HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 1, 2018

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THIS WEEK

IN FOCUS

NEW HAMPSHIRE MEDICAID CARE MANAGEMENT DRAFT RFP

This week, our *In Focus* reviews the New Hampshire Medicaid Care Management (MCM) Services Draft request for proposals (RFP), released by the state Department of Health and Human Services (DHHS) on July 9, 2018. The MCM program, worth $750 million in annualized spending, will provide full-risk, fully capitated Medicaid managed care services to approximately 181,000 beneficiaries from July 1, 2019 through June 30, 2024. The final RFP is expected August 10, 2018.

The MCM program incentivizes value-based care over volume-based. The state is looking for managed care organizations (MCOs) that will improve population health, address the opioid crisis, expand community mental health services, and expand services in the child welfare system, among others. MCOs must provide person-centered, integrated care that offers all Medicaid managed care services.

Eligible Populations

The MCM program will cover approximately 181,000 beneficiaries, including 43,970 Medicaid expansion members, who will transition from the New Hampshire Health Protection Program to MCM's new Granite Advantage Health Care Program. Other eligible populations include: pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled. Excluded populations are those with eligibility under Family Planning Only, Health Insurance Premium Payment, In and Out Spend Down, Medicare Savings Program Only, members with Veterans Affairs benefits, and Retroactive/Presumptive Eligibility segments.

Eligibility Category	Projected MCM Members January 1, 2019
Low-Income Children - CHIP (Age 0-18)	14,100
Low-Income Children - Non-CHIP (Age 0-18)	73,030
Foster Care, Former Foster Care & Adoption Subsidy (Age 0-25)	2,420
Children with Severe Disabilities (Age 0-18)	1,180
Low-Income Non-Disabled Adults (Age 19-64)	12,140
Breast and Cervical Cancer Program (Age 19-64)	150
Adults with Disabilities (Age 19-64)	16,800
Elderly & Elderly with Disabilities (Age 65+)	8,710
NH Health Protection Program (Age 19-64) - Frail	8,880
NH Health Protection Program (Age 19-64) - Non-Frail	43,970
Total Enrollment	**181,380**

Source: New Hampshire DHHS

Services Covered

Plans will provide acute care, behavioral health, and pharmacy services for the covered populations. Long Term Services and Supports (LTSS), Developmental Disability and Acquired Brain Disorder services, and New Hampshire Division of Children, Youth, and Families (DCYF) Medicaid services are not covered. These services will continue to be offered through fee-for-service (FFS) outside of the MCM program, as will all services for select MCM exempt populations.
MCOs will develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, substance use disorder, and psychosocial needs of beneficiaries in every geographic area. MCOs will be required to provide emergency services at rates that are no less than the DHHS FFS rates, regardless of whether the provider has a partnership with the MCO or not. MCOs will also need to provide Non-Emergency Medical Transportation (NEMT) services for members.

Contracts

DHHS expects to award three MCOs with five-year contracts, running from July 1, 2019 through June 30, 2024. The current program, worth $540 million, will grow to $750 million in annualized spending with the addition of the Medicaid expansion program.

Evaluation Criteria

MCOs can score up to 800 points on their technical proposal, while the Cost Components of the RFP will be worth 200 points.

RFP Section(s)	Assigned Weight
Organization Overview, Overview of Relevant Experience, Subcontractors, Covered Populations, and Services	100
Pharmacy Management	70
Member Enrollment and Disenrollment, Member Services, Member Grievances and Appeals	70
Access and Utilization Management	60
Member Incentives and Education	60
Care Coordination and Care Management; including provision of Local Care Management	100
Children with Special Health Care Needs	50
Behavioral Health	100
Quality Management and Claims Quality Assurance and Reporting, Oversight and Accountability	70
Network Management, Provider Payments, Provider Appeals, and MCO Alternative Payment Models	70
Third Party Liability and Program Integrity	50
Total - Technical Proposal	**800**
Total - Cost Components	**200**
Total Points	**1,000**
Source: New Hampshire DHHS	

Current Market

New Hampshire transitioned to Medicaid managed care in 2013. As of 2017, there were 130,892 enrollees in the MCM program, served by Well Sense Health Plan (Boston Medical Center) and New Hampshire Healthy Families (Centene).

MCO	2017 Enrollment	Market Share
Well Sense Health Plan (Boston Medical)	71,036	54.3%
NH Healthy Families (Centene)	59,856	45.7%
Total Managed Care	**130,892**	

RFP Timeline

DHHS expects to release the final RFP on August 10, 2018. Proposals will be due in October and implementation will begin July 1, 2019.

RFP Activity	Date
Draft RFP Issued	July 9, 2018
RFP Release	August 10, 2018
Proposals Due	October 12, 2018
Implementation	July 1, 2019

Link to New Hampshire MCM Draft RFP
Link to New Hampshire MCM Draft Contract

HMA Medicaid Roundup

Arizona

Arizona Adds Transparency Rules to Address Drug Makers' Influence on Medicaid. *NPR* reported on July 27, 2018, that Arizona Governor Doug Ducey announced the addition of new transparency rules designed to reduce the influence of drug companies on Medicaid. The announcement follows a joint *Center for Public Integrity/NPR* investigation, which revealed that drug companies provide perks and payments to physicians who serve on committees that decide whether certain drugs should have preferred status on Medicaid formularies. Mohamed Ramadan, M.D., who served on the Arizona committee and reportedly accepted more than $700,000 in perks and payments, was asked by Ducey to step down. Read More

California

Anthem Blue Cross of California Launches Medi-Cal Health Homes Program. Anthem Blue Cross of California announced on July 24, 2018, the launch of a Medi-Cal health homes program aimed at improving access to care for individuals with multiple chronic conditions or severe mental illness in San Francisco County. San Francisco Health Plan is also participating in the program, which will partner with local clinics and community-based organizations to provide a full range of services, including physical health, behavioral health, and community-based long-term services and supports. Anthem is also piloting the program in Alameda County and plans to expand to Fresno, Sacramento, Santa Clara, Tulare, and Los Angeles counties in 2019. Read More

Colorado

Kaiser Permanente To No Longer Provide Medicaid Services in Parts of Colorado. *The Denver Post* reported on July 30, 2018, that Kaiser Permanente Colorado notified 2,500 patients that it will no longer be a Medicaid provider in the northern, southern, and mountain service areas as of June 30. Kaiser Permanente will continue to provide care to Medicaid patients in the Denver-Boulder region. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Dental Plans Drop Medicaid Award Challenge. *Health News Florida* reported on August 1, 2018, that Tampa-based Argus Dental and Vision has withdrawn its challenge to a recent Florida Medicaid dental managed care contract award. UnitedHealthcare withdrew its challenge ten days earlier. The Florida Agency for Health Care Administration faced the challenges after awarding prepaid dental contracts to MCNA Dental, DentaQuest of Florida, and Liberty Dental Plan of Florida. Read More

Florida Medicaid Sanctions Behavioral Therapists. *The Miami Herald* reported on July 26, 2018, that a Florida Medicaid fraud inquiry is causing delays in care for children with autism and other developmental disabilities. The Florida Agency for Health Care Administration (AHCA) has sanctioned four behavioral therapy companies for hiring unqualified therapists among other problems, including DRA Behavioral Health, MGM Behavioral, Harmony Mental Health Behavioral Services and Meli Medical Center. The state is urging parents to contact the agency if their child is not receiving necessary care. Read More

Florida Medicaid Enrollment to Fall to 3.86 Million in Fiscal 2019. *Health News Florida* reported on July 24, 2018, that Florida Medicaid enrollment is projected to decline from 4.02 million people to 3.86 million in fiscal 2019, ending June 30, according to the state's Social Services Estimating Conference. Enrollment declined by about 500,000 in fiscal 2018. Part of the decline is from improved income verification, according to Tom Wallace, assistant deputy secretary for Medicaid finance and analytics at the Florida Agency for Health Care Administration. However, there has been an increase in enrollment in the Florida KidCare program, a subsidized insurance program providing coverage for children whose families make too much to qualify for Medicaid. Read More

Indiana

McLaren Health Care Announces New CEO for MDwise. *Inside Indiana Buisness* reported on July 30, 2018, that McLaren Health Care named Bruce Hayes as president and CEO of MDwise in Indianapolis. Hayes succeeds Jim Parker who accepted a position with the U.S. Department of Health and Human Services. Read More

Iowa

UnitedHealthcare Community Plan of IA Names Bror Hultgren Interim CEO. *The Quad-City Times* reported on July 31, 2018, that UnitedHealthcare Community Plan of Iowa's CEO Kim Foltz will be leaving the company to pursue other opportunities. Bror Hultgren will serve as interim CEO of the plan, effective immediately, after previously serving as a senior vice president for UnitedHealthcare's Medicaid business, Community and State. UnitedHealthcare and Amerigroup Iowa are the two private insurers currently serving as managed care organizations for the state's Medicaid program. UnitedHealthcare serves over 400,000 Medicaid members in the state. Read More

Kentucky

Kentucky to Suspend Recently Enacted Medicaid Co-pays. *The Courier Journal* reported on July 27, 2018, that Kentucky has reversed course and announced it will suspend a series of Medicaid co-pays less than a month after they were implemented. The co-pays, which will be suspended on August 1, ranged from $1 to $50 for services including dental care, prescription drugs, doctors' visits and hospital stays. The state attributed the decision to the "inconsistent" application of co-pays. Read More

Mississippi

Mississippi Cancels CHIP Managed Care RFQ. The Mississippi Division of Medicaid (DOM) has cancelled a Request for Qualifications (RFQ) for managed care plans to handle the state's Children's Health Insurance Program, noting that the RFQ was not compliant with state law. Mississippi plans to re-issue this procurement as soon as possible. Read More

Mississippi Medicaid Awards Non-Emergency Medical Transportation Contract. The Mississippi Division of Medicaid announced on July 6, 2018, that it has awarded a non-emergency medical transportation (NEMT) contract to Missouri-based Medical Transportation Management. LogistiCare and Southeasttrans also submitted bids. Implementation begins October 1, 2018, with operations effective February 1, 2019. Read More

Montana

Governor Restores $45 Million in Medicaid Funding. *U.S. News/Associated Press* reported on July 26, 2018, that Montana Governor Steve Bullock has partially restored funding to state agencies, including the Department of Public Health and Human Services, which cut $49 million. Health officials had reduced the reimbursement rate for Medicaid providers, including nursing homes and assisted-living facilities, and ended contracts with four organizations providing case management services for individuals with developmental disabilities. The Medicaid reimbursement rate cut is the only budget item so far that was targeted to be restored using the $45 million in restoration money. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Launches Initiative to Encourage Community Living For Individuals With Disabilities. New York Governor Andrew Cuomo launched the "Able New York" agenda, an initiative that will emphasize enhanced accessibility to state programs and services for New Yorkers with disabilities. The Department of Health will lead the first phase of the initiative with a series of policies aimed at supporting community living for New Yorkers with physical disabilities. The Department will issue a series of guidance documents for providers on existing requirements and programs that emphasize choice and integration for people who receive support from the agency for their physical disabilities. Guidance will include reminders to nursing facilities and

educational efforts around the Managed Long-Term Care (MLTC) Housing Disregard, which provides an additional housing allowance to nursing home residents who are discharged back to the community when they join a MLTC plan. In addition, the Department will develop requirements for nursing homes to educate residents on community living options, and provide assistance to those wishing to return to community living. This may include requirements that nursing facilities certify they have assessed all resident's capacities and asked about their interest in residing in the community. They may also develop incentives for nursing home discharges using a quality metric that rewards facilities for discharging long stay residents to the community. Read More

Governor Denies Insurance Rate Increases. *Politico* reported on July 30, 2018, that New York Governor Andrew Cuomo ordered the state Department of Financial Services (DFS) to reject any insurance rate increase tied to the repeal of the Affordable Care Act's individual mandate. Under New York's Prior Approval law, DFS reviews individual plan requests for rate changes and can modify those requests. For 2019, DFS had asked plans to develop their rate requests in two parts, with one part calculating the impact of the repeal of the individual mandate under the Affordable Care Act. About half the average increase in premiums requested was attributed to the repeal. The governor justified rejecting that piece of the rate request by saying that he would not succumb to the president's attempts to destabilize the insurance market. DFS must review all rate requests to assure that they are actuarially sound. Read More

New York Justice Center Releases Five-Year Progress Report. The New York State Justice Center for the Protection of People with Special Needs has released a report describing its five years of operations. The Justice Center was established in 2013 in response to a series of exposés reported in the press on wide-spread abuse and neglect at state-run facilities for people with disabilities. The Justice Center was meant to put in place safeguards and protections for the one million people with special needs and disabilities who are receiving services from a state agency. A key function of the Justice Center is the operation of a state-wide hotline and centralized reporting system. Since the Justice Center began operations, it has investigated 46,000 allegations of abuse or neglect, prosecuted 550 cases and barred 450 people from employment. The Justice Center also conducts reviews to identify problems and risks to people receiving services and provides training and resources to create safe and abuse-free environments. Yet reporting by the Albany Times-Union notes that critics think the agency has an inherent conflict of interest and has not succeeded in its core function. The article notes that over 10,000 individuals died while in state care over a three-year period, including 140 cases where the Justice Center determined that abuse or neglect likely occurred, and yet no criminal charges were brought. The article notes further that the Justice Center is a state agency overseeing other state agencies, and conjectures it may be more interested in protecting due process rights of state employees than in pursuing criminal justice for victims. Read More

Ohio

Ohio Is on Track to Implement Electronic Visit Verification. *The Alliance Review* reported on July 29, 2018, that Ohio will not delay the implementation of electronic visit verification (EVV), even after Congress passed legislation allowing states until January 2020 to roll out EVV systems. Ohio awarded a $66.5 million, seven-year contract to Sandata Technologies to administer EVV in the state. An estimated 150,000 Ohioans who receive Medicaid services would be impacted by the EVV rollout. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Loses $3 Million in Medicaid Battle With HHS Over Nursing Home Staff Training. *McKnight's Long-Term Care News* reported on July 30, 2018, that Pennsylvania must pay back $3 million to the Department of Health and Human Services, after a judge ruled that the state improperly charged for nursing home staff training. The Third Circuit has clarified that Medicaid rules don't allow states to be reimbursed for training their providers, issuing a precedential decision affirming that Pennsylvania must pay back $3 million it had received from the federal government for instructing nursing homes on a new law. From 1996-2011 Pennsylvania claimed the costs of a training program, the Pennsylvania Restraint Reduction Initiative, as administrative costs under its Medicaid program. The Centers for Medicare & Medicaid Services (CMS) reimbursed Pennsylvania for about $3 million. After an audit, CMS sought a return of the money on the grounds that funds spent on training programs are not reimbursable as administrative costs under Medicaid. The court noted CMS could have reimbursed Pennsylvania if the state factored the amount into its rate-setting scheme instead of claiming it as administrative costs. Read More

Pennsylvania Medical Assistance Advisory Committee (MAAC) Meeting Provides Budget Update. Sally Kozak, Deputy Secretary for the Office of Medical Assistance Programs (OMAP), provided a brief budget overview at Pennsylvania's July MAAC meeting. The total Department of Human Services budget is $39.5 billion and OMAP accounts for $19.8 billion of that total. Notable changes in the budget included increased rates for ambulance services, a switch to a standardized model for the Medical Assistance Transportation Program (MATP) through a broker model, Medicaid outcomes-based programs for hospitals, and assessment programs. Regarding the MATP broker model, Kozak stated a request for proposal (RFP) for a statewide or regional program must be issued by January 1, 2019 and a state plan amendment must be submitted to CMS. The current MATP model includes 37 counties on a vendor model, 12 counties with direct contracts with vendors, 10 counties using a hybrid model, 7 counties operating under a service provider model where the county offers the transportation, and Philadelphia, which is already using a broker model. Kozak acknowledged existing issues and said the office is evaluating the advantages of statewide versus regional models.

National

HHS Expands Availability of Short-Term Health Plans. *Kaiser Health News* reported that the Trump administration issued a final rule relaxing restrictions on short-term health plans, allowing insurers to sell policies for up to 12 months and allowing plans to be renewable for up to three years. Short-term plans can offer coverage that do not comply with certain Affordable Care Act requirements for individual health insurance, including those related to mandatory benefits and pre-existing conditions. Read More

States Push for Partial Medicaid Expansion; Trump Delays Discussion Until After Midterms. *The New York Times* reported on July 30, 2018 that several states would like to partially expand Medicaid under the Affordable Care Act (ACA), however President Trump has halted the discussion until after the midterm elections in November. The U.S. Department of Health and Human Services (HHS)stated that allowing a partial expansion could result in savings compared to the full expansion. The Centers for Medicare & Medicaid Services (CMS) administrator Seema Verma and secretary of HHS Alex Azar both support limited Medicaid expansions. Read More

GAO Urges CMS to Increase Oversight of Medicaid Managed Care Plans, Track Over-Payments. *Modern Healthcare* reported on July 27, 2018, that the Centers for Medicare & Medicaid Services (CMS) needs to increase oversight of Medicaid managed care plans and to track improper provider payments, according to report released by the U.S. Government Accountability Office. The GAO report also indicated that the CMS does not have a process to determine whether states consider over-payments when setting capitation rates. The GAO recommended that CMS expedite the release of guidance related to audit procedures and program integrity and require states to report over-payments. Read More

Trump Administration Maintains Support for Medicaid Work Requirements. *The Hill* reported on July 26, 2018, that despite a federal court ruling blocking Kentucky's Medicaid work requirement, the Trump administration will continue to approve similar requirements in other states. Health and Human Services Secretary Alex Azar made the comment after the administration announced it would reopen public comments on the Kentucky plan. Work requirement in Arkansas, Indiana, and New Hampshire have been approved with applications pending in six states. Read More

Voters Favor Medicaid Expansion, Protections for People with Pre-Existing Conditions, Kaiser Survey Says. The Kaiser Family Foundation reported on July 25, 2018, that more than half of voters in states that haven't expanded Medicaid favor expansion, according to the July Kaiser Health Tracking Poll. The survey also found that individuals are more likely to support expansion with work requirements. Protections for people with pre-existing conditions ranked as the most important issues for voters across all party lines. The findings are based on a survey of 1,200 adults. Read More

CMS to Deny Single-Payer State Health Care Waivers Like Medicare for All. *Modern Healthcare* reported on July 25, 2018, that the Trump administration will deny waivers to states seeking to launch single-payer health care systems such as Medicare for all. Seema Verma, administrator of the Center for Medicare & Medicaid Services (CMS), noted that a Medicare for all system could cause Medicare funds to dry up, depriving seniors and disabled individuals of care. Read More

Wisconsin, Maine Approved for New Reinsurance Funds. *Modern Healthcare* reported on July 30, 2018, that the U.S. Department of Health and Human Services (HHS) approved 1332 waiver applications from Wisconsin and Maine to create individual market reinsurance funds. In Wisconsin, the reinsurance fund will reimburse insurers for 50% of an enrollee's claims between $50,000 and $250,000. In Maine, up to 90% of claims between $47,000 and $77,000 and 100% of claims in excess of $77,000 for high-risk enrollees will be paid. HHS has also approved reinsurance pools in Alaska, Hawaii, Minnesota, and Oregon. Read More

Industry News

Pfizer CEO Suggests Drugmakers Will Move Away from Rebates. *Bloomberg* reported on July 31, 2018, that on an investor conference call, Pfizer CEO Ian Read predicted that drugmakers will likely move away from using rebates to compete for pharmacy benefit managers' formulary access. The Trump administration is considering proposals limiting the use of rebates to help increase competition among drugmakers impacting pharmacy benefit managers. Read has promised to hold off on increasing drug prices that were originally slated to go into effect on July 1. Read More

KEPRO Acquires Health Information Designs. KEPRO announced on July 31, 2018, that it has acquired Health Information Designs (HID), a pharmacy administrative services vendor. HID provides clinical services to 39 health care organizations in 31 states. This acquisition enhances KEPRO's services in pharmacy management. Read More

Centene, Ascension to Explore Joint Medicare Advantage Plan. Centene announced on July 30, 2018, that it has signed a letter of intent with the Ascension health system to explore a potential joint venture to launch a Medicare Advantage plan serving "multiple geographic markets" in 2020. The letter is non-binding. Read More

ProMedica Completes HCR ManorCare Acquisition. *Modern Healthcare* reported on July 27, 2018, that Ohio-based ProMedica has completed the $1.4 billion acquisition of bankrupt post-acute services provider HCR ManorCare. The $7 billion combined organization will be the 15th-largest not-for-profit health system in revenues. Randy Oostra, CEO of ProMedica, will be the CEO of the combined organization, while Steve Cavanaugh, former CEO of HCR ManorCare, will be president of the HCR ManorCare division at ProMedica. As part of the deal, Welltower acquired HCR landlord Quality Care Properties for $2 billion. Read More

Centene Has No Plans To Buy Clinics In Every Market, CEO Says. *St. Louis Business Journal* reported on July 26, 2018, that Centene does not have plans to buy physician practices across the nation, but instead will expand services where needed, according to Michael Neidorff, chief executive. Neidorff added that deals like the acquisition of Miami-based provider Community Medical Group in March wouldn't be common. Centene has been expanding into additional states with products like Medicare Advantage. Read More

Active Day Acquires Florida, Minnesota Adult Day Care Centers. Active Day, an Audax Private Equity portfolio company, announced on July 25, 2018, that it had acquired three adult day care centers: Sunrise Community Inc. in Florida and two Millennium Adult Day Care Centers in Minnesota. All three centers serve elderly individuals with developmentally disabilities. 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

COMPANY ANNOUNCEMENTS

Curtailing Medicaid's transportation benefit is 'penny-wise and pound-foolish.' Read More

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- SC Medicaid Managed Care Enrollment is Down 1.2%, Jul-18 Data
- AZ Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- DE Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- GA Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- IL Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- IN Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- KS Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- LA Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- MA Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- MD Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- MN Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- MO Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- NV Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- SC Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- UT Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- VA Medicaid Fee for Service vs. Managed Care Penetration, 2014-17

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- AR Independent Verification and Validation Services for the Integrated Eligibility and Benefit Management Solution IFB, Jul-18
- NC Provider Data Contractor RFP, Jul-18
- TN TennCare Provider Data Management System (PDMS) RFI, Jul-18
- TX Draft NEMT RFP and Related Documents, Aug-18

Medicaid Program Reports and Updates:

- FL 1115 MMA Waiver Reimbursement and Funding Methodology for DY 12, Jun-18
- FL Statewide Medicaid Managed Care Financial Summaries, Jan – Mar-18
- IA Medicaid MCO Quarterly Performance Reports, 2016-3Q18
- MS MississippiCAN Cost Effectiveness Study Report, 2017
- MS Cost–Containment Measures and Initiatives Report, 2017
- PA Medical Assistance Advisory Committee Meeting Materials, Jun-18
- AZ Enacted Budget, SFY 2019
- GA Enacted Budget, SFY 2019

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