HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 5, 2018

Edited by:
Greg Nersessian, CFA
Email

Carl Mercurio
Email

Alona Nenko
Email

Nicky Meyyazhagan
Email

THIS WEEK

IN FOCUS

NORTH CAROLINA AND DISTRICT OF COLUMBIA MEDICAID MANAGED CARE RFPS

This week, our *In Focus* reviews North Carolina's much-anticipated Prepaid Health Plan Services request for proposals (RFP), released by the Department of Health and Human Services, Division of Health Benefits on August 9, 2018, and District of Columbia's Medicaid Managed Care RFP released on August 14, 2018. North Carolina is transitioning its Medicaid fee-for-service program to Medicaid managed care through its procurement. DC is reprocuring its managed care program, covering the District of Columbia Healthy Families Program (DCHFP), Alliance program, and the Immigrant Children's Program (ICP).

North Carolina

North Carolina has been working on a plan to transition 1.5 million individuals to Medicaid managed care since 2015. Following feedback from beneficiaries, clinicians, hospitals, counties, health plans, and elected officials, the state released an RFP for Prepaid Health Plans (PHPs) to provide coverage beginning in 2019, worth an estimated $6.4 billion in annual spending. PHPs, which include Commercial Plans (CPs) and Provider-Led Entities (PLEs), will integrate physical health, behavioral health, and pharmacy services for Medicaid and North Carolina Health Choice (health insurance for low-income children) beneficiaries. Proposals are due October 12, 2018, and contracts will be awarded on February 4, 2019.

Eligible Populations

Most North Carolina Medicaid and North Carolina Health Choice populations will be mandatorily enrolled in PHPs.

Exempt Populations:

- Medicare-Medicaid dual eligibles for whom North Carolina's coverage is limited to Medicare premiums and cost sharing
- Medically needy
- Program of All-Inclusive Care for the Elderly (PACE) beneficiaries
- NC Health Insurance Premium Payment (HIPP) program beneficiaries
- Medicaid Family Planning program beneficiaries
- Prison inmates
- Community Alternatives Program for Children (CAP/C) beneficiaries
- Community Alternatives Program for Disabled Adults (CAP/DA) beneficiaries
- Qualified aliens subject to the five-year bar

Temporarily Excluded Populations:

- Nursing facility residents
- Medicare-Medicaid dual eligibles whom North Carolina Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding individuals served through CAP/DA

Individuals with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or a traumatic brain injury will be exempt until the state establishes Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans). These plans are expected to be operational at the start of the first State fiscal year one year after the implementation of the first contracts for Standard Benefit Plans.

Services Areas

The RFP was released as a statewide procurement. The state has established six Medicaid Managed Care Regions, called PHP Regions. The Department will cap the number of regional contracts awarded at one (1) for each of Regions 1 and 6, and two (2) for each of Regions 2, 3, 4 and 5. Each PHP must serve a minimum of 45,000 to 50,000 lives across all regions it is awarded. To meet this requirement, the state strongly encourages PHPs to submit a bid for more than one region.

Section I. Table 1: List of Counties by PHP Region

PHP Regions	Counties
Region 1	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region 2	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
Region 3	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Region 4	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
Region 5	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
Region 6	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

Timeline

Medicaid and North Carolina Health Choice beneficiaries who are not members of designated special populations will be transitioned from fee-for-service to managed care on a regional basis. The state is planning a two-phase approach with two distinct open enrollment periods to help ensure each region has an appropriate balance of enrollees, PHPs, and other considerations. Phase 1 is scheduled to begin on November 1, 2019, and Phase 2 is scheduled to begin on February 1, 2020. Following the awards, the state will announce which Regions will be selected for Phase 1 and Phase 2, depending on factors such as the number of members in the region, a goal of including urban and rural regions in Phase 1, and including a mix of commercial plans and PLEs, in Phase 1. North Carolina expects Tailored Plans to be operational at the start of the first fiscal year, one year after the implementation of the first contracts.

RFP Activity	Date
RFP Issued	August 9, 2018
Proposals Due	October 12, 2018
Awards	February 4, 2019
Phase 1	November 1, 2019
Phase 2	February 1, 2020

Evaluation

Proposal Evaluation Criteria	Sub Weight	Weight
Qualifications/Experience		20%
Scope of Services		70%
a) Develop, implement and sustain the organizational, operational, technical and administrative functions and capabilities to reliably serve as an effective partner in delivering Medicaid Managed Care to North Carolinians.	7.5%	
b) Improve the likelihood of better health outcomes by enhancing the Member experience through promoting Member rights, engaging Members through health education, providing optimal customer service and support, and delivering services in a culturally competent manner.	15%	
c) Develop coordinated programs and services that deliver health through whole-person care, comprehensive care management, improve population health, and provide programs and services addressing healthy opportunities.	25%	
d) Develop and maintain a robust provider network that maintains strong provider and community participation and demonstrates an understanding of the health needs of the North Carolina population to ensure available, accessible, high quality care and services are delivered to all Members.	15%	
e) Develop a comprehensive quality improvement and value-based purchasing approach to drive the Department's overall vision for advancing and measuring high-value care.	15%	
f) Engage and integrate key Department partners and stakeholders including tribal populations, county agencies, community-based organizations, other managed care program entities, and Department partners to support North Carolina's Medicaid Managed Care goals.	7.5%	
g) Promote and monitor North Carolina's Medicaid Managed Care sustainability by developing the processes, standards, and data protocols needed to demonstrate good financial stewardship of limited resources and adherence to financial management objectives.	10%	
h) Promote a culture of compliance through comprehensive oversight and program integrity strategies aligned with industry best practices and compliant with federal and state law and regulation.	5%	
Use Cases		5%
Client References		5%
Bonus Points: Marketplace Participation		2.5%

Contracts

The contracts will be effective for three years, with two additional optional years. Phase 1 contracts will begin November 1, 2019 and Phase 2 contracts will begin February 1, 2020. Contract Year 1 for both phases will run through June 30, 2020, followed by an additional two years ending June 30, 2022. The program will be worth $6.4 billion in annualized spending.

Contract Period	Effective Dates
Contract Year 1 for Phase 1	November 1, 2019 through June 30, 2020
Contract Year 1 for Phase 2	February 1, 2020 through June 30, 2020
Contract Year 2	July 1, 2020 through June 30, 2021
Contract Year 3	July 1, 2021 through June 30, 2022
Optional Years Through	June 30, 2024

Link to NC RFP

District of Columbia

The District of Columbia is reprocuring its Medicaid Managed Care Program (MMCP), worth approximately $1 billion. Managed care organizations (MCOs) will serve the Medicaid program, District of Columbia Healthy Families Program (DCHFP); Alliance program, covering low-income residents not eligible for Medicaid; and the Immigrant Children's Program (ICP), covering low-income immigrant children not eligible for Medicaid.

The RFP comes after an administrative law judge ruled in December 2017 that the District failed to treat all bidder's equally and "undermined the integrity of the procurement process," ordering DC to reevaluate the bids of the previous procurement. The District announced contract awards to AmeriHealth Caritas, Trusted Health Plan, and Anthem/Amerigroup in May 2017. Incumbent MedStar was not awarded a contract and filed a protest.

Contracts

DC expects to award up to three new contracts. Proposals are due September 13, 2018. Contracts will run from the date of award to September 30, 2019. DC may extend the contracts for four one-year option periods. The total duration of the contracts cannot exceed five years.

Evaluation

Proposals will be scored out of a total of 112 points, consisting of technical criteria, price, and preference points. The price evaluation is objective, with the lowest price receiving the maximum score.

Evaluation Criteria	Points
Technical Criteria	**90**
Technical Approach and Methodology	**45**
Offeror's comprehensive explanation about the processes, resources, and activities it will employ to successfully implement the Medicaid managed care contract (operations and scope of work) in the District of Columbia, including the organizational description listing Offeror's proposed key personnel.	20
Offeror's detailed explanation and description of its processes for improving access and utilization of perinatal visits and birth outcomes within the eligible populations, as defined in Section B.1, including how the Offeror proposes to enhance Enrollee engagement to increase prenatal visits and Provider engagement to achieve timely access to perinatal services and improved birth outcomes.	15
Offeror's detailed explanation of its approach and methodology to ensure all of its Network Providers are enrolled as Medicaid providers with the District as of the Start Date and prior to the Offeror rendering services to Enrollees.	10
Technical Expertise	**25**
The extent to which the Offeror's Utilization Management (UM) program and processes: uses nationally recognized clinical practice guidelines/criteria and adverse action notification procedures; uses the UM committee; encompasses a prior authorization process; demonstrates integration between UM and Case Management departments; and includes UM program evaluation methodologies with the expected outcomes.	10
Offeror's detailed description of its proposed complex case management program and methodology for identifying Enrollees who are appropriate for case management; efforts to engage Enrollees in case management, once Enrollees are enrolled in case management; and care coordination amongst various health care providers, the Enrollee's family, social support agencies, and other relevant entities who will be involved in the Enrollee's care.	15
Past Performance	**20**
Price Criterion	**10**
Preference Points	**12**
Total	**112**

Link to DC RFP

HMA Medicaid Roundup

California

Bill to Cap Dialysis Reimbursements Heads to Governor's Desk. *Modern Healthcare* reported on August 30, 2018, that the California State Assembly and Senate passed a bill that could affect dialysis revenues for companies like DaVita and Fresenius Medical Care. The legislation would restrict third-party premium assistance to dialysis patients and cap provider reimbursements to Medicare levels if they don't comply. The bill heads to Governor Jerry Brown for his signature. Read More

Delaware

Delaware Releases Health Care Benchmark Recommendations Report. On September 7, 2017, Delaware Governor John Carney signed landmark legislation giving authority to the Department of Health and Social Services (DHSS) to establish a health care spending benchmark for Delaware. The legislation, approved by the General Assembly, comes after a federal analysis found Delaware had the third-highest per capita level of health spending of all the states. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida to Receive $49.4 Million in Additional Federal Funding to Combat Opioid Crisis. *WUSF Public Media* reported on September 3, 2018, that Florida is set to receive an additional $49.3 million in federal funds this year to fight opioid abuse, including up to $10 million for Broward County. The amount represents the state's share of nearly $1 billion in funds set aside by the federal government to address the opioid crisis. The funds are expected to increase access to medication-assisted treatments like Vivitrol, methadone, and buprenorphine. Read More

Insurers Request Lowest ACA Premium Increases. *Health News Florida/The Associated Press* reported on August 29, 2018, that Florida health insurers have requested the lowest Affordable Care Act (ACA) marketplace premium increases since the start of the ACA. Florida Blue, the state's largest insurer, requested a rate increase of less than half a percent, while nine other insurers offering plans next year requested to increase rates by an average of 5 percent. In comparison, the average rate increase was 45 percent last year. The state has an estimated 1.7 million individuals enrolled in the federal Exchange. Several insurers in other states, including North Carolina and Illinois, also requested lower rates for 2019. Read More

Medicaid Award Challenges Continue After Additional Contract Agreements. *The Gainesville Sun* reported on August 27, 2018, that Medicaid contract disputes continue in Florida as a judge looks into claims that the Agency for Health Care Administration (AHCA) did not comprehensively review the bids and allegedly removed items from review because of lack of time. The AIDS Healthcare Foundation and the South Florida Community Care Network, both of which filed challenges after they were denied contracts, are asking a judge to require new bids or to award new contracts. AHCA has negotiated five-year contract agreements with an additional four companies since the original award announcement but the decision will not impact challenges filed by the AIDS Healthcare Foundation and the South Florida Community Care Network. The five-year contracts are expected to be worth $90 billion, according to Medicaid officials. Read More

Magellan Receives Medicaid Contract in AHCA Settlement. Magellan Complete Care announced on August 27, 2018, that it will withdraw its challenge against the Florida Agency for Health Care Administration (AHCA) after the agency had shut the health plan out of the state's Medicaid managed-care market. An agreement in concept has been reached; Magellan will receive a Medicaid contract as part of the agreement with AHCA. The AIDS Healthcare Foundation and the South Florida Community Care Network continue to challenge state decisions. Read More

Community Health Centers Receive $5.5 Million in Federal Grants. *Health News Florida* reported on August 23, 2018, that Florida's federally qualified community health centers have received more than $5.5 million in federal quality improvement grants, up 17 percent from last year. The money will be used to improve or create programming for low-income patients, of which about 35 percent are uninsured, 43 percent are enrolled in Medicaid, and 90 percent report income below 200 percent of the federal poverty level. The U.S. Health Resources and Services Administration awarded the grants based on performance in six categories, including access, outcomes, cost-effectiveness, addressing health disparities, health information technology, and patient-centered care. More than 500 community health centers in Florida serve nearly 1.4 million state residents annually. Read More

Florida Hit with Medicaid Contract Award Lawsuit from Best Care Assurance. *Health News Florida* reported on August 23, 2018, that Best Care Assurance, LLC, filed a lawsuit in Florida's Leon County circuit court to challenge a Region 8 Medicaid managed care contract awarded to Molina Healthcare by the Florida Agency for Health Care Administration. Best Care has previously tried to challenge the award in the state Division of Administrative Hearings; however, an administrative law judge ruled that Best Care didn't have legal standing. Best Care is affiliated with Lee Health Systems. Read More

Georgia

DCH Submits Budget Request to Cover Rising Medicaid Costs. *Georgia Health News* reported on August 23, 2018, that the Georgia Department of Community Health (DCH) is requesting $72.9 million in additional funding for the current fiscal year 2019 and $195.8 million more for fiscal year 2020. Much of the proposed funding would go to Medicaid: $25.9 million in fiscal year 2019 and $88.9 million in fiscal year 2020. DCH CFO, Lisa Walker, says the additional funding is needed due to higher enrollment, increases in medical costs, and higher usage rates. The budget request will now go from the board of the DCH to the governor's office for review. Read More

Illinois

Illinois Halts Enrollment into BCBS Dual Plan. *The Chicago Tribune* reported on August 29, 2018, that the Illinois Department of Healthcare and Family Services and the Centers for Medicare & Medicaid Services (CMS) has fined Blue Cross Blue Shield of Illinois $150,000 and will no longer automatically assign people to the Blue Cross Community Medicare-Medicaid Alignment Initiative plan, effective October 1. According to state and federal officials, the Blue Cross plan is out of compliance with requirements related to completing health risk assessments and member grievances. Read More

Iowa

Medicaid Plan Yet to Pay Millions in Outstanding Bills. *The Des Moines Register* reported on August 30, 2018, that AmeriHealth Caritas has yet to pay outstanding claims, totaling over $14.6 million for medical care to Medicaid beneficiaries after terminating its Iowa contract last year. The outstanding bills include over $1 million at the University of Iowa Hospitals and Clinics and $541,000 at Broadlawns Medical Center for over 6,000 individual charges. Until the end of their contract, AmeriHealth was Iowa's largest Medicaid insurer for more than a third of the 600,000 residents enrolled in Medicaid. Read More

Iowa to Increase Medicaid MCO Rates by 7.5 Percent. *The Des Moines Register* reported on August 24, 2018, that Iowa has agreed to increase Medicaid managed care rates by 7.5 percent, or $344 million. UnitedHealthcare and Anthem/Amerigroup manage the state's Medicaid program, covering approximately 680,000 lives. Governor Kim Reynold's director of human services, Jerry Foxhoven, said the funds will help pay for expanded mental-health services, but did not specify how much of the increased funds would go to these services. Read More

Kansas

Task Force Supports Medicaid Expansion. *The Associated Press* reported on August 23, 2018, that a Kansas task force created by Governor Jeff Colyer is recommending that the state legislature expand Medicaid, with a focus on helping individuals with substance abuse problems. Expansion would include almost 150,000 uninsured state residents. Colyer has previously opposed Medicaid expansion. Read More

Kentucky

Kentucky Names Carol Steckel Medicaid Commissioner. *The Glasgow Daily Times* reported on September 4, 2018, that the Kentucky Cabinet for Health and Family Services has named Carol Steckel Medicaid commissioner. Steckel spent the past five years as director of alliance development for WellCare Health Plans and also served as director of Medicaid administration for North Carolina. Interim Medicaid commissioner Jill Hunter will become senior deputy commissioner. Read More

Kentucky Considers Ending Medicaid Expansion to Avoid Financial Shortfall. *U.S. News/The Associated Press* reported on August 30, 2018, that Kentucky officials are considering ending Medicaid expansion as they face what could be a $300 million shortfall in the state's Medicaid program by 2020. Of the 1.4 million people who receive Medicaid benefits in the state, 480,000 gained coverage when the program was expanded. The Cabinet for Health and Family Services will consult with the state legislature before making a decision, giving lawmakers a chance to offer an alternative solution. One proposal, pitched by a group of hospitals, is to tax health care providers, a plan which could generate an estimated $372 million by 2020. The proposal has generated interest from Senator Ralph Alvarado (R) and Senator Morgan McGarvey (D). Alvarado wants lawmakers to have a hearing on the proposal. Read More

Public Comments Reflect Opposition to Kentucky Medicaid Work Requirements Waiver. *The Courier Journal* reported on August 28, 2018, that a higher than expected number of comments – 11,561 – were received during a public comment period on Governor Matt Bevin's Medicaid proposal. The proposal, Kentucky HEALTH, would implement changes to the state's Medicaid program, including work requirements and monthly premiums. The Centers for Medicare & Medicaid Services (CMS) decided to reopen the public comment period for the proposal after a federal judge vacated CMS's original approval of the plan, finding administration officials failed to consider that an estimated 95,000 Medicaid beneficiaries would lose coverage and that the administration failed to show consideration for public comment. According to an advocacy group reviewing the materials, comments in opposition to the plan outnumber those in support by 20-1. Read More

Maine

Maine Governor Asks CMS to Reject Voter-Approved Medicaid Expansion Plan. *The Portland Press Herald* reported on September 4, 2018, that Maine Governor Paul LePage complied with a court order to apply for Medicaid expansion, but asked federal regulators to reject the application. In a letter to the Centers for Medicare & Medicaid Services (CMS), LePage argued that no funds have been appropriated for the voter-approved expansion measure, which would cover up to 90,000 individuals. Proponents of expansion note that in June, LePage vetoed a bill that would have provided $60 million for expansion. Read More

Supreme Court Rejects Governor's Request to Delay Medicaid Expansion. *The Hill* reported on August 23, 2018, that Maine must implement a voter-approved Medicaid expansion plan, after the state Supreme Court lifted a temporary stay and denied Governor Paul LePage's request to delay the initiative. However, the Supreme Court didn't rule on the merits of the case. Instead, it sent the case back to the Superior Court to resolve any outstanding issues. The lawsuit was filed by advocates after Lepage failed to submit a plan to expand Medicaid in April. Read More

Mississippi

Mississippi Rereleases CHIP RFQ. On August 31, 2018, the Mississippi Division of Medicaid (DOM) rereleased a request for qualifications (RFQ) for the state's Children's Health Insurance Program (CHIP). The previous RFQ was canceled in July for failing to comply with state law. Proposals are due October 5, 2018, with awards expected to be announced on November 21, 2018, and contracts effective July 1, 2019. DOM will contract with no more than two managed care organizations. Incumbents are UnitedHealthcare of Mississippi and Centene/Magnolia Health Plan. As of March 2018, a total of 46,958 children were enrolled in CHIP. Read More

Medicaid Work Requirements Request Raises Concerns Because of State's Decision Not to Expand Medicaid. *The Hill* reported on August 22, 2018, that implementing Medicaid work requirements in a non-expansion state like Mississippi could jeopardize health care coverage for tens of thousands of residents and have far broader implications than work requirements in non-expansion states. Medicaid work requirements in a non-expansion state could result in beneficiaries earning too much for Medicaid but not but not enough for Exchange plan subsidies. Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS), acknowledged the need to work with non-expansion states to ensure Medicaid beneficiaries do not lose their coverage. Read More

Missouri

Medicaid Plan Exposed PHI of Children. *The Kansas City Star* reported on August 29, 2018, that Missouri Medicaid Plan WellCare accidentally exposed the personal health information of 19,570 Medicaid children. According to a letter from WellCare's VP Ted Webster, reminders about well-child visits, which contained personally identifiable information including the child's name and age, were sent to the wrong addresses. Missouri Care plans cover about 275,000 people, mainly children and pregnant women, throughout the state. Read More

Montana

Montana to Restore Medicaid Provider Rate Cuts. *The Missoulian* reported on August 30, 2018, that the Montana Governor's budget director, Dan Villa, announced the state will put $30.5 million back into the Department of Public Health and Human Services, restoring 2.99% cuts to Medicaid provider rates and replacing funding for dental and orthodontic services and the targeted case management (TCM) program for children's behavioral health. The budget director did not provide specific details on how the funding would be restored to the TCM program. Many of the organizations impacted by the cuts that took effect January 2018 say the cuts started a dismantling of community-based care that will take "more than a couple of months to build the system back up." For instance, some organizations, like Helena Industries, completely shut down. Villa was hopeful the money to restore rates would also lead to dropping several lawsuits that have been filed by providers. However, Beth Brenneman, attorney for Disability Rights Montana, says there is still more to resolve. Read More

Nebraska

Medicaid Expansion Opponents to Appeal Ballot Initiative Decision. *The Omaha World-Herald* reported on August 20, 2018, that opponents of Medicaid expansion will continue their legal challenge to keep the measure off the Nebraska general election ballot, despite losing in the district court. Lancaster County District Judge Darla Ideus rejected the claims that the successful Medicaid petition is "invalid and legally insufficient." Senator Lydia Brasch and Former State Senator Mark Christensen, those who filled the lawsuit, have filed notice that they plan to appeal the ruling. Read More

Judge Dismisses Lawsuit to Block Medicaid Expansion Ballot Measure. *The Omaha World-Herald* reported on August 29, 2018, that Nebraska District Judge Darla Ideus dismissed a lawsuit that sought to keep a Medicaid expansion measure from appearing on the November general election ballot. The proposed expansion would provide coverage to adults without minor children. Supporters of Medicaid expansion submitted almost 137,000 signatures to put the issue on the ballot. Read More

Medicaid Expansion Ballot Initiative Moves Closer to General Election. *Bloomberg* reported on August 24, 2018, that Nebraska Secretary of State, John Gale, certified that a Medicaid expansion effort met the required number of signatures to make it to the 2018 general election ballot. Gale reported, "The measure will be placed on the 2018 general election ballot, barring an order from the district court handling the pending lawsuit that challenges the initiative petition." The lawsuit, brought by Senator Lydia Brasch and former Senator Mark Christensen, seeks to block the proposal from reaching the November ballot, calling it invalid and legally insufficient. Gale and Insure the Good Life, the organization responsible for spearheading the ballot initiative, have filed motions to dismiss the lawsuit. Read More

New Hampshire

New Hampshire Releases Medicaid Managed Care RFP. On August 30, 2018, the New Hampshire Department of Health and Human Services (DHHS) released a request for proposals (RFP) for Medicaid Care Management (MCM) services. DHHS expects to select three Medicaid managed care organizations (MCOs) with contracts effective July 1, 2019 through June 30, 2024. Proposals are due October 30, 2018. A total of 181,380 individuals will be eligible, including 43,970 Medicaid expansion enrollees that will transition from the state's insurance Exchange. The state had previously released a draft RFP on July 9. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid Posts Core Medicaid and MLTSS Quality Technical Report. The New Jersey Division of Medical Assistance and Health Services (DMAHS) published a quality report on the performance of its contracted managed care organizations for the period April 2016 – December 2017. The *Core Medicaid and MLTSS Quality Technical Report* was prepared by the state's External Quality Review Organization, IPRO. The report provides an in-depth account of each managed care organization's (MCO's) performance by the following plans: Aetna Better Health of New Jersey (Aetna), Amerigroup New Jersey, Inc. (Amerigroup), Horizon NJ Health (Horizon), UnitedHealthcare Community Plan (United), and WellCare Health Plans of New Jersey, Inc. (WellCare). The report captures their performance across several quality performance methods including: annual assessment of MCO operations, performance measure validation, quality improvement projects (QIPs), core Medicaid encounter data validation, focused quality studies, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, core Medicaid care management (CM) audits, and MLTSS CM Audits. A copy of the findings can be found here.

Medicaid MCO Benefit Plan Changes Delayed. The New Jersey Division of Medical Assistance and Health Services (DMAHS) recently informed providers that changes to the managed care health benefit plan for certain beneficiary groups as it pertains to mental health and substance use disorder (SUD) services would go into effect on October 1, 2018. The changes were previously scheduled for July 1, 2018.

DMAHS will carve in all mental health benefits and expand the managed care benefit to include coverage for all SUD services for the following groups: 1) beneficiaries enrolled in MLTSS, and 2) beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and Division of Developmentally Disabled (DDD) managed care members. Further, partial care services provided to DDD-enrolled beneficiaries will become the responsibility of the MCO.

Also beginning October 1, 2018, MCOs will be responsible for all acute care admissions to any hospital, including admissions for an acute psychiatric diagnosis. This change applies to all Medicaid MCO enrollees regardless of age.

New Jersey Expands FamilyCare CHIP Benefits. Beginning July 1, 2018, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) added additional covered services for individuals enrolled in NJ FamilyCare Plan D which covers enrollees eligible for coverage under the Children's Health Insurance Program (CHIP). The new services for NJ FamilyCare Plan D benefits now include:

- Nonemergency transportation, through LogistiCare covered by Medicaid fee-for-service
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services including medical exams, dental, vision, hearing and lead screenings
- Medically necessary durable medical equipment and medical supplies
- Medically necessary home health care and private duty nursing (no maximum limit)
- Medically necessary outpatient rehabilitation including physical therapy (PT), speech therapy (ST) and cognitive rehabilitation therapy (CRT) services with no maximum limits

New York

HMA Roundup – Denise Soffel (Email Denise)

DOH Sponsors Social Determinants of Health Innovation Summit. The New York Department of Health is sponsoring a Social Determinants of Health Innovation Summit on September 26, 2018. The summit is meant to showcase winning submissions from the state's solicitation of innovative solutions that can effectively address social determinants of health (SDH) for Medicaid members across the state. The 'Call for SDH Innovations' solicited creative ways to improve outcomes through SDH from community-based organizations, healthcare providers and plans, and private sector technology firms. While applicants will not receive funding or monetary awards, it is an opportunity for organizations to share best practices in the field. The summit will be held at the New York Academy of Medicine from 9:30 – 2:30. Click here to register for the summit.

New York Releases Draft Standards for Specialized Managed Care Plans for Individuals with Intellectual/Development Disabilities for Public Comment. New York is in the process of a transformation of its service system for individuals with intellectual/developmental disabilities (I/DD), with the goal of moving to managed care arrangements. As part of the transformation the state is creating a model of care that enables qualified plans, called Specialized I/DD Plans – Provider Led (SIPs-PL), formed by experienced providers of developmental disability services throughout the state, to meet the needs of individuals with I/DD. The application notes that any savings achieved due to more efficient service utilization will be invested back into the Office for People with Development Disabilities (OPWDD) service system. The draft standards also include an implementation timeline, which indicates that voluntary enrollment of individuals with I/DD will begin in August 2019, with mandatory enrollment beginning in 2021-22.

Comments on the draft requirements and standards document are due by October 3, 2018. The draft can be found here.

Business Groups Express Concerns About Single-Payer Proposal. *The State of Politics* reported on August 30, 2018, that a letter signed by 30 New York groups including the Chambers of Commerce, small businesses, insurance plans, and providers, raises concerns about the single-payer health care system proposed under Assembly member Richard Gottfried's New York Health bill. The proposal was the subject of a recent RAND analysis, which found that the proposal would decrease health care costs slightly and would require significant new taxes. The letter raises three areas of concern: 1) significant tax increases, 2) cuts to provider payments, and 3) uncertainty about whether needed federal approvals were likely, especially given that the Centers for Medicaid and Medicare Services (CMS) has already signaled it will not grant such waivers for state-based, government-run health care proposals. The letter was sent to both Governor Cuomo and his opponent for the Democratic nomination, Cynthia Nixon. Nixon has expressed strong support for a single-payer approach. The governor has said that he supports single payer in concept but argues that it would be too expensive for the state to enact on its own. Read More

New York Funding for Essential Plan Restored. In response to a lawsuit filed by New York's Attorney General, Barbara Underwood, the Trump administration has restored $574 million to the Essential Plan. The Essential Plan, established under the Affordable Care Act's Basic Health Program, provides coverage to New Yorkers with income between 150 and 200 percent of the federal poverty level. The lawsuit was filed after the federal government stopped making cost-sharing reduction payments, based on their determination that Congress had never appropriated funding. The Essential Plan provides coverage to about 730,000 New Yorkers. Read More

New York MLTC Plan to Discontinue Operations December 1. *Crain's New York Business* reported on August 28, 2018, that GuildNet, a New York managed long-term care (MLTC) plan affiliated with Lighthouse Guild, expects to discontinue its health plan on December 1, 2018, affecting nearly 7,500 members enrolled as of July. A non-profit entity, GuildNet withdrew from Long Island and Westchester County in June 2017 due to financial challenges, a change that affected 4,500 members. GuildNet has participated in NY's MLTC program for many years, pre-dating the move to mandatory enrollment that began in 2012. There are 19 partially capitated MLTCs still operating in the state. Read More

Oklahoma

Oklahoma to Consider Medicaid Provider Rate Increase for First Time Since 2009. *The Oklahoman/The Associated Press* reported on August 31, 2018, that the Oklahoma Health Care Authority is considering increasing rates paid to Medicaid providers for the first time since 2009. Long-term care facilities are expected to receive a four percent rate increase, while physicians, hospitals and pharmacies would receive a three percent increase. If approved, providers would begin receiving the increased rates on October 1. Oklahoma's Medicaid program currently covers an estimated 796,000 individuals. Read More

Medicaid to Negotiate Drug Prices Based on Effectiveness. *Reuters* reported on August 24, 2018, that Oklahoma has received approval from the Centers for Medicare & Medicaid Services (CMS) to factor the effectiveness of prescription drugs into its contract negotiations with drug manufacturers. This strategy will offer better rebates the longer the member adheres to a prescription regimen, which can result in improved quality, value, and efficiency of drug-based treatments. However, it is unclear how much money the state will save and whether enough drug makers will participate. Oklahoma has signed its first contract with Alkermes Plc for Aristada, a schizophrenia treatment, with more contracts pending, according to Nancy Nesser, Director at the Oklahoma Health Care Authority. Read More

Oregon

Chief Executive Janet Meyer to Leave Health Share. *Oregon Live* reported on August 30, 2018, that Health Share of Oregon Chief Executive Janet Meyer will be stepping down after six years of leadership. Health Share serves about 215,00 Medicaid patients and is one of 16 coordinated care organizations. Read More

Medicaid Plan Expects $96 Million in Losses. *The Oregonian* reported on August 25, 2018, that Portland-based CareOregon, a major Medicaid plan in Oregon, expects to experience losses exceeding $96 million over the three year period ending in December 2018. CareOregon, a key player in providing coordinated care in the state, attributes the losses to limits on annual rate increases for coordinated care organizations of 3.4 percent. According to CareOregon's CEO and president Eric Hunter, "the state's Medicaid reimbursement rate is too low and doesn't allow local providers to keep up with health care costs." Read More

Pennsylvania

Supreme Court Upholds Executive Order on Direct Care Workers. *The Morning Call* reported on September 4, 2018, that the Pennsylvania Supreme Court upheld an executive order from Governor Tom Wolf to organize workers who care for elderly or disabled people in their homes under a union-like structure. A divided Supreme Court ruled Tuesday that Wolf's 2015 executive order formalizes a voluntary system to obtain information and discuss issues and does not impinge on the Legislature's prerogative. Under it, workers would choose representatives to meet with the state about pay and benefits. Overturning a lower court's ruling, the Supreme Court said Wolf is within his rights because the order is "voluntary, nonbinding, nonexclusive and unenforceable." The court, however, wants a lower court to examine whether the administration violated privacy rights by giving unions the names and contact information for the 20,000 direct care workers. Read More

Pennsylvania Cancels Independent Enrollment Broker Procurement for LTSS. On August 31, 2018, the Pennsylvania Department of General Services (DGS) and the Department of Human Services (DHS) cancelled the request for proposals (RFP) for an Independent Enrollment Broker (IEB) to facilitate long-term support services eligibility and enrollment for applicants. Based on the recent implementation of Community HealthChoices, DHS will re-evaluate the scope of the procurement and services the IEB would provide. DHS will continue to work with current vendors for independent enrollment broker services and long-term care clinical assessments. Read More

Pennsylvania Announces Selection of Fiscal Management Services Vendor. The Pennsylvania Office of Long-Term Living (OLTL) announced that Public Partnerships, LLC, has been selected as the new statewide Vendor Fiscal/Employer Agent (VF/EA) for Financial Management Services (FMS) for OLTL-administered programs. The VF/EA performs fiscal-related functions for the successful operation of participant direction for multiple home and community-based waivers managed by OLTL. FMS reduce the employer-related burden for participants while making sure Medicaid and Commonwealth funds used to pay for services and supports are managed and disbursed appropriately as authorized. The new contract begins October 1, 2018.

South Dakota

South Dakota is the Latest State to Seek Approval for Medicaid Work Requirements. *CQ Health* reported on August 28, 2018, that South Dakota is the latest state to move toward implementing Medicaid work requirements. The proposal is aimed at parents and caretakers ages 19-59 who live in Minnehaha and Pennington counties, the two state counties with the highest populations. The five-year pilot program would require these beneficiaries to work or participate in job training for at least 80 hours a month. The state estimates that the new requirement could result in 15 percent of Medicaid beneficiaries becoming ineligible due to increased incomes or nonparticipation. Read More

Tennessee

Health System Files Lawsuit Against TennCare. *The Times Free Press/The Associated Press* reported on August 28, 2018, that Tennessee's Erlanger Health System has filed a lawsuit again the state's Medicaid program, TennCare, claiming state officials were favoring managed care organizations (MCO) at the expense of hospitals treating patients most in need. Erlanger's concerns involve hospital reimbursement by MCOs for out-of-network emergency services to Medicaid enrollees. Read More

Texas

Texas Medicaid Wins Court Ruling in Case Against ACA Health Plan Premium Tax. *The Austin American-Statesman* reported on September 2, 2018, that a federal judge in Texas ruled that the Affordable Care Act (ACA) health plan premium tax improperly saddled the Medicaid programs in Texas and five other states with $839 million in fees. The lawsuit, led by Texas Attorney General Ken Paxton, is attempting to recover money collected through the ACA's Health Insurance Provider Fee. Texas alone would receive $304.7 million if the ruling stands. Among other states, Louisiana would received $172.5 million, Kansas ($142.1 million), Indiana ($94.8 million), Wisconsin ($88.9 million), and Nebraska ($36.2 million), according to the Texas attorney general's office. Read More

Legislators Hear Medicaid Managed Care Complaints. *The Austin American-Statesman* reported on August 29, 2018, that the Texas House Committee on Human Services heard several healthcare providers and Medicaid patients express concerns with Medicaid managed care organizations (MCOs) in a hearing held on Wednesday. Providers complained that there has been an increase in delays of patient services and payments, causing a provider shortage and leaving children with disabilities without treatment. According to Stephanie Muth, deputy executive commissioner with the Texas Health and Human Services Commission, the agency is working to improve the appeals process, streamlining and identifying inconsistencies in denials among the MCOs. Read More

Texas Governor Appoints HHSC Executive Commissioner. *The Texas Tribune* reported on August 23, 2018, that Texas Governor Greg Abott has announced Courtney Phillips, current chief executive officer for the Nebraska Department of Health and Human Services, as the new executive commissioner for the Texas Health and Human Services Commission (HHSC) starting October. Phillips will oversee 60,000 employees and a biennial budget of $80 billion. Read More

Virginia

Virginia Closes Another State Institution for Individuals with IDD. *WTOP/The Associated Press* reported on September 4, 2018, that Virginia has closed another state institution for housing individuals with developmental and intellectual disabilities. The closure of the Southwestern Virginia Training Center on August 21 is the third since the state reached a settlement with the Department of Justice in 2012, aimed at addressing concerns that the state was warehousing people instead of providing community-based services. A fourth facility is scheduled to close, while a fifth will remain open. Read More

Virginia Begins Transition Towards E-Prescribing Opioid Mandate by July 2020. *The Richmond Times-Dispatch* reported on August 30, 2018, that a Virginia medical industry work group agreed on a set of changes to move towards the 2017 state mandate to transition to electronic prescribing of all opioids by July 2020. The draft legislation included nine possible exemptions, including prescriptions dispensed in medical facilities and extenuating circumstances, like technological failure or patient risk. Almost 56.8 percent of prescribers in the state are active e-prescribers, while only 6.3 percent are compliant with the Drug Enforcement Administration requirements for opioid e-prescription. Last year, the work group determined the state should adopt temporary waivers and exemptions to the e-prescribing mandate before the deadline for prescriber compliance. Read More

National

CMS Issues Guidance on Auto Enrollment of Medicaid Managed Care Members into D-SNP Offered by Same Company. The Centers for Medicare & Medicaid Services (CMS) issued guidance on August 31, 2018, to Medicare Advantage plans concerning the new default enrollment process for integrated dual eligible special needs plan (D-SNP) members. Under the new rule, CMS will permit automatic enrollment of Medicaid managed care plan enrollees into a D-SNP offered by the same company, previously known as "Seamless Conversion Enrollment." CMS will begin accepting enrollment proposals October 1, 2018, with effective dates January 1, 2019 or later.

Medicaid Specialty Plans Improve Provider Access for Children in Foster Care. *Kaiser Health News* reported on August 24, 2018, that despite nearly all foster children across the country receiving health care coverage through Medicaid, some health needs, notably mental health services, are still not being met. States including Florida, Georgia, and Texas have begun placing foster children in specialized Medicaid health plans usually run by private, for-profit Medicaid managed care companies. Read More

CMS Releases Guidance to Ensure Budget Neutrality of State Waiver Demonstrations. *Modern Healthcare* reported on August 22, 2018, that the Centers for Medicare & Medicaid Services (CMS) issued formal guidance aimed at ensuring states meet budget neutrality requirements in their Medicaid waiver demonstrations. CMS also announced a new financial monitoring tool, which will require states to upload financial data concerning each demonstration. "Today's guidance is a comprehensive explanation of how CMS and our state partners can ensure that new demonstration projects can simultaneously promote Medicaid's objectives and keep federal spending under control," said Seema Verma, CMS administrator. Read More

Medicaid Buy-In Faces Roadblock in Hospitals. *Modern Healthcare* reported on August 23, 2018, that hospitals are averse to Medicaid buy-in proposals over concerns that commercial health plan reimbursements would be replaced by lower Medicaid plan payments. At least six states have legislative proposals enabling Medicaid buy-in, a concept that health care advocate are pushing ahead of the 2020 elections. Read More

Industry News

California Hospital System Verity Health Files for Chapter 11 Bankruptcy. *Modern Healthcare* reported on September 4, 2018, that Verity Health System of California Inc., a not-for-profit operator of six California hospitals, has filed for Chapter 11 bankruptcy protection, blaming mounting losses and debt. Chief executive Rich Adcock said that Verity has secured $185 million in financing, allowing it to continue to operate as it restructures and seeks potential buyers. Verity, formerly known as Daughters of Charity Health System, is backed by Patrick Soon-Shiong, a prominent California entrepreneur and investor. Read More

WellCare Completes Acquisition of Meridian Health Plans, MeridianRx PBM. WellCare Health Plans Inc. announced on September 4, 2018, that it has completed the previously announced acquisition of Meridian Health Plans of Michigan and Illinois as well as the MeridianRx pharmacy benefit management operation. The deal, which closed September 1, expands WellCare's membership by about 1.1 million Medicaid, Medicare Advantage, dual-eligible, and Exchange plan members. Read More

BayMark Health Services Acquires Counseling Solutions. BayMark Health Services announced on August 31, 2018, the acquisition of Counseling Solutions, which operates outpatient medication-assisted treatment facilities in Chatsworth, Georgia, and Brasstown, North Carolina. BayMark operates MedMark Treatment Centers, which provide access to medications like methadone and buprenorphrine in conjunction with counseling and behavioral therapy for patients with opioid addiction. Read More

Otsuka to Roll Out Digital Abilify Pill to Magellan Medicaid Patients. *STAT News* reported on August 31, 2018, that drug maker Otsuka will roll out the first "digital pill" with an implanted sensor at an estimated cost of $1,650 per pill. Magellan Health Medicaid beneficiaries will have the option to opt-in to Abilify MyCite, a pill embedded with a sensor that can alert doctors when it's swallowed, aimed at helping patients with mental illness adhere to their medication as prescribed. While regions for where the product will be initially rolled out have not been finalized, Florida and Virginia are top candidates, according to Magellan's chief innovation officer Dr. Seth Feuerstein. Read More

HCA Healthcare to Acquire North Carolina Health System for $1.5 Billion. HCA Healthcare announced on August 31, 2018, a definitive agreement to acquire Mission Health, a nonprofit North Carolina health system, for an estimated $1.5 billion. The proceeds of the sale will be contributed to the nonprofit Dogwood Health Trust to improve the health of individuals in western North Carolina. Read More

Caravel Autism Health Receives Investment from Frazier Healthcare Partners. Caravel Autism Health announced on August 29, 2018, that it will receive a strategic investment from Frazier Healthcare Partners. The investment will allow Caravel to pursue geographic expansion, additional treatment models, and additional technology initiatives. Caravel Autism Health is a leading provider of Applied Behavioral Analysis (ABA) therapy to children on the autism spectrum. Read More

Centene Subsidiary Awarded Florida Correctional Medical Services Contract. Centene announced on August 27, 2018, that its subsidiary, Centurion Detention Health Services, was awarded a five year contract to provide comprehensive healthcare services to detainees of Volusia County's detention facilities in Florida, effective January 2019. The contract is for a five-year base period with five one-year renewal options and is subject to forthcoming contract negotiations. Read More

HCA Nurses Vote to Strike, Seek "Safe Staffing" Levels. *Health News Florida* reported on September 5, 2018, that registered nurses at 15 Hospital Corporation of America (HCA) hospitals in five states have voted to authorize a strike if ongoing contract negotiations are not resolved, according to the National Nurses Organizing Committee. Among the demands, nurses are calling for "safe staffing" levels to ensure patients receive proper care and ensuring nurses receive allotted breaks. Contracts for registered nurses at HCA facilities expire May 31 in Florida, Kansas, and Missouri, and June 30 in Texas and Nevada. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
Summer 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
September 13, 2018	Washington DC	Proposals Due	~200,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 1, 2018	Virginia Medallion 4.0 - Northern/Winchester	Implementation	178,416
October 12, 2018	New Hampshire	Proposals Due	181,380
October 12, 2018	North Carolina	Proposals Due	1,500,000
November 1, 2018	Virginia Medallion 4.0 - Charlottesville/Western	Implementation	88,486
November 1, 2018	Puerto Rico	Implementation	~1,300,000
December 1, 2018	Virginia Medallion 4.0 - Roanoke/Alleghany	Implementation	72,827
December 1, 2018	Virginia Medallion 4.0 - Southwest	Implementation	46,558
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
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)
February 4, 2019	North Carolina	Contract Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
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
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000

HMA WELCOMES

Jonathan Blum, Managing Principal – Washington, DC

Jonathan (Jon) Blum has more than 20 years of senior-level experience working in public and private healthcare financing organizations, including the Centers for Medicare and Medicaid Services (CMS).

From 2009-2014, Jon had direct responsibility for administration of the Medicare program, leading the development and implementation of many of the cost-reduction and delivery system improvements that remain in place today and have been adopted by an array of public and private healthcare organizations. These reforms include fundamental changes to the Medicare Advantage program that accelerated its rapid growth, the Accountable Care Organization (ACO) program, bundled-payment initiatives, value-based purchasing, new competitive bid pricing systems, and improvements to the Medicare Part D prescription drug program.

Under Jon's leadership, the Medicare program experienced its lowest sustained period of overall spending and premium growth. He also directed the release of unprecedented levels of Medicare data to make the program more transparent and accountable to the public.

Most recently, Jon was an executive vice president at CareFirst BlueCross BlueShield, overseeing its medical policies, pharmacy benefit, provider networks, and care coordination programs. Earlier in his career, he was a Congressional healthcare staffer to the Senate Finance Committee, a Medicare budget analyst at the White House Office of Management and Budget, and an executive at Avalere Health.

Jon is active on many non-profit boards and health policy advisory councils. He is a graduate of the John F. Kennedy School of Government at Harvard University, where he earned a master's degree in public policy, and the University of Pennsylvania.

HMA News

HMA MMS Experts Decipher Budget Neutrality Changes for 1115(a) Demonstrations

On August 22, CMS published a State Medicaid Director letter clarifying some existing policies and highlighting policy changes related to budget neutrality for section 1115(a) demonstrations.

Some of the key areas addressed in the letter include:

- When CMS will require budget neutrality to be calculated
- Populations and services that would not factor into a budget neutrality calculation
- Methodologies for calculating budget neutrality
- Alignment with federal budgeting
- Re-evaluating budget assumptions
- Phasing down savings rollover
- Plans for budget neutrality monitoring and oversight

Our experts at HMA Medicaid Market Solutions created a summary to help you understand the key policies. Read more

New this week on HMA Information Services (HMAIS):

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

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

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

Medicaid Data and Updates:

- Alabama Medicaid Eligibility by Eligibility Group, Age, Gender, Race, Jul-18 Data
- Florida Medicaid Eligibility by County, Age, Sex, Jul-18 Data
- Georgia Medicaid Managed Care Enrollment is down 2.7%, Aug-18 Data
- Idaho Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Kansas Medicaid Managed Care Enrollment is Down 1.1%, Jul-18 Data
- Louisiana Medicaid Managed Care Enrollment is Flat, Jul-18 Data
- Maryland Medicaid Managed Care Enrollment is Flat, Jul-18 Data
- Michigan Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Mississippi Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- North Dakota Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Nebraska Medicaid Managed Care Enrollment Rises 1.8%, Aug-18 Data

- New Hampshire Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- New Jersey Medicaid Managed Care Enrollment is Up 1.6%, Aug-18
- New York Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Ohio Dual Demo Enrollment is Flat, Aug-18 Data
- Oklahoma Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Pennsylvania Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Rhode Island Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Virginia Medicaid MLTSS Enrollment is Over 212,000, Jul-18
- Vermont Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Washington Medicaid Fee for Service vs. Managed Care Penetration, 2014-17
- Wisconsin Medicaid Fee for Service vs. Managed Care Penetration, 2014-17

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Mississippi Children's Health Insurance Program (CHIP) RFQ, Aug-18
- Georgia Families Medicaid Managed Care Contracts and Extensions, 2017-19
- New Hampshire Medicaid Care Management Services RFP and Related Documents, Aug-18
- Washington Behavioral Health Administrative Service Organization (BH-ASO) RFP, Proposals, Scoring/Evaluation, and Award, 2018
- Colorado Independent Verification & Validation for Medical Assistance Medicaid Enterprise Systems RFP, Aug-18
- Louisiana Fiscal/Employer Agent for Self-Directed Services RFP, Proposals, Evaluation Documents, 2017
- Louisiana MMIS Modernization Project Management Services RFP, Related Documents, Aug-18
- Tennessee Pharmacy Benefits Management RFP, Aug-18
- Vermont Medicaid Pilot Prototypes for Alternative Systematic Approaches to Management of Chronic Pain RFP, Aug-18
- Washington Individual Provider (IP) Program RFI and Responses, 2

Medicaid Program Reports, Data and Updates:

- Colorado Medical Premiums Expenditure and Caseload Reports, FY 2014-18
- Delaware DHSS Report to Governor Carney on Establishing a Health Care Benchmark, Aug-18
- Delaware Managed Care External Quality Review Performance Reports, 2016-17
- Georgia Medicaid Managed Care Rate Certifications, FY 2018
- Idaho BRFSS Annual Reports, 2014-16
- Idaho Health Quality Planning Commission Annual Report, 2018
- Idaho Medical Care Advisory Committee Meeting Materials, Jul-18
- Illinois Medicaid Annual Reports, 2013-17
- Illinois Medical Programs Quality Strategy Reports, 2012-18
- Indiana Medicaid Managed Care Quality Strategy Plan, 2018
- Kansas KanCare Annual Reports, 2013-17
- Kansas Medical Assistance Reports, FY 2014-18
- Louisiana Medicaid Annual Reports, 2011-17
- Maine Approved 1332 State Innovation Waiver Documents, 2018
- Maryland Approved 1332 State Innovation Waiver Documents, 2018
- Massachusetts One Care Duals Demonstration 2.0 Listening Session Presentations, 2018

- Minnesota Health Care Disparities Report, 2016-17
- Missouri HealthNet Monthly Management Reports, 2014-16, Jun-18
- Missouri HealthNet Oversight Committee Meeting Materials, Aug-18
- Nebraska Long Term Care Redesign Committee Minutes, Aug-18
- New Jersey Medicaid and MLTSS Quality Technical Report, 2016-17
- New Mexico Medicaid Managed Care Quality Strategy Report, 2013-17
- Nevada Medicaid Managed Care Actuarial Rate Certification, CY 2018
- Nevada Medical Care Advisory Committee Meeting Materials, Aug-18
- New York Children's Medicaid System Transformation Draft Transition Plan and Rates, Aug-18
- Ohio Medicaid Annual Reports, 2014-17
- Ohio Medicaid Expansion Assessment Presentation, Aug-18
- Ohio Medicaid Managed Care Quality Strategy Report, 2018
- Oklahoma Health Care Authority Annual Reports, 2014-17
- Oklahoma Health Care Authority Strategic Plan, FY 2018-22
- Oklahoma Provider Fast Facts by County, Jul-18
- Rhode Island Medicaid Annual Expenditure Reports, SFY 2013-17
- Tennessee External Quality Review Organization Technical Reports, 2016-17
- Tennessee Medicaid Managed Care HEDIS/CAHPS Reports, 2015-18
- Virginia Medallion 4.0 Draft Data Book and Appendices, FY 2019
- Virginia Medallion 4.0 Launch Memo, Jan-18
- Virginia Medicaid Managed Care Quality Strategy Reports, 2011-15, 2017-19

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.