almost 30 years, will serve as interim CFO of UPMC during a search for a replacement. [Read More](#)

Humana Files Antitrust Lawsuit Against Generic Drug Makers. *Modern Healthcare* reported on October 21, 2019, that Humana has filed an antitrust lawsuit alleging pharmaceutical companies, including Teva Pharmaceuticals, fixed prices for more than 100 generic drugs. In May, more than 40 states filed a federal lawsuit alleging drug companies were inflating prices. [Read More](#)

Centene, WellCare Announce Five More State Approvals for Pending Merger. On October 18, 2019, Centene Corp. and WellCare announced that the insurance departments of Arizona, Connecticut, Georgia, Ohio and Texas have approved Centene's pending acquisition of WellCare, bringing the total number of states to approve the merger to 24. The companies expect the completion of the transaction by the first half of 2020. [Read More](#)

Centene, Walgreens Invest in RxAdvance. On October 17, 2019, Walgreens announced a small investment in pharmacy benefit manager RxAdvance, while Centene Corp. increased its stake in the company following an initial investment in 2018. The three companies also announced a partnership to aimed at enhancing transparency and helping pharmacists make decisions at the point of care. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Washington DC	RFP Release	276,000
October 2019	Texas STAR+PLUS	Awards	530,000
December 1, 2019	Texas STAR and CHIP	Awards	3,400,000
December 17, 2019	Pennsylvania HealthChoices Physical Health	Proposals Due	2,260,000
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 - March 2020	Ohio	RFP Release	2,360,000
Spring 2020	Washington DC	Awards	276,000
January 1, 2020	Louisiana - Protests May Delay Implementation Date	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	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	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
January 6, 2020	Hawaii	Awards	340,000
January 6, 2020	Indiana Hoosier Care Connect ABD	Proposals Due	90,000
February 1, 2020	North Carolina - Phase 1 (delayed) & 2	Implementation	1,500,000
April 30, 2020	Indiana Hoosier Care Connect ABD	Awards	90,000
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
December 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
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 ANNOUNCEMENTS

Truth, Lies, and The Evidence: The Controversy about Screening Mammography

HMA WELCOMES

Ana Paola Bueno - Senior Associate

Ana Paola Bueno is an accomplished nonprofit professional with more than 16 years of senior level experience in the state of Maryland. A thoughtful and dedicated leader, she has deep experience overseeing agency administration, programs, and strategic direction, specializing in operations and development of efficient processes, community engagement and facilitation.

Before joining HMA, Ana Paola worked as chief executive officer of Mission of Love Charities, Inc. (MOLC), a nonprofit organization that provides basic life needs to low income and homeless individuals in Prince George's County. While there, she developed resources and programs to ensure the organization's mission of empowering, educating and advocating for low-income families was fulfilled.

With an established background in nonprofit leadership and operations, she has launched new initiatives, including opening a nonprofit family planning clinic in Silver Spring, Maryland. She also worked as director of finance and administration for Mobile Medical Care, Inc., a Federally Qualified Health Center (FQHC) which operates nine facilities in Montgomery County, Maryland.

Throughout her career, she has worked to lead organizations with integrity and transparency as well as focus on fostering diverse environments for staff and clients. In her different roles within the nonprofit sector, Ana Paola has worked to address social determinants of health with public agencies, FQHCs, hospitals, stakeholders and other nonprofit organizations with major emphasis on community engagement.

Ana Paola has a bachelor's degree in business management and a master's degree in nonprofit and association management, both from the University of Maryland University College.

Susan Fleischman - Principal

A seasoned clinician and healthcare executive, Susan Fleischman, MD, has excelled as a strategic business leader with expertise in Medicaid Managed Care policy, financing and care delivery with organizations including an integrated health plan and delivery system; she brings this vast experience and know-how to help guide HMA clients.

Prior to joining HMA, she served as national vice president for Medicaid, Charitable Care and Coverage for Kaiser Permanente where she was responsible for the creation and implementation of strategies for Kaiser Permanente to participate in Medicaid.

She has also served as a Medicaid health plan medical director providing medical oversight for a one million-member program serving members insured through government payers including Medicaid and the Children's Health Insurance Program (CHIP).

Her clinical experience includes serving as medical director and physician for a Federally Qualified Health Centers providing healthcare services to low-income uninsured individuals and families, including the homeless. She has also been an associate professor at the University of California, Los Angeles (UCLA) teaching community medicine to residents and medical students.

Dr. Fleischman is active in advocacy and improving programs and care for families in need. She earned a Doctor of Medicine degree and bachelor's degree in chemistry from UCLA and is a graduate of the first class of the California Healthcare Foundation Medical Leadership Fellowship. She has also participated as faculty for the program.

Moira Muir - Senior Consultant

Moira Muir has more than 25 years of experience in behavioral healthcare including program administration, managed care, direct patient care and population health management. As a licensed mental health counselor, she has specialized in overseeing emergency mental health services and organizations.

She has extensive subject matter expertise in behavioral health emergency services and oversaw statewide emergency services programs (ESPs) in Massachusetts including strategic planning for 21 ESPs to ensure high quality, culturally competent, clinically and cost-effective integrated community-based behavioral health crisis assessment, intervention, and stabilization services. Her efforts helped establish these ESPs as viable service alternatives to hospital emergency departments.

Moira has collaborated with the Massachusetts Medicaid program and the Department of Mental Health to redesign the statewide ESP system including development of quality metrics and key performance indicators. She is a key contributor to statewide initiatives relative to emergency department policies and access to behavioral healthcare.

Before joining HMA, Moira was vice president of population health at Lahey Health Behavioral Services, a community-based organization that provides a wide range of integrated behavioral health and substance use disorder treatment. In that role, Moira led the organizations' healthcare reform implementation efforts. She served as the behavioral health director for the health system's Medicaid accountable care organization (ACO). She also launched a successful behavioral health community partner program- a community-based entity that works with ACOs and managed care organizations to provide targeted care management and coordination to Medicaid members with significant behavioral health needs, including serious mental illness and addiction.

Moira spent 15 years working as a clinician in a variety of settings with a primary focus on crisis intervention.

She earned her master's degree in counseling psychology from Northeastern University and her bachelor's degree from University of California, Los Angeles.

David Wedemeyer - Principal

David Wedemeyer is an established data expert and a seasoned consultant with expertise developing Healthcare Effectiveness Data and Information Set (HEDIS) and risk programs, process improvements, and software tools.

In the medical management field, he has experience with quality improvement and has provided subject matter expertise in building software tools to auto-code service and diagnosis codes for electronic medical records (EMR) systems. This included working with certified vendors and health plans. In addition, he has developed processes for standardized data pulls from electronic medical records databases and supplemental sources.

David has significant accreditation expertise, specifically National Committee for Quality Assurance (NCQA) Accreditation and has been a featured speaker on this topic at numerous conferences including the Medicare Advantage Congress conference. At HMA, he will assist clients with a wide range of NCQA needs while helping them navigate process improvement, risk adjustment, Medicare Stars programs, and requests for procurement of new state and federal programs.

He has prepared, audited, and submitted all requirements for NCQA Accreditation. With a focus on improvement and return on investment, he also developed HEDIS, Consumer Assessment of Healthcare Providers and Systems, and Health Outcomes Survey and Starts proactive programs to save organizations efforts and resources.

David has extensive experience writing responses to request for proposal (RFP) questions pertaining to all medical management areas for state and federal business including Medicaid and Medicare programs in California and Arizona.

Before joining HMA, David served as senior director of quality improvement with LA Care Health Plan where he directed and developed model of care and care plans, created company-wide Medicare Stars improvement programs, and oversaw all annual credentialing, quality review, and evaluations including HEDIS, NCQA, Medicare and Medicaid programs.

With a background in direct patient care, David began his career in nursing, serving as a registered nurse, nurse coordinator, urgent care staff nurse and staff development coordinator. He received a Bachelor of Science in Nursing degree from the University of Phoenix. He also completed certifications as an emergency medical technician and licensed vocational nurse.

HMA NEWS

New this week on HMA Information Services (HMAIS):

Medicaid Data

- California Medicaid Managed Care Enrollment is Down 1.8%, Sep-19 Data
- Colorado RAE Enrollment is Down 3.2%, Sep-19 Data
- Florida Medicaid Managed Care Enrollment is Down 2.2%, Sep-19 Data
- Iowa Medicaid Managed Care Enrollment is Up 4.0%, Oct-19 Data
- Illinois Dual Demo Enrollment is Up 7.2%, Sep-19 Data
- Illinois Medicaid Managed Care Enrollment is Down 1.7%, Sep-19 Data
- Michigan Dual Demo Enrollment is Up 7.6%, Sep-19 Data
- Michigan Medicaid Managed Care Enrollment is Down 0.9%, Sep-19 Data
- Minnesota Medicaid Managed Care Enrollment is Down 1.4%, Oct-19 Data
- Ohio Dual Demo Enrollment is Down 0.7%, Oct-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Down 0.8%, Jul-19 Data
- Pennsylvania Medicaid Managed Care Enrollment is Down 1.2%, Aug-19 Data
- Rhode Island Dual Demo Enrollment is 14,263, Oct-19 Data
- Vermont Medicaid Fee for Service vs. Managed Care Penetration, 2014-18
- Washington Medicaid Managed Care Enrollment is Down 1.7%, Sep-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Colorado Medicaid Enterprise Systems Services Integrator RFI and Amendment, Oct-19
- Iowa D-SNPs Contracts, 2017-19
- Indiana Hoosier Care Connect Managed Care RFP, Oct-19
- Indiana Proposed Approach for Medicaid Services for Eligible DCS Children and Youth RFI, Oct-19
- Kentucky Independent Assessment for 1915b Waiver Renewal RFP, Oct-19
- Minnesota Qualified Grantees to Provide Services to Pregnant and Post-Partum Women with Substance Use Disorders RFP, Oct-19
- Minnesota Qualified Responders to Improve Quality of Services for People Receiving Customized Living Services Through Elderly Waiver RFP, 2019
- Oklahoma Consulting Contractor for Various Medicaid Issues RFP, Oct-19
- Virginia DMAS Inter-rater Reliability for LTSS Functional Eligibility Screenings RFI, Oct-19

Medicaid Program Reports, Data and Updates:

- GAO Report on Actions Needed to Address Weaknesses in Oversight of Costs to Administer Medicaid Work Requirements, Oct-19
- Colorado Children's Health Plan Plus Caseload by County, Sep-19
- DC State Medicaid Health IT Plan, 2018-23
- Iowa Home and Community Based Services (HCBS) Final Settings Statewide Transition Plan (STP), Oct-19
- Indiana Medicaid Managed Care Demographics by Age, Aid Category, and Program, 2016-18, Aug-19

- Maryland Medicaid Advisory Committee Meeting Materials, Sep-19
- Michigan Enacted DHHS Budget, FY 2020
- Michigan Nursing Home Variable Cost Limit Rate Change Proposed Policy Draft, Sep-19
- South Dakota Medicaid Advisory Committee Meeting Materials, May-19
- Texas TANF State Plan Draft Renewal, Oct-19
- Vermont Medicaid Program Enrollment and Expenditures Reports, SFY 2018-19

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

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HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With 23 offices and over 200 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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