HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

WASHINGTON FQHC ALTERNATIVE PAYMENT METHODOLOGY

This week, our *In Focus* reviews a case study called, "Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology," authored and prepared for the National Association of Community Health Centers by Health Management Associates' Principal Art Jones and Senior Consultant Liz Arjun. The study, published in May 2018, looks at Washington's fourth federally qualified health center (FQHC) Alternative Payment Model (APM4), implemented in July 2017.

BACKGROUND

Washington adopted its initial FQHC APM in 2000 by inflating the FQHC Prospective Payment System (PPS) by a rate higher than the rate used nationally through a State Plan Amendment. As health care reform has continued to move away from fee-for-service, Washington State health centers became interested in developing FQHC APMs in partnership with their state Primary Care Association (PCA) and Medicaid agency that delink payment from the face-to-face visits through a primary care capitation approach with quality performance metrics.

APM4

Washington launched APM4 on July 1, 2017, with the state's 16 of 27 FQHCs participating. The goal of the new model was to allow clinics to improve access to primary care by using the full care team and to provide alternative access beyond face-to-face visits with billable clinicians. This model enables primary care providers to manage a larger member panel without increasing their work load. This in turn increases the per practitioner revenue for his/her panel. The quality component assures that the transition from a fee-for-service to a capitated approach does not reduce access to primary care services. The APM4 model applies to Medicaid managed care enrollees only. In addition, it enhances their performance on other pay-for-quality and shared savings arrangements already in place with the health plans for the same population. The previous version, known as APM3, relied on face-to-face encounter fee-for-service payments without incentives for quality or efficiency.

Changes to the APM:

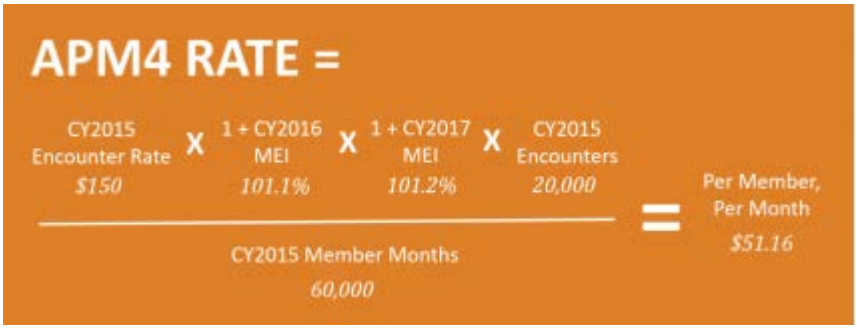
Source: Washington State Health Care Authority

Dental services, specialty mental health services, and services aimed at treating substance use disorder are carved out of APM4 reimbursement and will continue to be paid on a fee-for-service basis.

Rates

APM4 calculates an individual per member, per year (PMPY) budget neutral amount for each FQHC and pays that amount in a per member, per month (PMPM) amount. The PMPM is calculated by multiplying the FQHC's encounter rate under APM3 times the total number of billable encounters to enrollees in Medicaid managed care and dividing that by total Medicaid managed care months. It trends the PMPM rate by the Medicare Economic Index (MEI) annually. The baseline PMPM rate is then carried forward in future years as long as quality targets are met. Quality targets are set for each FQHC individually based on improvement from their historical performance.

Example:



Quality Measures

APM4 uses a subset of the Washington State Common Metrics. Failure to meet these quality performance measures results in a prospective reduction of the PMPM payments. The PMPM rate will never go below encounter-based equivalent payment amounts. After being adjusted downward for failure to meet quality targets, clinics can earn back the full benefit of the baseline PMPM rate in the future (as trended by the MEI) upon meeting quality improvement targets.

1. Comprehensive diabetes care - poor HbA1c control (>9%)
2. Comprehensive diabetes care - blood pressure control (<140/90)
3. Controlling high blood pressure (<140/90)
4. Antidepressant medication management
    a. Effective acute phase treatment
    b. Effective continuation phase treatment (6 months)
5. Childhood immunization status - combo 10
6. Well-child visits in the 3rd, 4th, 5th and 6th years of life
7. Medication management for people with asthma: medication compliance 50%
    a. (Ages 5-11)
    b. (Ages 12-18)

PROGRAM MONITORING

Although it is too early to gauge the success of the model, health centers are committed to working together with the Health Care Authority to address any future challenges. A small working group meets regularly to focus on:

- Quality performance measure reporting process and data validation sustainability
- The approach to reconciliation
- The change in scope process
- The health plan credentialing process

APM4 hopes to achieve improved access to primary care for individuals through a consumer-centric approach, not obtainable under a fee-for-service model.

Link to Case Study Report

HMA Medicaid Roundup

Alaska

Alaska Seeks to Recoup $15 Million in Medicaid Overpayments From Providers. *The Seattle Times* reported on July 19, 2018, that the Alaska Department of Health and Social Services is seeking repayment from primary, specialty and acute care medical professionals of up to $15 million in Medicaid overpayments, after the state failed to implement a 10 percent reduction in reimbursement rates that was supposed to take effect in October. The state is applying the reduction retroactively. Read More

Arkansas

Arkansas Judge Upholds Medicaid Payment Suspension to Preferred Family Healthcare. *The Northwest Arkansas Democrat Gazette* reported on July 24, 2018, that Arkansas administrative judge Vicki Pickering upheld the state's suspension of Medicaid payments to Preferred Family Healthcare, a Missouri-based not-for-profit, behavioral health provider. The suspension comes after allegations of improper claims for mental health services. In addition, the state will terminate Preferred Family contracts for mental health and substance abuse services outside of Medicaid. Read More

California

California Health Exchange Rates to Rise 8.7 Percent. *Kaiser Health News* reported on July 19, 2015, that individual health insurance rates on the Covered California Affordable Care Act Exchange will rise 8.7 percent in 2019. Covered California said the increase would have been about 5 percent if the penalty associated with the individual insurance mandate hadn't been repealed. The state expects about 262,000 Exchange and non-Exchange members to drop coverages in 2019. Nearly 90 percent of Covered California's 1.4 million enrollees qualify for subsidies. Read More

Connecticut

Medicaid NEMT Vendor Faces Patient Complaints. *The CT Mirror* reported on July 18, 2018, that Veyo, a California-based company contracted to provide non-emergency medical transportation (NEMT) services to Connecticut Medicaid beneficiaries, continues to face complaints over problems in getting patients to their appointments. Many of the complaints concern the wheelchair accessibility of Veyo vehicles. In response, the company has expanded its fleet of vehicles. Veyo is a division of Total Transit. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Judges to Consolidate Medicaid Managed Care Contract Award Challenges. *Health News Florida* reported on July 25, 2018, that judges from the Florida Division of Administrative Hearings will consolidate 27 challenges by health plans protesting the state's recent Medicaid managed care contract awards into a handful of cases grouped by type of eligibility category. Cases will be heard in August. For example, challenges filed by specialty managed care plans serving HIV/AID members would be consolidated into one case, while challenges filed by plans for people with serious mental illness would be consolidated into another. Other categories include comprehensive coverage and children with complex medical needs. Read More

Governor Faces Backlash After Two Specialty Medicaid Plans Lose Contracts. *Health News Florida* reported on July 19, 2018, that Florida Governor Rick Scott is facing a public backlash following a recent state decision not to award Medicaid managed care contracts to two plans that serve 90 percent of the state's specialty members, including individuals with HIV/AIDS and serious mental illness. Specialty plans Positive Healthcare, which serves 2,000 HIV/AIDS members in Florida, and Magellan, which serves 80,000 individuals with serious mental illness, are asking a state administrative judge to block the transition to new Medicaid plans. Winners of the recent procurement were Simply Healthcare/Clear Health Alliance for HIV/AIDS and WellCare of Florida for people with serious mental illness. Read More

Prison Health Costs Increase to $375 Million. *Health News Florida* reported on July 19, 2018, that health care costs for Florida prisons rose to $375 million from $278 million over the past five years. Florida fired the first company contracted to manage the prison health care system, and the second company walked away from the contract. Centurion of Florida, which is a joint venture of Centene Corp and MHM Services, won the contract in 2017. It was the only bidder. The contract allows for an 11.5 percent administration fee. Read More

Kentucky

Kentucky Restores Dental, Vision Benefits to Medicaid Beneficiaries. *The Associated Press* reported on July 20, 2018, that Kentucky Governor Matt Bevin restored dental and vision benefits to 400,000 Kentuckians affected by the cut after a federal judge rejected the state's proposed Medicaid work requirement. Benefits will be reinstated retroactively to the first of July. The state will also reinstate non-emergency medical transportation services for those recipients. Read More

Medicaid Work Requirement Waiver to Be Reopened for Public Comment. *Modern Healthcare* reported on July 18, 2018, that the Centers for Medicare & Medicaid Services (CMS) will reopen the Kentucky Medicaid work requirement waiver for another 30-day public comment period. The decision comes after a federal judge struck down the waiver and sent it back to CMS, ruling in a lawsuit filed by opponents that regulators failed to take into consideration the impact on Medicaid coverage. A CMS spokesman said the new public comment period would "better inform any future decision on the demonstration that was remanded back to the department for further review." Read More

Missouri

Health Advocates Express Cautious Optimism Regarding Medicaid Expansion. *St. Louis Post-Dispatch* reported on July 23, 2018, that Missouri health care advocates have renewed hope that Medicaid expansion is a possibility in the state, after seeing successful efforts in Maine, Idaho and Nebraska to put expansion on the ballot. Missouri lawmakers have opposed expansion, citing concerns over long-term funding of the program. Read More

Montana

Medicaid Agency, Nursing Homes Disagree Over Court Order on Rate Cuts. *U.S. News/Associated Press* reported on July 24, 2018, that the Montana Health Care Association has accused the state of defying a court order blocking cuts to reimbursement rates for nursing homes and assisted-living facilities serving Medicaid patients. However, the Montana Department of Public Health and Human Services is arguing that the court order has expired. Montana District Judge James Reynolds had previously issued a temporary restraining order preventing the cuts from taking effect until a new order is issued. He also said the state only had to pay the higher rates until June 30. A hearing is scheduled for August 2. Read More

New Hampshire

New Hampshire Releases Medicaid Managed Care Draft RFP. On June 28, 2018, the New Hampshire Department of Health and Humans Services (DHHS) released a draft request for proposals (RFP) for its Medicaid managed care program. The final RFP will be issued on August 10, 2018, with contracts effective July 1, 2019, through June 30, 2024. The state Medicaid Care Management (MCM) program will serve about 180,000 members, including nearly 44,000 Medicaid members who will transition from the state Exchange to the MCM program. DHHS expected to award contracts to three plans. Current incumbents are New Hampshire Healthy Families and Well Sense Health Plan. Read More

Lawmakers Hope to Avoid Rate Cuts to SUD, Mental Health Centers Serving Medicaid Expansion Members. *The Concord Monitor* reported on July 24, 2018, that New Hampshire lawmakers will push for $7.5 million in funds to avoid reimbursement rate cuts to substance abuse and mental health treatment centers serving the state's Medicaid expansion population. The cuts would take effect next year as part of the state's five-year Medicaid expansion reauthorization. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey MAAC Meeting Provides DSRIP Program Update, Medicaid Innovation Accelerator Program Projects Update. On July 18, 2018, Robin Ford, Executive Director of the Office of Health Care Financing, New Jersey Department of Health (DOH), gave an update to the Medical Assistance Advisory Council (MAAC) on the plan to sustain and reform the state's Delivery System Reform Incentive Program (DSRIP). DSRIP was originally approved by the Centers for Medicare & Medicaid Services (CMS) under the 1115 waiver demonstration and ran over five years, concluding in June 2017. New Jersey was granted a three-year program extension beginning July 2017 ending in June 2020. A total of 46 hospitals are implementing DSRIP projects across seven key areas:

1. Behavioral Health
2. Cardiac Care
3. Asthma
4. Chemical Addiction/Substance Use Disorder
5. Diabetes
6. Obesity, and
7. Pneumonia

The goal of DSRIP has been to support the hospitals through performance based incentive payments to enhance access to health care, improve the quality of care and the health of the patients and families the hospitals serve through payment and delivery system reforms. About 800,000 patients have been attributed across the participating hospitals each year with funding of $166.6 million per year.

DOH is planning to submit a DSRIP sustainability and transition plan to CMS for review by September 30, 2018. They will develop and submit a framework for measuring and scoring performance by June 30, 2019. A DSRIP successor program will begin July 2020 pending CMS approval to address the latest DOH priorities:

1. Reduce maternal morbidity and mortality with a focus on reducing disparities
2. Reduce pediatric disparities by improving access to quality healthcare services
3. Increase connections to care for high utilizers, behavioral health, substance use disorder and pediatric populations

The transition plan envisions that Medicaid managed care organizations (MCOs) would pay hospitals funds earned based on meeting quality performance targets, DSRIP funds that have been included in the capitation rates.

Julie Cannariato, Policy Director with the Division of Medical Assistance and Health Services (DMAHS) provided the MAAC with an update on the work New Jersey Medicaid is doing on delivery system reform efforts under support from the CMS Medicaid Innovator Accelerator Program (MIAP). DMAHS is engaged in the following activities under MIAP:

- DMAHS entered into a Business Associate Agreement with the National Opinion Research Center in June 2018 to conduct a financial simulation of a bundled payment for pediatric asthma. The simulation will overlay DMAHS data onto Tennessee's model for a pediatric bundle. Results from the financial simulation are forthcoming.
- DMAHS is planning to design a VBP HCBS strategy.

DMAHS is waiting to learn if New Jersey will be selected by CMS by the end of July 2018 as one of the states to participate in a value-based purchasing and financial simulation.

New York

HMA Roundup – Denise Soffel (Email Denise)

United Hospital Fund Hosts Annual Medicaid Conference. The United Hospital Fund hosted its annual Medicaid conference on July 18, 2018. New York State Medicaid Director Donna Frescatore provided the key note address, "Medicaid in New York: Fostering Collaboration to Improve Care." She provided an update on the Delivery System Reform Incentive Payment (DSRIP) program, now in its fourth year. Years 4 and 5 are focused on project outcomes and sustainability. Pay for performance metrics have kicked in, and the state has achieved required accountability measures, including reducing preventable hospital use. Frescatore provided a series of patient anecdotes describing specific Performing Provider System interventions and achievements. She then talked about the move to value-based payment (VBP), a requirement of the DSRIP program. A move to VBP is necessary to allow for sustainability of the DSRIP efforts. True reimbursement reform, including the engagement of community-based organizations, are required by the state's VBP Roadmap, which commits the state to shifting 80 percent of managed care expenditures to providers to be in value-based arrangements, including 35 percent of arrangements including both upside and downside risk, by DSRIP's end in April 2020. Frescatore identified challenges the state is facing in this transformation that include identifying which reforms have been most successful for patients, and how to stay on track with reimbursement reform. She went on to say that lessons learned through DSRIP would need to be applied more broadly to include other payors. Slides from her address will be posted on the United Hospital Fund website. Read More

New York Launches Second Year of Value-Based Payment University. The New York Department of Health has launched the second year of its on-line learning program, VBP University. VBP University is an educational resource designed to raise awareness, knowledge and expertise in the move to Value Based Payment (VBP). VBP University combines informational videos and supplemental materials that stakeholders interested in VBP can use to advance their understanding of the topic. The program will consist of four semesters, and individuals who successfully complete all four semesters will be awarded a certificate of completion. Semester One provides a deeper dive into VBP fundamentals, including information on the Medicare Access & Children´s Health Insurance Reauthorization Act (MACRA), guidance documents for Chief Medical Officers (CMOs), and guidance documents for addressing social determinants of health through VBP. Read More

New York Releases Request for Information for Need Methodology for Home Care Agencies. The New York Department of Health has released a Request for Information (RFI) to inform its development of a public need methodology for Licensed Home Care Services Agencies (LHCSAs). LHCSAs provide nursing, home health aide, and personal care services. They can also provide other long term supports and services, including therapies, medical social services, and medical equipment and supplies. In 2018, New York enacted a law requiring that the state develop a needs methodology to assure that services are available and accessible, while avoiding a proliferation of unneeded agencies. Currently the state has 1,100 approved operators with 1,450 licensed sites statewide. The RFI seeks recommendations for planning area designations, factors to include in the methodology, exceptions to the methodology, and additional requirements or priority considerations to include. Comments should be sent to the state by October 12, 2018. Read More

Ohio

Ohio Medicaid Releases External Quality Review RFP. On July 12, 2018, the Ohio Department of Medicaid (ODM) released a request for proposals (RFP) for up to two qualified suppliers to perform independent external quality review (EQR) services. The RFP includes two distinct components – one focused on performance evaluation, analytics, and quality improvement activities and the second focused on administrative compliance and audit activities. The selected suppliers will also provide ODM and health plans with technical assistance, national expertise, and other support to improve the overall performance of the managed care delivery system. The deadline to submit proposals is September 18, 2018. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Supreme Court Affirms July 2019 End to Highmark-UPMC Medicare Advantage Contract. *Modern Healthcare* reported on July 19, 2018, that the Pennsylvania Supreme Court has ruled that Highmark Medicare Advantage members' access to the University of Pittsburgh Medical Center network will end by July 2019. The unanimous court reversed a Commonwealth Court decision that had allowed access to the UPMC network through the end of next year. Highmark had argued that a consent decree required UPMC to grant access through 2019, but the state Supreme Court said that a provision in the decree allows UPMC to end the agreement and provide access only until June 30, 2019. Read More

South Dakota

South Dakota Releases RFP for Medicaid, CHIP Eligibility System. South Dakota released a request for proposals (RFP) on July 17, 2018, for the Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment system. The procurement is part of the state's Eligibility and Enrollment System Modernization Project. The eligibility and enrollment system would also support the state's End State Renal Program and the Optional Supplemental Payment Program. Read More

Texas

Texas Reissues STAR+PLUS RFP. On July 23, 2018, the Texas Health and Human Services Commission (HHSC) reissued a request for proposals (RFP) for the state's STAR+PLUS Medicaid managed care program, which serves individuals who are aged, blind, or disabled. The original RFP was cancelled on July 5. HHSC intends to award contracts for acute and long-term care coverage to at least two managed care organizations in each service area (Bexar, Central Texas, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Northeast Texas, Nueces, Tarrant, Travis and West Texas). Proposals are due August 22, 2018, with implementation beginning June 1, 2020. Contracts will run through August 31, 2022, with optional additional extensions not to exceed a total of eight operational years. Read More

Medicaid Dental RFP Is Likely to Attract Bids From Six Dental MCOs, 'Industry Insider' Says. *Texas Dentists for Medicaid Reform* quoted an "industry insider" on July 23, 2018, saying that six dental managed care organizations, including incumbents MCNA and DentaQuest, as well as Liberty Dental, Delta Dental, Avesis and Skygen, are likely to vie for Texas Medicaid dental managed care contracts during the current procurement, which closes in September. The Texas Health and Human Services Commission stated in the recently released request for proposals that it will award two contracts. Read More

National

CMS to Resume Exchange Plan Risk-Adjustment Payments. *Modern Healthcare* reported on July 24, 2018, that the Centers for Medicare & Medicaid

Services (CMS) issued a final rule to resume making $10.4 billion in risk-adjustment payments to health insurers participating on the individual Exchanges. Earlier this year, the agency stopped payments, citing a federal judge's ruling that had questioned the agency's payment methodology and risk-adjustment formula. Read More

27 Percent of Adults Know About President Trump's Prescription Drug Pricing Plan, Poll Says. *Politico* reported on July 23, 2018, that 27 percent of adults say they know about President Trump's prescription drug pricing plan, according to a poll by Politico and Harvard T.H. Chan School of Public Health. The poll also found that 63 percent of the 1,001 individuals surveyed believe drug companies are responsible for high drug prices, while 34 percent believe pharmacy benefit management companies are responsible. Republicans and Democrats agreed on several components of the administration's plan, including having television commercials include drug pricing as well as having the Food and Drug Administration approve more generic, over-the-counter and biosimilar drugs. Read More

State-Level Individual Mandates for Health Insurance Would Boost Coverage, Decrease Premiums, Report Says. *CQ Health* reported on July 20, 2018, that health insurance Exchange premiums would decrease by 11.8 percent in 2019 if individual health insurance mandate penalties were reinstated at the state level, according to a study by the Commonwealth Fund and the Urban Institute. The study also found that individual mandates at the state level would lower the number of uninsured by 3.69 million in 2019 and 7.5 million in 2022. New Jersey, Vermont, and the District of Columbia are set to implement a requirement for most individuals to have coverage by next year. Read More

Medicaid Work Requirements May Increase Administrative Costs, Fitch Report Says. *Forbes* reported on July 22, 2018, that increased administrative costs related to Medicaid work requirements could limit state savings if enrollment numbers decrease, according to a new report from Fitch Ratings. Fitch reported that Kentucky Medicaid administration costs increased more than 40 percent, in part from the implementation of work requirements. Read More

Industry News

LifePoint Health to Merge with RCCH HealthCare Partners. LifePoint Health announced on July 23, 2018, that it has entered a definitive agreement to merge with RCCH HealthCare Partners, owned by certain funds managed by affiliates of Apollo Global Management. The combined company will be privately held, operate under the LifePoint Health name, and be led by William F. Carpenter III, chairman and chief executive officer of LifePoint. The transaction is expected to close over the next several months. Read More

Community Health Systems to Sell Sparks Health System to Baptist Health. Community Health Systems announced on July 18, 2018, a definitive agreement to sell Sparks Health System to Baptist Health in Arkansas. The transaction is expected to close at the end of the year. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
August/September 2018	North Carolina	RFP Release	1,500,000
Summer 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
August 10, 2018	New Hampshire	RFP Release	181,380
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 12, 2018	New Hampshire	Proposals Due	181,380
November 1, 2018	Puerto Rico	Implementation	~1,300,000
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
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
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
July 1, 2019	North Carolina	Implementation	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
January 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
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	TBD
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000

HMA News

HMA Conference to Feature Session on Medicare-Medicaid Integration, Dual Eligibles

The annual HMA conference on *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers, and States*, October 1-2, 2018, at The Palmer House in Chicago, will feature a session on models and opportunities for better integrating care for dually eligible, Medicare-Medicaid members.

Bernadette Di Re, chief executive of UnitedHealthcare Community Plan of Massachusetts; Cheryl Phillips, M.D., president and chief executive of the SNP Alliance; and Michael Monson, senior vice president of long-term services and supports, and dual eligibles at Centene Corp. will address how states and the federal government are increasingly turning to managed care to integrate and improve quality of care and outcomes, as well as realize cost-efficiencies.

Last year's conference attracted more than 400 attendees. Visit the conference website for complete details: https://conference.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Louisiana Medicaid Managed Care Enrollment is Flat, Jun-18 Data
- Ohio Dual Demo Enrollment is Flat, Jul-18 Data
- New Hampshire Medicaid Enrollment by MCO, County and Eligibility Group, 2014-17
- Vermont Medicaid Enrollment by County, 2014-17
- Bed Days Per 1000 Members Average 2846 at Texas Medicaid MCOs, 2017 Data
- Bed Days per 1000 Average 4173 at Iowa MCOs, 2017 Data
- Bed Days Per 1000 Members Average 418 Among Puerto Rico Medicaid MCOs, 2017 Data
- Alabama Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Florida Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Colorado Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Bed Days Per 1000 Members Average 367 at DC Medicaid MCOs, 2017 Data
- Bed Days per 1000 Members at 689 for Kentucky Medicaid MCOs, 2017 Data
- Bed Days per 1000 Members Average 898 for Michigan Medicaid MCOs, 2017 Data
- Bed Days per 1000 Members Average 567 for Mississippi Medicaid MCOs, 2017 Data
- Bed Days per 1000 Average 528 for NH Medicaid MCOs, 2017 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Texas STAR+PLUS RFP Reissue, 2018
- New Hampshire Medicaid Managed Care Draft RFP and Contract, 2018
- Virginia 1115 Waiver Implementation RFI, Jul-18
- Louisiana Coordinated System of Care RFP and Related Documents, Jul-18
- South Dakota Medicaid & CHIP Eligibility System RFP, Jul-18
- Montana MPATH Care Management RFP, Jul-18
- New Hampshire Medicaid Managed Care Contracts, SFY 2019

Medicaid Program Reports and Updates:

- North Carolina Medicaid Managed Care Updates Proposed Policy Paper, Jul-18
- North Carolina Data Strategy to Support Advanced Medical Home Program Proposed Policy Paper, Jul-18
- New Hampshire Medicaid Managed Care Capitated Rate Certifications, SFY 2019
- New Hampshire Medicaid Care Management Re-procurement Stakeholder Presentation, Jul-18
- New Hampshire DHHS DCYF Adequacy And Enhancement Report, Jul-18
- New Mexico Medicaid Advisory Committee and Subcommittee Meeting Materials, Apr-18
- North Carolina Medical Care Advisory Committee Meeting Materials, Jul-18
- Oregon Medicaid Advisory Committee Meeting Materials, Jul-18
- Utah Medical Care Advisory Committee Meeting Materials, Jul-18

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