HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

The HMA Weekly Roundup will be off next Wednesday, August 15th. We will resume regular weekly publication on August 22nd.

IN FOCUS

NEW REPORT ASSESSES EFFECTS OF A SINGLE-PAYER MODEL FOR NEW YORK

This week, our *In Focus* reviews a New York State Health Foundation-commissioned report titled, "*An Assessment of the New York Health Act: A Single-Payer Option for New York State*." The study, conducted by the RAND Corporation, analyzes a proposal that would establish a single-payer system in New York. The proposal, known as the New York Health Act (NYH Act), was developed by New York Assembly Health Committee Chair Richard Gottfried.

It was passed by the Assembly several years in a row, but has never been brought to a vote in the Senate. The New York State Health Foundation commissioned the study to provide an independent, rigorous, and credible analysis of the proposal to understand the near-term and longer-term impact of the single-payer proposal. The study assesses how the plan would affect health care coverage and costs in the state.

According to the legislation, A.4738 (2018), the NYH plan would provide health care coverage to all residents of New York State. Health benefits under the NYH plan would be comprehensive, including all acute care benefits covered by Medicare, Medicaid, Child Health Plus, and those mandated under the Affordable Care Act (ACA). The plan does not include coverage for long-term care (LTC), although it includes the provision that those benefits could be added at a later time. Under the plan there are no out-of-pocket costs, including deductibles and co-payments.

The program would be financed through a new trust that combines funds from the federal government representing current federal financing for health programs, current state funding for health care programs, and revenues from two new progressively graduated state taxes: a payroll tax paid jointly by employers (80 percent) and employees (20 percent), and a tax on income not subject to the payroll tax, such as interest, dividends, and capital gains. Substantial new tax revenue would be required to finance the program. Even after redirecting all existing federal and state outlays for health to the NYH plan, additional tax revenue to finance the program would total $139.2 billion in 2022, and $210.1 billion by 2031. Since the NYH legislation does not describe a taxation structure, RAND modeled a possible graduated tax schedule to fully fund the plan. Under the base case scenario, payroll tax rates would range from 6 to 18 percent, and non-payroll tax rates would range from 6 to 19 percent.

The plan would have significant redistributive effects. Because the plan is financed through tax payments rather than through premiums and out-of-pocket payments, payments for health care would decline substantially among lower-income residents and rise substantially among highest-income residents. Under the base case, on average, people with incomes below the 90th percentile would pay less, while the highest-income households would pay more. They estimate that in 2022, those with household compensation below the 75th percentile would pay $3,000 less per person; those in the 75th – 90th percentile would pay $1,500 less per person; those in the 90th – 95th percentile would see health care payments increase by $1,700 per person, and for those in the top 5th percentile (where household compensation averages $1,255,700), health care payments would increase by $50,200 per person.

RAND developed a microsimulation modeling approach to estimate the plan's effects on key outcomes and compare them with outcomes under the status quo for three future years: 2022, 2026, and 2031. The report concludes that New York could expand coverage without substantial increases in overall health care spending. The model estimates that demand for hospital care would increase around ten percent, and demand for physician services would increase around 15 percent. By restraining the growth of provider payment rates, however, increases in utilization of health care services would be offset by decreases in provider payment rates and as well as reductions in overall administrative costs.

Any simulation model is driven by assumptions, and the report clearly articulates the assumptions that drive its conclusions.

- Federal waivers for Medicaid, Medicare and ACA requirements are approved.
- All residents of New York State have insurance coverage from the NYH plan.
- NYH does not cover long-term care, but Medicaid- and Medicare-eligible enrollees would continue to be eligible for nursing home and home health services under waiver arrangements.
- The ACA continues without the individual mandate penalty.
- Provider payment rates in NYH in 2022 would be similar to the dollar-weighted average payment rate across all payers in the status quo, and grow at a rate equal to payment rate growth in public health care programs like Medicare and Medicaid.
- The administrative rate in NYH would be 6 percent of spending for health care services.

The report notes that assumptions about provider payment rates are particularly important for estimating the health care cost under the NYHA. While moving to an all-payer average would reduce payment for services currently billed to commercial payers, the change would increase payment for current Medicaid services. Medicare payment rates are similar to the all-payer average rates.

In addition to provider rates, the model's estimated effects depend heavily on assumptions about administrative costs and drug prices, meaning that the state's willingness and ability to negotiate or set drug prices and generate administrative efficiencies are critical to reducing health care spending. The estimates also depend heavily on the design of the tax schedule and individual behavior in response to new taxes. The report notes that NYH could be threatened if some wealthy individuals leave the state to avoid paying the higher taxes. The table below show the projected difference in health care spending under alternative assumptions, relative to the status quo.

Table S.2. Projected Percent Difference in Total Health Care Spending Under the New York Health Act with Alternative Assumptions, Relative to the Status Quo

Scenario	2022 (%)	2031 (%)
Base case: NYH provider payment rates grow at same rate as public health care in SQ NYH health plan administrative rate 6% NYH drug prices 10 percent lower than Medicare prices in SQ NYH does not cover LTC No cost sharing Providers have medium sensitivity to payment rates Providers have medium sensitivity to patient demand	−1	−3
Alternative implementation assumptions		
1a: NYH provider payment rates grow at same rate as private health care in SQ	−1	3
1b: NYH provider payment rates 5% below SQ in 2022	−4	−6
2a: NYH health plan administrative rate 12%	5	2
2b: NYH health plan administrative rate 3%	−4	−6
3a: NYH drug payments 2.5% higher than SQ	1	<1
3b: NYH drug prices equal to Medicaid in SQ	−5	−10
4a: combined higher provider payment (1a), administrative rate (2a), drug payments (3a)	7	12
4b: combined lower provider payment (1b), administrative rate (2b), drug payments (3b)	−12	−15
Alternative NYH specifications		
5: NYH covers LTC benefits	5	2
5a: larger increase in LTC demand	8	4
5b: smaller increase in LTC demand	3	−<1
6: NYH with modest cost sharing	−2	−4
Alternative provider behavior assumptions		
7a: providers less sensitive to payment rates	−1	−3
7b: providers more sensitive to payment rates	−1	−4
8a: providers more sensitive to patient demand	1	−1
8b: providers less sensitive to patient demand	−2	−5

Source: RAND Corporation
*Note: SQ is Status Quo.

The analysis has already generated strong responses. Prior to its release, CMS administrator Seema Verma had indicated that the Trump administration was unlikely to approve single-payer waivers. As reported in Becker's Hospital Review, in a July 25 speech Verma stated "It doesn't make sense for us to waste time on something that's not going to work." According to Becker's Hospital Review, Ms. Verma said the current administration believes Medicare for All, or a single-payer system, is unaffordable and limits choice for patients.

https://www.beckershospitalreview.com/hospital-management-administration/trump-administration-unlikely-to-approve-single-payer-waivers-says-cms-head.html

Two powerful health industry associations in New York, the Greater New York Hospital Association and the Healthcare Association of New York State, raised concerns about the high cost of the proposal, the elimination of commercial insurance, and the impact on academic teaching hospitals due to a loss of revenue currently generated through commercial payers.

http://www.crainsnewyork.com/article/20180802/PULSE/180809985/hackensack-meridian-to-expand-behavioral-health-services-with

The New York Health Plan Association came out strongly against the proposal, saying that government-run health care would lead to massive tax increases and less consumer choice.

http://nyhpa.org/wp-content/uploads/2018/08/HPA-statement-on-Health-Foundation-Single-Payer-Report.pdf

Those concerns were echoed by the state Conference of Blue Cross and Blue Shield Plans, which noted that the study's assumptions were "aspirational if not unrealistic."

http://www.crainsnewyork.com/article/20180803/PULSE/180809971/after-four-years-bassett-to-leave-health-department-for-harvard

If you'd like to learn more, please contact HMA Principal Denise Soffel at dsoffel@healthmanagement.com.

Link to Report

HMA Medicaid Roundup

Arkansas

Arkansas Reports Decline in Medicaid Spending, Enrollment. *KATV* reported on August 3, 2018, that the Arkansas Department of Human Services is seeing declines in Medicaid spending and enrollment. Governor Asa Hutchinson noted that the reduction is not related to any change in services. "This is simply the result of people that are working," he said, adding that this was a first in Arkansas history. As of June, nearly 7,500 individuals had not complied with the state's Medicaid work requirements. Read More

California

California Again Warns Health Net for Withholding Payments to Addiction Treatment Facilities. *Fierce Healthcare* reported on August 2, 2018, that the California Department of Insurance again warned Health Net for withholding payments to addiction recovery facilities. Health Net, a division of Centene, could face fines, pending a hearing before an administrative law judge. Health Net has stated that its actions were in response to fraudulent claims from out-of-network providers. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Healthy Kids Releases CHIP Medical Services, Coverage ITN. The Florida Healthy Kids Corporation (FHKC) released an Invitation to Negotiate (ITN), on August 8, 2018, for the Florida Healthy Kids Children's Health Insurance Program (CHIP) subsidized plan and full-pay plan. FHKC currently contracts with four insurers regionally for the subsidized plan, covering 176,500 children as of July 2018, and one insurer statewide for the full-pay plan, covering 36,000 children not eligible for CHIP. Proposals are due September 24, 2018, and program implementation will begin January 1, 2020. Read More

Florida Faces Delay In Implementing Changes to Retroactive Medicaid Eligibility. *Health News Florida* reported on August 7, 2018, that Florida now expects to end 90-day Medicaid retroactive eligibility in January 2019, a six-month delay that is projected to cost the state $100 million in savings. Florida has been awaiting federal approval for the change, which would require Medicaid recipients to apply for coverage in the same month they need care. The change, which was originally scheduled for July 1, is expected to impact 39,000 people, primarily seniors and people with disabilities. Read More

Florida Judge Rules Against Best Care Assurance in Medicaid Contract Challenge. *CBS12/The News Service of Florida* reported on August 6, 2018, that Best Care Assurance does not have legal standing to challenge the Medicaid managed care contract award recently made the Florida Agency for Health Care Administration (AHCA), a state administrative law judge ruled. The case will now return to AHCA for final action. Best Care had challenged Florida's decision to award a Region 8 Medicaid managed care contract to Molina Healthcare. However, the judge ruled that the company missed its opportunity to intervene in the case. Best Care is a managed care plan affiliated with Lee Memorial Health Systems. Read More

Illinois

Illinois Enacts Law to Address Medicaid Eligibility Backlog for Nursing Home Residents. *WQAD* reported on August 3, 2018, that Illinois Governor Bruce Rauner signed legislation designed to address a costly backlog of 15,000 individuals in nursing homes awaiting Medicaid eligibility determinations. While waiting for the state, nursing homes have been fronting over $300 million in costs. Rauner also signed a law eliminating the need for annual Medicaid redetermination for individuals whose financial circumstances have not changed. Read More

Massachusetts

Massachusetts Provider-Owned Neighborhood Health Plan to Rebrand as AllWays Health Partners. *The Boston Globe* reported on August 7, 2018, that Neighborhood Health Plan of Massachusetts will change its name to AllWays Health Partners effective 2019, in light of the company's push into commercial health insurance. Neighborhood, which is owned by Partners HealthCare, has approximately 110,000 commercial members and 33,000 Medicaid members in the state.

Minnesota

Immigrants Could Feel Pressure to Drop Out of Medicaid, CHIP Under Trump Proposal. *The Star Tribune* reported on August 5, 2018, that Minnesota immigrants might be pressured to drop out of Medicaid, Children's Health Insurance Program (CHIP) and other federal government social services programs for fear of being denied a visa or permanent residency, state officials say. The proposal would classify anyone who accesses these services as a "public charge," thereby jeopardizing their immigrant status. Previously, the "public charge" classification only applied to a narrowly defined group of people. In a letter to federal regulators, Minnesota Governor Mark Dayton said the proposal would have a "chilling effect" on enrollment in public health programs. The proposal will be open to public comment before it's finalized. Read More

Nebraska

Nebraska Medicaid Fee for Service vs. Managed Care Penetration, 2014-17. Total Medicaid enrollment in Nebraska was 242,321 in 2017. About 95.1% of Medicaid beneficiaries were enrolled in a managed care plan. The remainder are in fee-for-service Medicaid. Total Medicaid expenditures in Nebraska were $2.0 billion in 2017, with about 51.4% through managed care and the rest through fee-for-service.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Medicaid Lifts Moratorium on Medical Suppliers. Effective July 1, 2018, NJ FamilyCare has lifted the provider moratorium on medical suppliers that has been in effect since July 1, 2006. The program will begin accepting applications from providers of medical supply services through Molina Medicaid Solutions Provider Enrollment Unit. Read More

New Jersey Medicaid Prepares for MMIS Conversion; Sends out Frequently Asked Questions (FAQ). The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) is preparing to convert its Medicaid Management Information System (MMIS) to a Replacement MMIS (RMMIS) called Health PAS. Health PAS uses application-ready, Commercial-Off-the-Shelf (COTS) products to support the Medicaid program. It will be a web-enabled, browser-based system that integrates a new business data warehouse and an electronic health record. To help all providers who submit claims or encounters to NJ FamilyCare prepare for this change, DMAHS issued a provider newsletter on July 20, 2018, with implementation highlights about:

- Completing a new HIPAA Trading Partner Agreement on-line in the RMMIS provider web portal
- Setting up a new Medicaid Provider Identification Number in RMMIS to identify a provider's specialty or specialties
- The process for submitting test transactions
- Submit questions about RMMIS (njrmmisinformation@molinahealthcare.com)
- Changes to prior authorization request procedures

New York

HMA Roundup – Denise Soffel (Email Denise)

Health Insurance Rate Changes Approved. *Crain's New York Business* reported on August 6, 2018, that the New York Department of Financial Services Superintendent Maria Vullo announced that the Department of Financial Services (DFS) has reduced health insurers' 2019 requested rates increases for New York's individual market by 64 percent overall for individuals, and reduced requested rate increases for 2019 small group plans by 50 percent. 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. Per instructions from Governor Andrew Cuomo, DFS rejected any insurance rate increase requests tied to the repeal of the Affordable Care Act's individual mandate. Reductions in this year's rate requests were significantly higher than last year's. Last year insurers asked for a weighted average 17.7 percent increase and were granted 14.5 percent.

Individual Market: Approximately 330,000 New Yorkers are currently enrolled in an individual commercial plan. DFS reduced insurers' total weighted average increase requested for individuals by 64 percent, from 24 percent to 8.6 percent. The largest reductions were to Capital District Physicians' Health Plan (CDPHP) (requested 5.1 percent increase, approved a 1.9 percent reduction), Empire Healthchoice (requested a 24.0 percent increase, received a 0.0 percent increase, and IHBC (Independent Health) (requested a 21.3 percent increase, received a 0.6 percent increase). The largest plan in the market, Fidelis, which was recently acquired by Centene Corporation, had requested the largest rate increase of any plan – a 38.6 percent increase. Their request was reduced to 13.7 percent, a decrease of almost 65 percent.

Small Group Market: More than 1 million people are insured by plans in the small-group market. Insurers selling plans to small businesses asked for a weighted average 7.5 percent increase to premiums and DFS approved a 3.8 percent hike. Oxford, which controls over half of the small-group market, sought an 8.3% increase and receive 3.0 percent. Three plans – Healthnow, MetroPlus and Empire Healthchoice, actually received increases in their rate requests. Read More

New York Faces Class Action Lawsuit for Limits on Medicaid Dental Coverage. The New York Times reported on August 2, 2018, that the New York Legal Aid Society and Willkie Farr & Gallagher have filed a class action lawsuit in federal court against the New York State Department of Health for certain limits on dental care for Medicaid members. Specifically, the program doesn't cover dental implants and limits replacement dentures. Read More

North Carolina

North Carolina Awards Medicaid Managed Care Enrollment Broker Services Contract to Maximus. The North Carolina Department of Health and Human Services announced the award of a $17 million contract to Virginia-based Maximus for Medicaid managed care enrollment broker services. Maximus is expected to provide counseling, enrollment assistance, and education services to individuals following North Carolina's planned transition to a hybrid Medicaid managed care program. Maximus "will help members select the health plan and primary care provider that is most appropriate," the state said. A request for proposal for the contract was issued in March. Read More

Medicaid Overhaul to Focus on Social Determinants of Health. *Modern Healthcare* reported on August 3, 2018, that social determinants of health will be an important focus of North Carolina's planned transition to Medicaid managed care in 2019. The state plans to require managed care organizations to screen Medicaid recipients for access to food, housing, and transportation. The North Carolina Health and Human Services Department has developed a standardized tool to help cases managers and providers screen patients for social determinants of health, with pilots in 40 to 50 settings. Patients will also be directed to organizations that can connect them with resources. Currently, there are more than 2 million individuals enrolled in the state's Medicaid program. Read More

Gateway Health to Offer North Carolina DSNP With Access to Community Care Physician Network. On August 2, 2018, Gateway Health announced that it would offer a Dual Eligible Special Needs Plan (D-SNP) in North Carolina with access to Community Care Physician Network, LLC (CCPN), effective August 1, 2018. CCPN will provide medical services, intensive care management outreach, provider support services and targeted analytics. Read More

Ohio

Ohio CareSource Cuts Opioid Use by 40 Percent Among Medicaid Members. *10TV/Associated Press* reported on August 1, 2018, that Ohio-based CareSource says that it has reduced the amount of opioids prescribed for its Medicaid members by 40 percent over the last 18 months, with plans to reduce that number by 50 percent by the end of the year. CareSource, the largest Medicaid plan in the state, has an estimated 1.8 million Medicaid members. Read More

Washington

Washington Awards Medicaid Managed Care Dental Contracts. On August 1, 2018, the Washington Health Care Authority announced that it will award Medicaid managed care dental contracts to Anthem/Amerigroup, Dentegra, and MCNA. Contracts will run from January 1, 2019, to December 31, 2020, with possible extensions of up to five years. Read More

National

Medicaid Expansion Makes Diabetes Medication More Affordable, Study Finds. *Kaiser Health News* reported on August 6, 2018, that prescriptions filled for diabetes management rose 40 percent in states that expanded Medicaid under the Affordable Care Act (ACA), according to a *Health Affairs* study conducted by the University of Southern California. The study, which included 30 states and the District of Columbia, also found an increase in diabetes diagnoses. States that chose not to expand Medicaid, like Texas and Florida, have seen no change in diabetes prescription fill rates. Read More

CMS to Eliminate 25 Percent Rule for LTC Hospitals. *Modern Healthcare* reported on August 2, 2018, that the Centers for Medicare & Medicaid (CMS) finalized a plan to eliminate the 25 percent rule, which penalized long-term care hospitals if more than a quarter of their patients came from a single acute-care hospital. The elimination of this policy is expected to increase long-term care hospital payments by 0.9 percent in 2019. Read More

Medicaid Managed Care Patients Have Shorter Behavioral Stays, Research Finds. *Modern Healthcare* reported on August 1, 2018, that as behavioral health Medicaid patients transition to managed-care programs, patient length of stay declined seven percent compared to Medicaid fee-for-service patients. Research shows that managed-care providers provide better care coordination and are focused on seeking alternative care settings beyond traditional hospitals. Read More

Industry News

Private Equity Firm Advent In Talks to Sell Genoa Healthcare. *Bloomberg* reported on August 7, 2018, that private equity firm Advent International is in talks regarding the possible sale of portfolio company Genoa Healthcare, which operates 400 full service pharmacies in community mental health centers. Advent invested in Genoa in 2015, alongside existing shareholders including Nautic Partners. Read More

Community Health Systems, LifePoint Complete Sale of Hospitals in FL, LA. *Modern Healthcare* reported on August 1, 2018, that Tennessee-based Community Health Systems (CHS) and LifePoint Health completed divestitures in Florida and Louisiana, respectively. CHS sold Munroe Regional Medical Center to Florida Hospital Ocala, a subsidiary of Adventist Health Systems Sunbelt Health Corp, effective August 1. LifePoint completed the sale of its three Louisiana hospitals to Allegiance Health Management, a Louisiana-based organization. Read More

Molina Shares Rise 17 Percent After Cost-Cutting Measures. *Modern Healthcare* reported on August 1, 2018, that Molina Healthcare posted a net income of $202 million for the second quarter of 2018 compared with a net loss of $230 million in the same period in 2017. As a result, the insurer's shares surged over 17 percent. Molina, recording a medical loss ratio of 83.5 percent, credits its improvement to cost-cutting measures, including removing high cost providers from its network, starting new contracts with local providers, and utilization control. 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 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
January 1, 2020	Florida Healthy Kids	Implementation	212,500
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000

HMA News

HMA Conference to Feature Session on Value-Based Contracting in Behavioral Health

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 how the nationwide rollout of value-based payments could benefit traditional providers of behavioral health care.

Lou Dierking, SVP, Behavioral Health Payer Channel Lead, Optum; David Guth, CEO, Centerstone America; Jim Spink, President, Mid-Atlantic Region, Beacon Health Options; and Ann Sullivan, Commissioner, New York State Office of Mental Health will outline strategies for ensuring that behavioral health providers have the tools and resources they need to successfully make the transition to emerging value-based payment methodologies.

More than 300 attendees have already registered for this year's conference, with a total of more than 400 expected to sign up. 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:

- Missouri Medicaid Managed Care Enrollment is Down 1.7%, Jul-18 Data
- New York Medicaid Managed Care Enrollment is Up 1.0%, Jul-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 2.7%, Aug-18 Data
- Alaska Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Arkansas Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- California Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Connecticut Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- DC Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Nebraska Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Oregon Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Tennessee Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Texas Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- West Virginia Medicaid Fee for Service vs. Managed Care Penetration, 2014-17

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Maine Pharmacy Benefit Manager (PBM) and Point of Purchase System (POS) RFP, Jul-18
- Maine Assessing Services Agency RFP, Scoring, and Award, 2018
- MaineCare Disability Determination Services RFP, Jun-18
- Maine Accountable Communities Data Analysis and Reporting RFP, Scoring, and Award, 2018
- Washington Behavioral Health Administrative Service Organization (BH-ASO) RFP and Award, 2018
- Washington Medicaid Managed Care Dental RFP and Award, 2018
- Arkansas Prior Authorization Reviews, Retrospective Reviews and Medical Reviews/Consults Draft IFB, Jul-18
- Oklahoma Pharmacy Electronic Prior Authorization System RFI, Jul-18
- Oklahoma Support Services for Verification of Medicaid Eligibility RFI, Jul-18
- Virginia Smiles for Children (SFC) Medicaid and CHIP Dental Program RFI, Aug-18
- Minnesota Qualified Grantee to Provide Innovative Solutions for People with Disabilities to Achieve Integrated Life Outcomes RFP, Jul-18

Medicaid Program Reports and Updates:

- Alabama Home and Community-Based Alabama Community Transition (ACT) Waiver Amendment, Aug-18
- Alaska Medicaid 1115 Behavioral Health Demonstration Waiver Application, Jan-18
- North Carolina Medicaid Transformation: Supporting Provider Transition to Medicaid Managed Care Presentation, Jun-18
- Washington 1915(b) Behavioral Health Waiver Amendment Draft, Jul-18
- Washington Medicaid Transformation Waiver Documents, 2015-18
- Washington Approved Fully Integrated Managed Care State Plan Amendment (SPA), May-18
- CBO Exploring the Growth of Medicaid Managed Care Report, Aug-18
- GAO Report on Medicaid Managed Care Payment Risks, Jul-18

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