

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... November 14, 2018



[RFP CALENDAR](#)

[HMA News](#)

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THIS WEEK

- **IN FOCUS: CMS RELEASES PROPOSED MEDICAID MANAGED CARE REGULATIONS**
- FLORIDA CLOSES ITN FOR REGIONS 3-7 OF SMMC MMA PSN
- MAINE GOVERNOR TO IMPLEMENT MEDICAID EXPANSION UPON TAKING OFFICE
- MONTANA VOTERS REJECT TOBACCO TAX TO FUND MEDICAID EXPANSION
- NEW JERSEY CREATES CONSUMER PORTAL TO FACILITATE ACA OPEN ENROLLMENT
- CMS CONSIDERS ALLOWING HOSPITALS TO USE MEDICAID FUNDS FOR HOUSING
- CMS ANNOUNCES SHORT-TERM IMD EXCLUSION WAIVERS FOR SERIOUS MENTAL ILLNESS
- CMS TO PROPOSE RULE ALLOWING STATES TO LIMIT NEMT SERVICES
- GATEWAY HEALTH APPOINTS CAIN HAYES AS PRESIDENT, CEO
- **HMA LAUNCHES CONTINUING MEDICAL EDUCATION (CME) PLATFORM**

The HMA Weekly Roundup will be off Wednesday, November 21st. We will resume our regular weekly publication on November 28th. The HMA Weekly Roundup team wishes all our readers happy and safe holidays!

HMA ANNOUNCEMENT

HMA LAUNCHES CONTINUING MEDICAL EDUCATION (CME) PLATFORM BEGINNING WITH 12 MODULES COVERING POPULATION HEALTH IN THE SAFETY NET

Among the biggest challenges facing clinicians today is keeping up to date with the latest medical advances, care models, and delivery system redesign efforts. The need for ongoing learning is especially true for safety net providers, where new approaches to care and system redesign are rapidly emerging.

That's why Health Management Associates is happy to announce HMA Learning, a new continuing medical education (CME) platform specifically designed to help clinicians navigate changes within a safety net environment.

12 New CME Modules

HMA Learning's initial offering is a series of 12 online modules focused on population health in the safety net. Clinicians can select any module online for just \$20 each, \$200 for all 12, or contact HMA for group, network, or enterprise-wide rates. Subsequent modules will address a wide variety of other issues central to safety net providers.

This 12-module series provides a basic understanding of population health concepts and tools, representing HMA's best thinking on the topic. Modules can be completed in any order and count for 1.0 CME credits per module¹. Topics include:

1. Adaptive Leadership and Leading Change
2. Addressing Patients' Social Determinants of Health
3. LTSS: Understanding Services for Elderly and Individuals with Disabilities to Address Living Needs
4. MACRA and Value-Based Care
5. Principles for Negotiating Alternative Payment Methodologies Provider Vitality
6. Provider Vitality: Strategies for Ensuring an Energized & Effective Healthcare Workforce
7. Supporting Family Caregivers for Better Population Health
8. The Clinician Leader's Role in Developing a Telepsychiatry Program
9. The Role of Pharmacy Benefit Managers in Population Health
10. Transformed Care Management
11. Using Informatics to Guide Population Health Management
12. VBPC: Using Relationship-Centered Care to Transform Delivery Systems

Natural Extension of HMA Consulting Services

We chose to kick off HMA Learning with the 12-module population health series because of our nationally recognized consulting practice, where we have assisted hundreds of clients in developing and implementing delivery system redesigns and new models of care.

Because provider education is a key component of delivery system redesign, HMA has been able to develop broad training expertise and is registered as a CME provider with the American Academy of Family Physicians (AAFP).

¹ This Enduring Material activity, Population Health in the Safety Net, has been reviewed and is acceptable for up to 12.00 Prescribed credit(s) by the American Academy of Family Physicians. AAFP certification begins 10/01/2018. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

HMA experts work side by side with safety providers daily, training clinicians and clinician leaders to think differently.

To begin learning immediately, visit the HMA Learning website at <https://learning.hlthmgt.com/>. Questions about the modules or pricing can be directed to Margaret Kirkegaard, Principal, Health Management Associates (Chicago, IL), 312-600-6744, mkirkegaard@healthmanagement.com

Visit <https://learning.hlthmgt.com/> for details.

IN FOCUS

CMS RELEASES PROPOSED MEDICAID MANAGED CARE REGULATIONS

This week, our *In Focus* section comes to us from HMA Senior Consultants Amber Swartzell and Stephanie Baume (Indiana), who reviewed the Centers for Medicare & Medicaid Services (CMS) proposed Medicaid managed care regulations. On November 8, 2018, CMS released a proposed rule that would update several sections of the Medicaid and Children's Health Insurance Program (CHIP) managed care rules, which were most recently amended in 2016. This much anticipated proposal, scheduled to appear in the Federal Register on November 14, 2018, focuses on "promoting flexibility, strengthening accountability, and maintaining and enhancing program integrity." The key provisions of the proposed regulations are summarized below.

Payment Provisions

The proposed rule maintains the current regulatory requirement that states phase out pass-through payments to hospitals, physicians and nursing facilities in existing managed care programs. However, a new option is proposed for states transitioning services and populations from fee-for-service (FFS) to managed care. States with new or expanded managed care programs that are currently making supplemental payments under FFS would be permitted to require health plans to make pass-through payments to hospitals, nursing facilities or physicians for up to three years. To exercise this option, a state must have been making supplemental payments to these providers during the "12-month period immediately two years prior to the first year of the transition period." The proposed rule establishes a formula to determine the maximum aggregate amount of permissible pass-through payments to ensure the payments are less than or equal to the supplemental payments made via FFS.

Additionally, CMS maintains the general requirement that states may only direct health plan payments to providers under certain conditions. Currently, states may direct payments for performance improvement and delivery system reform models, mandate the use of minimum or maximum fee schedules, and require uniform dollar or percentage increases for a particular service. To further clarify the types of permissible reimbursement mandates, a new

provision is proposed that would explicitly allow states to require rates that are cost-based, Medicare equivalent, commercial or market-based.

Modifications are also proposed to the CMS approval process for directed payments, including eliminating the requirement that advanced approval is required to direct health plans to reimburse at State Plan rates. Additionally, they propose to permit multi-year versus annual approval when states require health plans to implement value-based purchasing models, participate in delivery system reform or performance improvement initiatives. Finally, CMS proposes to remove the current prohibition on states to set the amount or frequency of expenditures for directed health plan payments for delivery system or provider payment initiatives.

Capitation Rate Setting Provisions

CMS proposes modifications to the capitation rate setting processes. With implementation of the 2016 regulations, CMS stopped permitting the certification of rate ranges and instead required each rate cell to be certified as actuarially sound. In response to stakeholder feedback that this requirement reduces states' ability to receive the best rates through competitive procurement and increases administrative cost and burden, CMS is proposing to allow states to develop and certify a rate range when a series of requirements are met.

To avoid cost-shifting to the federal government, current regulations require that proposed differences among capitation rate cells be based on valid rate development standards and not on the rate of federal financial participation (FFP) associated with the covered population. For example, under the current regulations CMS would not approve rate cells that set minimum provider payment requirements only for populations with a higher FFP, unless supported by valid rate development standards. This requirement is maintained with proposed clarifying language prohibiting differences in the "assumptions, methodologies or factors" used to develop rates based on the FFP associated with the covered population "in a manner that increases Federal costs." To determine if rate setting methods increase cost to the federal government and vary by FFP, it is proposed that all managed care contracts and programs within a state would be compared. Additionally, a non-exhaustive list of prohibited rate development practices is proposed.

Further, CMS proposes to prohibit states from retrospectively adding or modifying risk-sharing arrangements. Additionally, since 2014, CMS has issued annual capitation rate review guidance; the proposed rule seeks to codify this practice and commits CMS to annual publication of such sub-regulatory guidance.

Quality Provisions

CMS maintains the Medicaid managed care quality rating system (QRS) established in the 2016 regulations but proposes a series of modifications intended to better balance the interests of standardization and state flexibility. States would no longer be required to receive advanced CMS approval to utilize an alternative state QRS but would be required to utilize federally mandated performance measures. Additionally, in recognition of the difficulty in producing comparable information across states with vastly different programs, the requirement that an alternative state QRS produce "substantially comparable" information to the CMS-developed QRS, includes

new language that this is required “to the extent feasible, taking into account such factors as differences in covered populations, benefits, and stage of delivery system transformation.” CMS also proposes language committing itself to engaging stakeholders in the development of sub-regulatory guidance for states to demonstrate they have met the requirement for substantial comparability.

Beneficiary Information Requirements

CMS proposes some modifications to beneficiary information requirements, including striking the current requirement that taglines in prevalent non-English languages, large print and alternative formats be provided for all written materials. To respond to reported state and health plan concerns that these requirements increase document length and reduce the use of effective formats to communicate with beneficiaries, CMS proposes to require this information only on materials which are “critical to obtaining services.” Further, under the proposal, modifications are made to the requirements for provider directories, most notably that health plans would no longer be required to update paper provider directories monthly if they have a “mobile-enabled, electronic provider directory.” Additionally, the timelines for health plans to notify enrollees of provider terminations are modified under the proposal, replacing the current 15-day standard with the requirement to notify beneficiaries the later of 30 days prior to the effective date or within 15 days after receipt or issuance of the termination notice.

Grievances and Appeals Provisions

CMS has proposed several revisions to regulations governing managed care grievances and appeals. First, CMS clarifies that health plans would not be required to generate adverse benefit determination notices to enrollees for claims denied for being “unclean.” This is intended to reduce administrative burdens for health plans as well as enrollee confusion. Additionally, the proposed rule would eliminate the current requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted to reduce barriers for enrollees, decrease the economic and administrative burden on managed care plans and expedite the appeals process.

Finally, CMS proposes to revise the timeframe for enrollees to request a state fair hearing to be no less than 90 calendar days and no greater than 120 calendar days from the date of the health plan’s notice of resolution. CMS is proposing to revise the current “no later than 120 calendar days from the date of the MCO’s, PIHP’s, or PAHP’s notice of resolution” language as it believes the proposed revision would allow states that wish to align managed care with the FFS filing timeframe to do so while not jeopardizing the enrollee’s ability to gather information and prepare for a hearing.

Network Adequacy Provisions

Under the proposed rule, the current requirement for states to develop time and distance standards for network adequacy would be replaced with a more flexible requirement to set a quantitative minimum access standard for specified health care and long-term services and supports (LTSS) providers. CMS has indicated these proposed changes would enable states to choose from a variety of quantitative network adequacy standards, including minimum provider-to-enrollee ratios, maximum travel time or distance to providers, or maximum wait times for an appointment.

Current regulations also specify the provider types for which states are required to establish network adequacy standards, which includes “specialist, adult and pediatric.” Under the proposed rule, CMS clarifies that “specialist,” for purposes of this requirement should be defined at a state level rather than a federal level to allow flexibility for states to determine the definition that best suits their respective program and managed care contract.

CHIP

CMS proposes several revisions, clarifications and technical corrections to the CHIP managed care regulations. This includes clarifying language to confirm the compliance effective date for CHIP regulations under the 2016 final rule is required as of the first day of the state fiscal year beginning on or after July 1, 2018, regardless of a state’s health plan contract term. While technical revisions are made to several sections of the CHIP regulations, the most notable revisions are proposed to the grievance and appeals section, which currently cross references the Medicaid regulations, in order to better describe the requirements under CHIP.

Miscellaneous Proposals

Current regulations require health plans that cover Medicare-Medicaid dually eligible enrollees sign a Coordination of Benefits Agreement (COBA) and participate in the automated crossover claim process administered by Medicare. CMS has received feedback that prior to the 2016 rule, states had effective processes in place to identify and send appropriate crossover claims to their health plans and that discontinuance of these processes adds unnecessary costs and burden to the state and health plans, creates confusion and delays provider payments. As a result, CMS proposes to remove the requirement that health plans must enter into a COBA directly and instead would require health plan contracts specify the methodology by which the state would ensure that the health plans receive all appropriate crossover claims, allowing states to determine the method that best meets the needs of their program.

Further, current regulations require that contracts between a state and health plan provide for the submission of all enrollee encounter data that the state is required to submit to CMS. CMS proposes to add language clarifying that allowed and paid amount must be included in the encounter data due to the importance of these data for proper monitoring and administration of the Medicaid program, principally for capitation rate setting and review, financial management and encounter data analysis.

While there had been speculation CMS would propose changes to the medical loss ratio (MLR) calculation, they proposed only minor technical corrections. Similarly, changes were not proposed to the current 15-day limit on stays in an institution for mental disease (IMD).

CMS will be accepting comments on the proposed rule for 60 days following publication in the Federal Register. The expected date of publication is November 14, 2018 with a comment period closing at 5 pm on January 14, 2019. Comments may be submitted electronically at <http://www.regulations.gov>. Mailed comments may be sent to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2408-P, P.O. Box 8016, Baltimore, MD 21244-8013. Written comments by express or overnight mail may be sent to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2408-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850. CMS requests that commenters refer to file code CMS-2408-P in their comment submission.

For further information regarding the proposed regulation, please contact Amber Swartzell aswartzell@hmamedicaidmarketsolutions.com or Stephanie Baume at sbaume@hmamedicaidmarketsolutions.com.

Proposed Rule



HMA MEDICAID ROUNDUP

Florida

Florida Closes ITN for Regions 3-7 of SMMC Managed Medical Assistance PSN. The Florida Agency for Health Care Administration (AHCA) issued on November 9, 2018, a notice that the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance Provider Service Network (PSN) Invitations to Negotiate (ITN) for regions 3, 4, 5, 6, and 7 are closed. AHCA received letters of intent for those regions from Independent Living Systems, LLC, in response to the ITN but deemed them non-responsive. The ITNs were originally for Regions 3, 4, 5, 6, and 7 of the state's 11 managed care regions, where no PSNs were awarded contracts in the recent reprocurement.

Florida Blue Is Hit with Antitrust Lawsuit Filed by Oscar Health. *Health News Florida* reported on November 13, 2018, that New York-based Oscar Health has filed an antitrust lawsuit against Florida Blue, alleging that the insurer is monopolizing the individual insurance market in Orlando. The suit claims that Florida Blue requires insurance brokers to sign exclusive contracts. Oscar claims that almost 200 brokers backed out of agreements to sell its plans, even though some of the Oscar options are less expensive for consumers. [Read More](#)

Louisiana

Louisiana May Have Spent \$85 Million On Ineligible Medicaid Recipients, Audit Finds. *The Advocate* reported on November 13, 2018, that Louisiana may have paid as much as \$85 million over 20 months for Medicaid enrollees who didn't qualify for coverage. A state auditor found that the Louisiana Department of Health and Hospitals relied too heavily on member self-reported income to determine eligibility instead of wage data from the state labor department. Average monthly spending per ineligible recipient was \$3,284, the study said. [Read More](#)

Maine

Governor-Elect Janet Mills to Implement Medicaid Expansion Upon Taking Office. *The Portland Press Herald* reported on November 7, 2018, that Maine Governor-elect Janet Mills has signaled her intention to implement the state's voter-approved Medicaid expansion plan immediately upon taking office in January. An estimated 70,000 low-income people would become eligible for Medicaid under the expansion. Mills, a Democrat, will consider authorizing coverage retroactive to July 2 for those that applied for coverage but were denied, a population of approximately 4,500. [Read More](#)

Maryland

Maryland May Have Enrolled Ineligible Individuals Into Medicaid Program, Audit Finds. *The Baltimore Sun* reported on November 8, 2018, that Maryland may have enrolled ineligible individuals in the state's Medicaid program for fiscal years 2015 through 2017. An audit of the Maryland health insurance Exchange found that the state may have not counted all income sources when determining Medicaid eligibility. In Maryland, the Affordable Care Act Exchange is also used to sign up Medicaid beneficiaries. [Read More](#)

Montana

Montana Voters Reject Tobacco Tax to Fund Medicaid Expansion. *Kaiser Health News* reported on November 9, 2018, that voters in Montana rejected a ballot measure to add a \$2 per pack tax increase on tobacco to help pay for the state's existing Medicaid expansion program beyond June 2019. Without continued funding, Montana may become the first state to undo Medicaid expansion after implementation. [Read More](#)

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

Governor Murphy's Administration Creates Consumer Portal to Facilitate ACA Open Enrollment. On November 9, 2018, the New Jersey Department of Human Services (DHS) Commissioner Carole Johnson released a notice that Governor Murphy's administration has created www.GetCovered.NJ.gov to serve as a portal for residents seeking health coverage. The site includes information about plan options, financial assistance, and contact information for New Jersey residents who want help to get covered. Residents can also call 1-877-9-NAVIG8 (877-962-8448) to talk about health insurance options and get help with enrollment.

In addition, five organizations are working with DHS to provide application assistance and organizing outreach events including:

- The Center for Family Services (1-877-922-2377)
- The Family Resource Network (1-800-355-0271)
- The Oranges ACA Navigator Project (1-973-500-6031)
- Fulfill Monmouth & Ocean (1-732-918-2600 or 1-732-731-1400)
- Urban League of Hudson County (1-201-451-8888, ext. 217)

New Jersey Enacts Medicaid Hospital Fee Program. *Becker's Hospital Review* reported on November 8, 2018, that New Jersey Governor Phil Murphy signed into law a bill that establishes a voluntary, five-year Medicaid hospital fee program in the state. The program would allow eligible counties to implement a fee on certain hospital procedures, which in turn would increase federal Medicaid matching funds. Eligible counties are Atlantic, Passaic, Essex, Hudson, Camden, Middlesex and Mercer. [Read More](#)

New York

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

New York DOH Seeking Evaluator for 1115 Waiver. On November 5, 2018, the New York State Department of Health (DOH) published a request for proposals (RFP) for potential vendors to conduct an independent evaluation of the New York State Medicaid Redesign Section 1115 Demonstration. The RFP seeks a vendor to conduct a comprehensive statewide interim independent evaluation to determine the effectiveness of the Demonstration in achieving its goals. [Read More](#)

New York Opens Two New Addiction Treatment Programs. On November 8, 2018, the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) announced the opening of the [Aurora Village Residential Treatment Facility](#) and on October 26, 2018, the [Champlain Valley Family Center Recovery Campus](#). Aurora Village, which will be operated by Horizon Health Services is a 25-bed facility which will provide addiction treatment services for women ages 18 and over. The Champlain Valley Family Center is a new residential detox and rehabilitation facility in Clinton County with 18 withdrawal and stabilization beds and residential treatment.

Analysis Looks at the Impact of Single-Payer on Hospital Reimbursement. On November 13, 2018, the Manhattan Institute released a report analyzing the impact of single-payer legislation on hospitals. The report's key findings suggest adoption of current Medicare reimbursement rates across the board would reduce New York hospitals revenues by 17 percent statewide, cutting income for 77 percent of the state's hospitals. Hospitals serving affluent downstate communities would face the biggest cuts under the scenarios presented in the report. [Read More](#)

North Carolina

Medicaid Expansion Is Still Uncertain After Midterms. *North Carolina Health News* reported on November 9, 2018, that the 2018 midterm elections may have brought change to the balance of power in North Carolina, but not enough to push forward Medicaid expansion without bipartisan support. Republicans still control both chambers of the legislature; although Democrats did win enough seats to break the Republican super-majority. Democratic Governor Roy Cooper supports expansion. [Read More](#)

Pennsylvania

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

Pennsylvania Awarded \$10 Million Grant to Better Integrate Substance Use Disorder and Mental Health Treatment. The Pennsylvania Department of Human Services (DHS) announced on November 8, 2018, that it will receive a \$10 million grant for the Office of Mental Health and Substance Abuse Services to improve integration between behavioral health and primary care. This funding, from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), will be distributed as \$2 million per year over the next five years to support the Promoting Integration of Primary and Behavioral Health Care Cooperative Agreements initiative. DHS established four partnerships with health centers around Pennsylvania in 2017. The partnerships will address disparities in behavioral health treatment for special populations by establishing fully integrated, comprehensive care models that address physical and behavioral health conditions. [Read More](#)

Pennsylvania Joins Growing Number of States Calling for PBM Transparency. *The Philadelphia Inquirer* reported on November 9, 2018, that Pennsylvania is among a growing number of states calling for additional transparency for pharmacy benefit management companies serving Medicaid. States like Louisiana and Ohio are rewriting PBM contracts to enhance transparency, while Virginia, Kentucky, and Georgia have passed legislation requiring additional disclosure of PBM payments. Much of the attention is around spread pricing, where PBMs profit by billing health plans more for a drug than what they pay pharmacies. [Read More](#)

South Carolina

South Carolina Remains Unlikely to Expand Medicaid, Says Former Medicaid Director. *The Post and Courier* reported on November 8, 2018, that South Carolina is unlikely to implement Medicaid expansion in the near term, according to Christian Soura, former state Medicaid director. Soura, who is now a vice president at the SC Hospital Association, noted that “it would be surprising to see a dramatic shift in Columbia over the course of the next legislative session.” Expansion in the state could cover a projected 170,000 adults. [Read More](#)

Utah

Utah Drops Limited Medicaid Expansion Proposal Following Voter Approval of Full Expansion. *Deseret News* reported on November 11, 2018, that the Utah Department of Health has asked for federal approval to cancel a partial Medicaid expansion proposal, following voter approval of full expansion in a ballot measure. Expansion, which will be implemented April 1, 2019, is expected to cover about a total of about 150,000 individuals. [Read More](#)

Utah Awards Contract to Evaluate Coverage Policy for Medicaid Autism ABA Services. The Behavioral Health Center of Excellence (BHCOE) announced on November 14, 2018, that it was awarded a contract to evaluate Utah Medicaid's three-year-old policy of covering applied behavioral analysis (ABA) services. BHCOE will also evaluate implementation practices, help identify high-quality providers, and suggest standards for training providers of ABA therapy. The state began covering ABA therapy for Medicaid beneficiaries in July 2015. [Read More](#)

National

CMS Considers Allowing Hospitals to Use Medicaid Funds for Housing. *Modern Healthcare* reported on November 14, 2018, that federal regulators are considering a plan to allow hospitals and health systems to use Medicaid funds to pay for food, housing, and other social determinants of health. California, Illinois, Minnesota and New York already have federal waivers for similar programs, and the Centers for Medicare & Medicaid Services (CMS) may give states additional flexibility. [Read More](#)

CMS Announces Short-Term IMD Exclusion Waivers for Serious Mental Illness. The Centers for Medicaid & Medicare Services (CMS) announced on November 13, 2018, a new opportunity for states to seek short-term IMD exclusion waivers, which would allow Medicaid to pay for inpatient mental health services for adults with serious mental illness and children with serious emotional disturbance. U.S. Health and Human Services Secretary Alex Azar also outlined the waiver opportunity in a speech before the National Association of Medicaid Directors, noting that the IMD exclusion has resulted in "the worst of both worlds," i.e., limited access to inpatient treatment and limited access to other options. Similar IMD waivers have been granted for inpatient substance abuse treatment. Azar added, "These waivers will help complement the good work so many of you are already doing to fight substance abuse and will help build a system where Americans with serious mental illness and their families can finally find the treatment and support they need." [Read More](#)

CMS Prenatal Care Initiative Reduces Preterm Births, Saves Money. *Modern Healthcare* reported on November 12, 2018, that the federal Strong Start for Mothers and Newborns program achieved a 20 percent reduction in the cost of delivery for pregnant women on Medicaid, according to a report funded by the Center for Medicare & Medicaid Services. The cost of delivery for women in Strong Start averaged \$6,527, or \$1,759 less than woman not in the program. Strong start also helped achieve a 36 percent reduction in preterm births, 44 percent reduction in low birth weight, and 28 percent reduction in NICU admissions. More than 200 providers in 32 states participated in Strong Start, which educates patients about child preparation, nutrition and family planning. [Read More](#)

CMS to Propose Rule Allowing States to Limit NEMT Services. *Modern Healthcare* reported on November 7, 2018, that the Centers for Medicare & Medicaid Services (CMS) is developing a proposed rule to limit non-emergency medical transportation (NEMT) for Medicaid beneficiaries, which could be released in May 2019. Iowa and Indiana have received federal waivers allowing them to cut NEMT services, while Kentucky and Massachusetts have waivers pending. Providers worry that without NEMT, the number of missed medical appointments will continue to rise. [Read More](#)



INDUSTRY NEWS

Veritas, Evergreen Strike \$5.7 Billion Deal to Acquire Athenahealth. *Modern Healthcare* reported on November 12, 2018, that Veritas Capital and Evergreen Coast Capital have agreed to acquire medical billing and electronic medical record company Athenahealth for \$5.7 billion in cash. Veritas and Evergreen will combine Athenahealth with Veritas-owned Virence Health, an analytics and software firm. Virence chief executive Bob Segert will lead the merged company. [Read More](#)

WellCare, Spectrum Health Join Blockchain Pilot to Streamline Provider Credentialing. *Fierce Healthcare* reported on November 12, 2018, that WellCare and Spectrum Health have joined a pilot project launched by ProCredEx, which uses blockchain technology to streamline physician credentialing and improve provider directories. Also involved in the pilot is Anthem's National Government Services, The Hardenberg Group, and Accenture. [Read More](#)

Gateway Health Appoints Cain Hayes as President, CEO. Gateway Health announced on November 8, 2018, the appointment of Cain Hayes as president and chief executive, effective November 26. Hayes will replace Patti Darnley, who left the company in August. Hayes was previously with Blue Cross Blue Shield of Minnesota. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
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
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
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	Implementation	~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

Solution Offering from MCG Health and Milliman Supports Successful Clinical Improvement Efforts

HMA NEWS

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- California Medicaid Managed Care Enrollment is Down 1.9%, Oct-18 Data
- Florida Medicaid Managed Care Enrollment is Down 0.7%, Oct-18 Data
- Hawaii Medicaid Managed Care Enrollment is Down 2.0%, Jun-18 Data
- Massachusetts Dual Demo Enrollment is 21.7%, Oct-18 Data
- Minnesota Medicaid Managed Care Enrollment is Flat, Nov-18 Data
- Missouri Medicaid Managed Care Enrollment is Down 7.3%, Oct-18 Data
- Ohio Medicaid Managed Care Enrollment is Down 3.1%, Oct-18 Data
- Pennsylvania Medicaid Managed Care Enrollment is Down 0.7%, Sep-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Florida SMMC Managed Medical Assistance Provider Service Network ITNs & Notices – CLOSED, 2018
- Indiana Pharmacy Benefit Management Services Contract and Amendments, 2017
- Missouri HealthNet Managed Care Model Contract, 2016
- Ohio Medicaid MCO Model Contract, Effective Jul-18
- Oklahoma Health Management Program RFP, Nov-18
- Pennsylvania HealthChoices Physical Health Model Contract, 2017
- Tennessee Medicaid Benefit Appeals Tracking System RFI, Nov-18
- Texas Medicaid Managed Care Model Contracts, 2017-18
- Virginia Medallion 4.0 Contract, 2019
- Virginia Smiles for Children (SFC) Medicaid and CHIP Dental Program RFI and Responses, Aug-18
- Washington Integrated Care for Kids (InCK) Model Project RFA, Oct-18

Medicaid Program Reports, Data and Updates:

- Alaska 2017 Drug Overdose Mortality Report, Nov-18
- Arizona AHCCCS Population Demographics, Nov-18 Data
- Florida SMMC Early Intervention Services Presentation, Oct-18
- Kansas Annual Insurance Update, 2018
- Montana DPHHS Enrollment, Expenditure Statistical Report, Jul-17
- MyCare Ohio Annual Reports, 2015-18
- New Mexico Documents Related to Renewal Application of 1115 Waiver, Centennial Care 2.0, Aug-18
- New Mexico Medicaid Advisory Committee and Subcommittee Meeting Materials, Nov-18
- Ohio Hospital Franchise Fee Amounts by Hospital, 2015-17
- Ohio MyCare Waiver Renewal Application, Aug-18
- Ohio Substance Use Disorder Treatment Draft 1115 Waiver, Oct-18
- Texas HHS Long-Term Care Facility Oversight Presentation, Nov-18
- CMS Proposed Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Rule, Nov-18

- CMS Opportunities to Design Innovative Service Delivery Systems for Adults with SMI and Children with SED, Nov-18
- CMS Strong Start for Mothers and Newborns Evaluation, Year 5, Volume 1, Oct-18

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