HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

TEXAS MEDICAID AND CHIP MANAGED CARE FINAL COMPREHENSIVE REPORT

This week, our *In Focus* section comes to us from Senior Consultant Ryan Mooney, reviewing the Texas Medicaid and Children's Health Insurance Program (CHIP) Evaluation report. The 85th Legislature of the State of Texas required the Texas Health and Human Services Commission (HHSC) to report on its findings for Rider 61, Evaluation of Medicaid Managed Care (the Report). HHSC recently published the Report, which includes the following:

1. Rider 61(a) - A review of the current Medicaid and Children's Health Insurance Program (CHIP) managed care delivery system and an assessment of the performance of managed care;
2. Rider 61(b) - An assessment of Medicaid and CHIP managed care contract review and oversight;
3. Rider 61(c) - A study of Medicaid Managed Care rate setting processes and methodologies in other states; and

4. Rider 61(d) - An analysis of MCO administrative costs, including a survey of each MCO to determine the nature and scale of administrative resources devoted to the Texas Medicaid and CHIP programs and the identification of cost reduction opportunities.

Overview of Texas Medicaid Managed Care

As of 2017, 92 percent of Texas Medicaid enrollees and all Children's Health Insurance Program (CHIP) enrollees were enrolled in managed care. Currently, there are seven different Medicaid managed care programs in Texas, including specific programs for low-income individuals and families, elderly individuals, adults and children with disabilities, and foster children. STAR is the Texas Medicaid managed care program, through which most eligible Texans get their benefits. The program covers preventive, primary, acute, behavioral health and pharmacy services for pregnant women, newborns, children, and parents who meet income requirements. STAR+PLUS is a Texas Medicaid Managed Care program integrating the delivery of acute care services and long-term services and supports (LTSS) for people who are age 65 or older, blind, or disabled. STAR Kids is the Texas Medicaid managed care program that provides Medicaid benefits to children and adults 20 and younger who have disabilities. STAR Health provides a full-range of Medicaid covered medical and behavioral health services for children in the Department of Family and Protective Services (DFPS) conservatorship and young adults in DFPS-paid placements.

Rider 61(a): A review of the current Medicaid and Children's Health Insurance Program (CHIP) managed care delivery system and an assessment of the performance of managed care

Enrollment and Cost Increases

Between FY 2014 and FY 2017, Texas' total Medicaid managed care enrollment increased by approximately 600,000 members while, over the same period, the aggregate per member per month (PMPM) costs increased by more than 10 percent annually. However, about 4.1 percent of that increase is tied to the implementation of the Dual-Eligible Integrated Care Demonstration Project (the "Dual Demonstration") program in SFY 2015 and the STAR Kids program in SFY 2017. After accounting for other service expansions, program changes, administrative expense changes, and population shifting from SFY 2009 to SFY 2017, the managed care program PMPM cost trended at 2.1 percent, slightly higher than the annualized Medicaid PMPM cost trend rate of 1.8 percent from the CMS National Health Expenditure (NHE) Report for Medicaid.

Quality Improvement

Of 19 unique measures that were analyzed, Texas MCOs' HEDIS® results were above the national benchmark (national Medicaid 50th percentile and other comparable states' 50th percentile) for nine measures and below the national benchmark for ten measures.

Access

The report compared states' access requirements and analyzed Texas's methodology to determine if it was similar to the methodologies used by other states. The analysis concluded that Texas's methodology was similar. The STAR, STAR+PLUS, and CHIP programs saw improvement in appointment availability metrics from 2015 to 2016, but one area of low compliance was OB/GYN appointment availability in the STAR program, with compliance rates below 50 percent for third trimester and for High-Risk OB/GYN appointments.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Texas MCOs experienced improvements across all consumer satisfaction composite measures that HHSC reviewed. The Report also compared Texas's CAHPS® results to the national Medicaid 50th percentile and found that Texas MCOs scored lower than the national benchmark for four out of the five CAHPS® composite measures that HHSC reviewed.

Estimated MCO Savings

HHSC noted that during transition years, or managed care expansion years, the assumed acute service and prescription drug benefit managed care savings gained from shifting from FFS to managed care built into the premium was at least budget neutral, and possibly greater than any additional costs associated only under a managed care program. HHSC reviewed cost savings by program, risk group, and medical and pharmacy costs and found that expanding managed care in the Texas Medicaid and CHIP programs between FY2009 and FY2017 has resulted in cost savings ranging from approximately $5.3 billion to $13.9 billion, or 4.7 percent to 11.5 percent, of the previous FFS model.

Rider 61(b): An assessment of Medicaid and CHIP managed care contract review and oversight

The findings of Rider 61(b) included new activities that HHSC may wish to implement to improve the oversight function. These opportunities fall into five broad categories:

- Increase efficiency and automation of processes, making them less time and/or labor-consuming;
- Share information across organizational units to strengthen oversight efforts using information that already exists;
- Improve data integration by merging existing data sources or pulling in additional data sources to offer HHSC more insights on addressing certain oversight functions;
- Improve the effectiveness of priority functions, such as strengthening key oversight efforts; and
- Increase transparency of relevant information, which would provide more information to policy makers and consumers.

Rider 61(c): A study of Medicaid Managed Care rate setting processes and methodologies in other states

Managed Care Rate Setting Methodology

The approach utilized by Texas and its consulting actuary to select and develop base data for rate setting is consistent with most of the states that were reviewed. Key similarities between Texas's approach and those utilized by other states include referencing different data sources to verify the most complete and accurate data is used to set the managed care capitation rates and utilizing a one-year period for base data. Texas's trend rate assumption development is also similar to other states in its use of state-specific historical data, a method preferred by CMS and an approach which Texas has been using for many years. Texas currently incorporates incentive arrangements, efficiency adjustments, and quality programs in a similar manner as the other states reviewed.

CMS Medicaid Managed Care rate setting guidance states that "the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital." The approach utilized by Texas to develop nonmedical expense loads is consistent with the other states reviewed. The annual update of Chronic Illness and Disability Payment System (CDPS+Rx) risk scores used in the Texas's rate development process is a similar risk-adjustment approach utilized by many other states. Other common risk-sharing methods used by other states to stabilize premium payments to MCOs against unexpected high costs include high-cost risk pools, risk corridors, and reinsurance. Finally, Texas has been certifying specific rates for each rate cell rather than rate ranges, putting it ahead of many states which are now adjusting their approaches to comply with the new federal managed care regulations.

MCO Selection

Texas currently contracts with MCOs based on competitive bidding with a technical component. HHSC's review of MCO selection across other states identified five considerations when reviewing the states utilizing competitive bidding processes: 1) Number of MCOs; 2) Published Rate Range; 3) Adjustments to Submitted Bids; 4) Procurement and Ongoing Administrative Costs; and 5) Cost Savings.

Rider 61(d): An analysis of MCO administrative costs, including a survey of each MCO to determine the nature and scale of administrative resources devoted to the Texas Medicaid and CHIP programs and the identification of cost reduction opportunities

HHSC conducted an analysis of MCO administrative costs, including a survey to understand the nature and scale of administrative expenditures and resources of the State of Texas's Medicaid and CHIP MCOs, to help identify potential savings and efficiencies that may be achieved. The Report examines recently available administrative expenditure data from MCOs, including annual Financial Statistical Reports (FSRs) and other MCO financial data provided to HHSC. While the STAR and STAR+PLUS programs have the highest administrative expenditures in total dollars, the STAR Kids program in its first year is the most expensive on a PMPM basis. While the new MLR standard of 85 percent will put increased pressure on MCOs to limit administrative expenditures, most already exceed the threshold (and on average, all of Texas's Medicaid Managed Care programs are above 85 percent MLR in SFY 2016 and SFY 2017).

The surveys showed that approximately 70 percent of MCO staff are employed in Texas, most of corporate allocations expenditures are for salary and other compensation, claims processing (non-capitated) and behavioral health services (capitated) are the most common outsourced services, and approximately three percent of total administrative expenditures were indicated as the result of Texas reporting requirements. In the survey, one of the most popular suggestions from MCOs involved potentially reducing the overall administrative expenses for the Texas Medicaid and CHIP programs through changing the State's reporting requirements. While the MCOs reported that less than 5 percent of total administrative expenses are attributable to HHSC reporting requirements as defined by the UMCM, there was variation by MCO with several low and high-cost outliers. For more information, contact Ryan Mooney at rmooney@healthmanagement.com.

Link to Report

HMA Medicaid Roundup

Arizona

Arizona Awards $16.4 Million MMIS Contract to CNSI. On October 2, 2018, the Arizona Health Care Cost Containment System (AHCCCS) announced it has awarded a three-year, $16.4 million Medicaid Management Information System (MMIS) contract to CNSI, a health information technology business solutions provider. Under the contract, CNSI will help modernize the state's 30-year-old MMIS, with the goal of streamlining Medicaid enrollment, verification registration, and provider screening. Read More

Arkansas

Medicaid Enrollees Still Lack Awareness of Work Requirements, Study Finds. The Kaiser Family Foundation reported on October 8, 2018, that Arkansas Medicaid recipients are still not aware of work requirements enacted by the state or lack the computer literacy needed to set up an online account and report their work activities. Additional obstacles include Internet access, transportation needed to get to work, and jobs for individuals with low educational levels. Since Arkansas implemented work requirements in June, more than 4,300 beneficiaries have lost coverage and another 5,000 are at risk. Read More

Florida

Florida Care Center to Close Amid Further Allegations of Abuse. *The Orlando Sentinel* reported that effective October 8, 2018, the Carlton Palms Educational Center for individuals with disabilities will close amid allegations of physical and verbal abuse of residents. A lawsuit filed in Circuit Court in Lake County on behalf of one resident claims that the abuse stemmed in part from the hiring of inexperienced caregivers. In April, the Florida Agency for Persons with Disabilities sought to revoke the center's license after various complaints. Carlton Palms' parent company is Delaware-based Bellwether Behavioral Management Corp. Read More

Hawaii

Medicaid Plans to Offer Adult Dental Coverage. *The Associated Press* reported on October 3, 2018, that AlohaCare and Ohana Health Plan will offer basic dental coverage to about 364,000 adult Medicaid beneficiaries beginning January 1, 2019. The two health plans are investing nearly $1 million to provide annual exams, cleanings, extractions and fillings. Hawaii hasn't offered Medicaid dental cover in over a decade. The program will operate at least until January 2020, when the state reprocures its Medicaid managed care business. Read More

Kansas

Senate Committee Approves Medicaid Inspector General Nomination. *U.S. News* reported on October 9, 2018, that a Kansas Senate committee has approved the nomination of Sarah Fertig for the position of Medicaid inspector general, a post that has been vacant for four years. The committee vote allows Fertig to begin serving pending a full Senate vote in 2019. Kansas Attorney General Derek Schmidt nominated Fertig in January 2018. She most recently served as assistant attorney general for seven years. Read More

Massachusetts

Massachusetts to Release One Care Duals RFP in 1-2 Months. MassHealth announced on October 9, 2018, that it will release a request for proposals in the next one to two months for health plans interested in bidding for the state's One Care dual eligible demonstration program. One Care contracts would be effective January 1, 2020. Updates on the One Care procurement process will be available at COMMBUYS and Mass.gov.

Montana

Republican Lawmakers Seek Medicaid Work Requirements. *The Independent Record* reported on October 9, 2018, that 67 Republican lawmakers in Montana urged Democratic Governor Steve Bullock to apply for federal approval to implement Medicaid work requirements in the state. In a letter to Bullock, lawmakers asked that able-bodied, adult Medicaid recipient be required to work, train or volunteer for a minimum of 20 hours a week. Bullock responded that Montana should instead focus on the state's voluntary workforce program, HELP-Link, which was created when the state expanded Medicaid in 2015. HELP-Link has served about 22,000 of the state's 96,600 expansion members. Read More

Montana Launches Website with Data on Medicaid Expansion. *KXLF* reported on October 6, 2018, that Montana has launched an online dashboard at medicaiddashboard.mt.gov allowing the public to view information about the state's Medicaid expansion, including the number of enrollees and the types of services they are receiving. The dashboard, developed in collaboration with the Montana Healthcare Foundation, allows users to organize data by county and month. Read More

New Jersey

New Jersey Medicaid Changes LARC Coverage Policy in Inpatient Settings. On October 8, 2018, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) released a newsletter to providers with an update to its policy for covering long-acting reversible contraceptive (LARC) devices. DMAHS notified providers that beginning July 1, 2018, the NJ FamilyCare program will provide inpatient hospital coverage for LARC immediate postpartum (within 10 minutes after delivery) with a patient's signed consent. This policy removes a restriction previously in place that limited access to LARC at the time of delivery. Providers must provide the LARC product for insertion and bill Medicaid for the product and the insertion. DMAHS is working on a solution to give providers access to LARC products in the inpatient hospital setting. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York City Health + Hospitals Announces Ambulatory Care Agenda. *Crain's HealthPulse* reported that New York City Health + Hospitals, NYC's public hospital system has announced a strategy for overhauling its ambulatory care strategy, aimed at reversing a decline in outpatient visits. The agency has developed a 5-point plan that aims to reduce the no-show visit rate by strengthening relationships between providers and patients. The plan also aims to improve clinic efficiency, reduce wait times for appointments for specialty care, and boost revenue through revised billing and coding practices. Crain's notes that the number of unique patients seen by the health system's primary care providers fell from 446,000 in fiscal 2016 to 417,000 in fiscal 2018, a 6.5% decline. Read More

CBC Releases Report On New York Medicaid Financing and Local Responsibility. The Citizens Budget Commission (CBC) has released a report that reviews New York's experience in financing the Medicaid program, and the reliance on financial contributions from localities. New York's Medicaid program is unique in the financial responsibility it imposes on counties. When the Medicaid program was implemented New York decided to split its non-federal share equally between state and local sources. Over decades budgetary and policy developments have shifted the burden somewhat, but counties still provide $7 billion/year to fund Medicaid. CBC notes three problems with New York's financing mechanism: it is an unfunded mandate on local government; it is a tax burden on local government; and it is regressive. The report provides a menu of options to finance the cost of a full state take-over of Medicaid that look at both spending reductions and revenue generation. Read More

Affinity Health Plan Withdraws from Medicare Advantage. *Crain's HealthPulse* reported that New York's Affinity Health Plan will be closing its Medicare Advantage plans as of the end of the year. The health plan has experienced some financial difficulty; Affinity lost $73.6 million on $1.46 billion in revenue in 2016. Affinity has 208,000 enrollees in its mainstream Medicaid managed care plan, as well as 5,000 people enrolled in its Health and Recovery Plan for Medicaid enrollees with serious mental illness and/or substance use disorders. The Medicare plans currently cover 13,600 people. Read More

New York Reports $2.6 Billion in Medicaid Fraud Savings, Recoveries. *Crain's New York* reported on October 5, 2018, that New York Medicaid inspectors identified and prevented $2.1 billion in Medicaid fraud and posted more than $500 million in recoveries in 2017. That's up from $1.9 billion in Medicaid fraud savings and more than $400 million in recoveries in 2016, according to the state Office of the Medicaid Inspector General (OMIG). Among OMIG's 2017 initiatives included stronger partnerships with managed care organizations through on-site visits and discussions related to special investigation, claims processing, subcontractors, and vendors. Read More

Ohio

Ohio Medicaid Expands Preferred Drug Formulary for Opioid Addiction Medications. *The Plain Dealer* reported on October 4, 2018, that Ohio Medicaid is updating its preferred drug formulary to include more medications used to treat opioid addiction and withdrawal. The Ohio Medicaid preferred drug list currently covers Suboxone and a generic drug with buprenorphine and naloxone; other drugs are covered with prior authorization. Beginning January 1, 2019, the preferred drug formulary will include all combinations of buprenorphine/naloxone without prior authorization. Read More

Wisconsin

Medicaid Plans Received Capitated Payments After Beneficiary Deaths, OIG Finds. *The Journal Sentinel* reported on October 4, 2018, that the Wisconsin Medicaid program improperly made capitated payments topping $600,000 to Medicaid managed care plans on behalf of deceased beneficiaries, according to an audit by the U.S. Office of Inspector General. The audit covered the years 2010 through 2015, a period in which Wisconsin contracted with 31 Medicaid plans and made total payments estimated at $12.8 billion. Read More

National

CMS to Move Ahead With Changes to ACO Medicare Payment Model. *CQ Health* reported on October 4, 2018, that the Trump administration is moving forward with changes to payment models for Medicare accountable care organizations (ACO), according to Adam Boehler, head of the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The administration hopes to limit Medicare Shared Savings Program ACOs to two years in the bonus-only model, while reducing bonuses from a maximum savings of 50 percent to 25 percent. CMS expects the changes to cause more than 100 out of 460 bonus-only ACOs to drop out. Read More

Supporters of Medicaid Expansion Target Deep South as Hospitals Close. *Forbes* reported on September 30, 2018, that supporters of Medicaid expansion are targeting southern states like Alabama, with marketing campaigns focused on the economic benefits of expansion. Alabama hospitals argue in part that expansion will bolster their financial stability in the wake of 12 hospital closures since 2011. Medicaid expansion supporters are also hoping for movement in states with expansion ballot measures in November as well as in states that will have new governors because of term limits or retirements. Studies suggest that the economic benefits of Medicaid expansion outweigh the costs. Read More

Arizona, Hawaii Release Joint RFP for EVV Vendor. On September 28, 2018, the Arizona Health Care Cost Containment System and the Hawaii Medicaid program (Med-QUEST) released a joint request for proposals (RFP) for an electronic visit verification vendor to implement and operate a single EVV system for the two states. Proposals are due November 23, 2018. An award is expected to be announced in April 2019, with implementation scheduled for October 2019. Read More

INDUSTRY NEWS

CVS, Aetna Merger Is Approved by DOJ Pending Sale of Part D Business. *Modern Healthcare* reported on October 10, 2018, that the U.S. Department of Justice has approved the $69 billion merger of CVS Health and Aetna Inc., provided Aetna completes the sale of its Medicare Part D drug plan business. As previously announced, WellCare Health Plans has agreed to acquire the Aetna Part D business. Read More

Centene to Expand Presence in Affordable Care Act Exchanges. Centene announced on October 10, 2018, that it will expand its presence in the Affordable Care Act (ACA) Exchanges. Under its Ambetter brand, Centene will enter Exchanges for the first time in Pennsylvania, North Carolina, South Carolina, and Tennessee, and will expand in six current Ambetter markets: Florida, Georgia, Indiana, Kansas, Missouri, and Texas. Read More

Private Equity Fund Backs Autism Behavioral Analysis Startup. Private equity firm MBF Healthcare Partners announced on October 9, 2018, its investment in the formation of Acorn Health, which will provide Applied Behavioral Analysis to children with autism in Michigan, Florida, and Virginia. Behavioral health executive Vicki Kroviak joined MBF in the formation of Acorn, which closed two acquisitions to establish its initial market presence. Kroviak was previously with eating disorder treatment centers Oliver-Pyatt Centers and Monte Nido & Affiliates. Read More

WellCare Signs Value-Based Network Agreement with Agilon Health. WellCare Health Plans, Inc. announced on October 8, 2018, that it has signed a value-based provider network agreement with Agilon Health for members in Texas. Under the arrangement, Agilon will receive incentive payments based on quality of care provided. Agilon manages care for more than 300,000 patients through a network of 14,000 physicians across four states. Read More

BayMark Health Services Acquires Tri-City Institute. BayMark Health Services announced on October 3, 2018, the acquisition of Tri-City Institute, which operates medication-assisted treatment facilities in Los Angeles, California. BayMark also recently acquired Counseling Solutions 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

Spectrum Finalizes Merger with Lakeland Health. *Modern Healthcare* reported on October 2, 2018, that Michigan-based Spectrum Health has finalized its merger with Lakeland Health, a three-hospital system in St. Joseph. Lakeland will continue to be overseen by a local board of directors, but will now be known as the Spectrum Health Lakeland division of Spectrum. With 12 hospitals, Spectrum is one of the largest not-for-profit health systems in Michigan. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
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
November - December 2018	Massachusetts One Care (Duals Demo)	RFP Release	150,000
December 1, 2018	Virginia Medallion 4.0 - Roanoke/Alleghany	Implementation	72,827
December 1, 2018	Virginia Medallion 4.0 - Southwest	Implementation	46,558
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
2019	Hawaii	RFP Release	360,000
January 1, 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- California Medicaid Managed Care Enrollment is Down 1.6%, Sep-18 Data
- Georgia Medicaid Managed Care Enrollment is Down 2.0%, Oct-18 Data
- Louisiana Medicaid Managed Care Enrollment by Plan, Region, and Subprogram, 2015-17, Aug-18
- Maryland Medicaid Managed Care Enrollment is Flat, Aug-18 Data
- Michigan Medicaid Managed Care Enrollment is Up 0.5%, Sep-18 Data
- Minnesota Medicaid Managed Care Enrollment is Flat, Oct-18 Data
- Mississippi Medicaid Managed Care Enrollment is Down 9.2%, Sep-18 Data
- North Carolina Medicaid Enrollment by Aid Category, 2015-17, Oct-18
- Tennessee Medicaid Managed Care Enrollment is Down 8.8%, Sep-18 Data
- West Virginia Medicaid Managed Care Enrollment is Down 4.1%, Oct-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arizona, Hawaii Electronic Visit Verification (EVV) System RFP, Sep-18
- Colorado NEMT RFI, Jul-18
- Iowa Medicaid Administrative Claims Implementation and Core Services Optimization RFP, Oct-18
- Kentucky Medicaid Managed Care Organization (MCO) Contract Renewal, SFY 18-19
- Washington Medicaid Managed Care Dental RFP, Proposals, Scoring, and Award, 2018

Medicaid Program Reports, Data and Updates:

- Alaska Enacted Budget, SFY 2019
- Arizona AHCCCS Population Demographics, Oct-18 Data
- Arizona LTC Home and Community Based Services Annual Reports, 2012-17
- Delaware Enacted Budget, SFY 2019
- Florida Vital Statistics Annual Reports, 2013-17
- Illinois Medicaid Advisory Committee Meeting Materials, Aug-18
- Kentucky 1115 Waiver Public Comment Responses, Sep-18
- Massachusetts Health Policy Commission Advisory Council Meeting Materials, 2016-18
- North Carolina Medical Care Advisory Committee Meeting Materials, Sep-18
- North Dakota Revised Statewide Transition Plan For HCBS Settings, Sep-18
- New York Medicaid Managed Care Advisory Review Panel Meeting Materials, Sep-18
- Oregon Medicaid Coordinated Care Organization Rate Certification, 2019
- Texas Acute Care Services and Long-term Services and Supports System Redesign for IDD Report, Sep-18

- Texas HHSC Evaluation of Medicaid and CHIP Managed Care Report, Aug-18
- Texas Medicaid and CHIP Managed Care Final Comprehensive Report
- Texas Medicaid CHIP Data Analytics Unit Quarterly Report, Sep-18
- Wisconsin Medicaid MCO Capitation Payments After Beneficiaries Deaths' Federal Audit, Sep-18

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