HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

HMA ANALYSIS OF NEW REQUIREMENTS EXPANDING MEDICARE ADVANTAGE ELIGIBILITY TO INDIVIDUALS WITH END-STAGE RENAL DISEASE

This week, our *In Focus* section comes from HMA Principal Eric Hammelman and Senior Consultant Narda Ipakchi. Today, Medicare beneficiaries with End-Stage Renal Disease (ESRD) are only eligible to enroll in Medicare Advantage (MA) plans if they select a MA Special Needs Plan (SNP) that specifically serves individuals with ESRD or develop ESRD while already enrolled in a MA plan. In 2018, approximately 121,000 MA enrollees (0.6 percent of the MA population) had diagnoses of ESRD, accounting for approximately 20 percent

of the total Medicare ESRD population.[i] The 21st Century Cures Act, which was passed in 2016, included a provision that alters the eligibility and enrollment options for Medicare beneficiaries with ESRD. Starting in 2021, Medicare beneficiaries with ESRD will be able to enroll in any MA plan in their area. The Centers for Medicare & Medicaid Services (CMS) estimates MA enrollment of individuals with ESRD will nearly double to 242,000 in 2024, or approximately 41 percent of the total Medicare ESRD population.[ii]

Total healthcare costs for individuals with ESRD are approximately 8.5 times higher than the average Medicare beneficiary,[iii] largely due to regular outpatient dialysis treatments as well as high rates of hospitalizations and emergency room visits. MA plans have expressed concerns that the payment mechanism CMS currently uses to account for costs of care for ESRD beneficiaries may not appropriately reflect the costs for these enrollees under MA.

The payment to MA plans for enrollees with ESRD is structured differently than that for other enrollees. Plans do not submit a bid with the estimated costs for ESRD enrollment. Instead, CMS calculates a state-level benchmark, as opposed to a county-level benchmark as used for other enrollees, that represents the average statewide fee-for-service (FFS) spending for beneficiaries with ESRD. Plans receive a risk adjusted payment based on the state-level benchmark for each enrollee. If an MA plan believes the average ESRD enrollee will cost more than the state-level benchmark, the plan must use rebate dollars or additional premiums to cover the additional costs. The statutorily-required maximum out-of-pocket (MOOP) on ESRD spending also results in higher plan liabilities than the costs borne by FFS.

In a white paper sponsored by the Anthem Public Policy Institute, Health Management Associates explored these issues to identify any possible modifications that either CMS or Congress could make to more closely align payment with costs.

In February, CMS issued MA guidance for plan year 2021, which includes proposed changes to increase MOOP thresholds to help ensure costs for enrollees with ESRD are taken into account. Notably, CMS has proposed to calculate the difference between non-ESRD Medicare FFS beneficiaries' costs in CY 2021 and all Medicare FFS beneficiaries' costs (including ESRD) and incorporate 40 percent of the difference in its calculations of MOOP limits. This would increase MOOP limits for all MA plan enrollees - not just those with ESRD. Rather than increase payments for MA plans to account for the anticipated higher costs of these enrollees, CMS has proposed to increase cost-sharing limits on Medicare Advantage enrollees.

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[i] Proposed Regulation CMS-4190-P. Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

[ii] Id.

[iii] HMA analysis of CMS Estimates. 2020 Medicare Advantage Final Rate Announcement, April 1, 2019.

In a proposed rule which includes policy and technical changes for plan year 2022 and later, CMS stated its intent to increase this percentage to 60 percent, 80 percent, and 100 percent for 2022, 2023, and 2024, respectively. Many stakeholders have expressed concerns that the proposed changes to out-of-pocket limits:

1. Will not sufficiently reflect the anticipated increase in costs, and specifically, do not address concerns regarding use of a statewide average payment amount as opposed to a local average, and
2. Create additional financial burden for all MA enrollees.

CMS also solicits comments on potential changes to network adequacy requirements for outpatient dialysis as plans have expressed anticipated difficulties in ensuring access for additional ESRD enrollees. These include: 1) removing outpatient dialysis from the list of facility types for which MA plans are required to meet minimum time and distance standards; and 2) granting exceptions to minimum time and distance standards when home dialysis is provided instead. These potential changes are intended to provide plans with increased flexibility as they develop provider networks to meet the needs of ESRD enrollees.

HMA has analyzed these changes, as well as other proposed requirements for MA plans as they prepare for plan year 2021 and later. The slide deck summarizing these changes can be accessed here.

The upcoming changes to MA eligibility and enrollment of individuals with ESRD creates significant uncertainty for plans and other stakeholders. As 2021 approaches, there are several questions that are relevant for understanding the implications of these changes:

1. To what extent will ESRD beneficiaries enroll in MA plans, particularly if network adequacy standards are relaxed and MOOP thresholds are increased?
2. Will increases in MOOP thresholds for all enrollees dissuade non-ESRD beneficiaries from enrolling in MA?
3. Does the MA delivery system provide better care delivery than FFS Medicare for the ESRD population? What changes are needed to better serve this population?

For more information, please contact Eric Hammelman and Narda Ipakchi.

HMA Medicaid Roundup

Arkansas

Arkansas Drops Plan to Cut Medicaid Supplemental Payments to Hospitals. *The Arkansas Democrat Gazette* reported on March 1, 2020, that the Arkansas Department of Human Services dropped a measure to cut $31 million in Medicaid supplemental payments to hospitals after talks with the Arkansas Hospital Association. Private psychiatric hospitals would have faced cuts ranging from 51 percent to 78 percent, according to state records. Read More

California

California Revises Medicaid Managed Care Procurement RFP Schedule. The California Department of Health Care Services (DHCS) announced on February 27, 2020, a revised Medi-Cal managed care request for proposal (RFP) timeline. The state expects to release RFPs for the state's Medi-Cal managed care program in 2021 for implementation in January 2024. That is delayed from previous RFP calendars, which had anticipated implementation as early as July 2021. Of the more than 8.1 million Medi-Cal managed care members in the affected counties, only 3.1 million are being reprocured under the new RFPs, including 1.6 million for commercial plans in two-county model markets, and 1.5 million in Geographic Managed Care (GMC), Imperial, Regional, and San Benito model markets.

Connecticut

Connecticut Offers Lessons on Attempt to Enact Public Option. *Kaiser Health News* reported on March 4, 2020, that the defeat of legislation to implement a public health insurance option in Connecticut last year offers lessons for lawmakers and advocates attempting to enact a similar measure at the federal level. The Connecticut bill faced significant health insurance industry opposition, and national proposals also have similar resistance from insurers, health systems, and hospitals. Read More

Delaware

Delaware Awards Two Corrections Contracts to Centene Subsidiary. Centene Corp. announced on March 4, 2020, that its subsidiary Centurion was awarded two contracts to provide medical health, behavioral health, and substance use disorder treatment services to justice-involved populations within four prisons and six community corrections centers across Delaware. The Delaware Department of Corrections (DOC) awarded both contracts, which will run for three years with two, two-year optional renewals starting April 1, 2020. Read More

Florida

Florida Miscalculation Leads to $85 Million to $100 Million Medicaid Payment Shortfall for Hospitals. *Florida Politics/News Service of Florida* reported on February 27, 2020, that the Florida Agency for Health Care Administration (AHCA) miscalculated hospital Medicaid reimbursements, resulting in underpayments between $85 million and $100 million in fiscal year 2020. The error impacted nearly every hospital but had a particular effect on children's hospitals. It is unclear if the error will be an issue in fiscal 2021. Read More

Georgia

Lawmaker Sponsors Medicaid Buy-in Bill. *The Center Square* reported on March 2, 2020, Georgia Senator Sally Harrell (D–Atlanta) sponsored a bill that would allow any state resident to buy into Medicaid. The bill, which was introduced into the Senate Appropriations Committee, would also create a committee to study the actuarial soundness of the plan. Read More

Illinois

Illinois Cook County Medicaid Plan Has $350 Million in Unpaid Claims. *Modern Healthcare* reported on February 28, 2020, that CountyCare, a Medicaid managed care plan owned by Cook County Health and Hospital System, has about $350 million in unpaid medical claims. CountyCare's chief executive James Kiamos said late payments from the state and the county are the reason for the claims payment backlog. Read More

Iowa

Senate Approves Medicaid Work Requirements for Expansion Members. *Radio Iowa* reported on March 3, 2020, that the Iowa Senate approved Medicaid work requirements for expansion members. Under the legislation, able-bodied expansion members would need 20 hours of work, community engagement, or job training per week to maintain coverage. Read More

Kansas

Governor, Senator to Participate in Roundtable Discussions on Medicaid Expansion. *The Wichita Eagle* reported on March 1, 2020, that Kansas Democratic Governor Laura Kelly and Senate Majority Leader Jim Denning (R-Overland Park) will participate in two roundtable discussions in Wichita to promote a bipartisan Medicaid expansion proposal. Expansion legislation is being held up by Senate President Susan Wagle (R-Wichita), who refuses to allow debate on the bill until the House passes a constitutional amendment ensuring the legislature's ability to restrict abortions. Read More

Michigan

Medicaid Work Requirements Are Struck Down By Federal Judge. *The Detroit News* reported on March 4, 2020, that a U.S. District Court Judge in Washington, DC, struck down Michigan Medicaid work requirements for expansion members. The state had asked for a quick ruling before it had to send letters to 80,000 individuals who did not meet the requirements in January. Read More

Michigan Medicaid Work Requirements Could Cause 100,000 Beneficiaries to Lose Coverage. *MLive* reported on February 28, 2020, that work requirements could impact more than 100,000 Michigan Medicaid expansion members. The state Department of Health and Human Services plans to send letters to 80,000 who didn't meet the requirements in January. The legislature rejected an earlier request from Governor Gretchen Whitmer to pause implementation while a lawsuit challenging the legality of the work requirements proceeds. Read More

Michigan Seeks Quick Ruling on Medicaid Work Requirements. *Crain's Detroit Business* reported on February 26, 2020, that Michigan has filed a motion with U.S. District Judge Boasberg in Washington, DC, asking for a quick ruling in a lawsuit challenging the legality of the state's Medicaid work requirements. A federal appeals court upheld an earlier Boasberg ruling, which invalidated work requirements in Arkansas. Michigan Governor Gretchen Whitmer said it is inevitable that the state's work requirement will also be invalidated, so the state should not move forward with implementation. Read More

Minnesota

Minnesota Issues Special Needs BasicCare RFP. On March 2, 2020, the Minnesota Department of Human Services issued a request for proposals seeking Special Needs BasicCare plans in Morrison, Todd, and Wadena counties. The program covers adults with disabilities eligible for Medical Assistance. Bidders must be current Special Needs BasicCare plans to be eligible. Proposals are due May 5, 2020, with contracts set to be implemented on July 1, 2020. Read More

Senators Propose Bill to Fine State Medicaid Agency for Overpayments. *The Star Tribune* reported on March 4, 2020, that a bipartisan group of Minnesota senators introduced a bill that would impose fines if the state Department of Human Services (DHS) fails to correct problems with its electronic system for tracking Medicaid eligibility and enrollment, which resulted in overpayments to health plans and providers. Under the legislation, the DHS monthly budget appropriation would be reduced by $158,000 for every month that the problem goes unresolved. Read More

Mississippi

Senate Advances Bill For Children Who Lose 'Katie Beckett' Coverage. *The Daily Journal* reported on March 1, 2020, that the Mississippi Senate Medicaid Committee advanced a bill to ensure some coverage for disabled children who become ineligible for the Disabled Child Living at Home or "Katie Beckett" waiver. The bill, co-sponsored by state Senators Chad McMahan (R-Guntown) and Rita Potts Parks (R-Corinth) and authored by Senator Kevin Blackwell (R-Southaven), must clear the Appropriations Committee in order to advance to the floor. Read More

Mississippi Announces Intent to Award External Quality Review Organization Contract. On February 25, 2020, the Mississippi Division of Medicaid (DOM) announced its intent to award an external quality review organization (EQRO) contract to Carolinas Center for Medical Excellence (CCME). The contract is for three years with up to two one-year renewals, beginning June 1, 2020. CCME will provide analysis and evaluation of aggregated information on the Coordinated Care Organizations' (CCOs) quality, timeliness, and access to certain Medicaid covered health care services and MississippiCHIP covered services.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Over One-Third of New Jersey PACT Reimbursements Unallowable, Audit Finds. In January 2020, the federal Office of Inspector General (OIG) released a report of its audit findings about improper claims for an estimated $14.9 million in federal Medicaid reimbursement for mental health services provided under New Jersey's Programs of Assertive Community Treatment (PACT). The audit found that over one-third of claims sampled did not include adequate documentation, prior authorizations, or represent staffing of required disciplines. While New Jersey disagreed with some of the findings, the state is taking steps to reinforce program guidance to PACT providers and to improve its own monitoring of the PACT program. Read More

Governor Murphy Delivers 2021 Budget Address. On February 25, 2020, New Jersey Governor Phil Murphy delivered his state budget address for fiscal 2021. Murphy proposed a $38.6 billion budget of which close to $4.7 billion is to pay for the Medicaid program. Here are the highlights of the health care and Medicaid budget initiatives planned for fiscal 2021:

1) **Corporate Responsibility Fee.** Large corporations that employ individuals on Medicaid because the employer does not provide health benefits, or the employee cannot afford their employer's health care premiums will be required to pay a Corporate Responsibility Fee to help support their employees' health care costs. The proposed budget targets $30 million in revenue from the fee.
2) **Senior Gold and PAAD Expansion.** Expand eligibility for the state's Pharmaceutical Assistance for the Aged and Disabled (PAAD) and Senior Gold pharmacy programs to ease the burden of prescription medication costs to as many as 21,000 additional low income seniors and disabled residents.
3) **Funding the State-based Exchange.** Introduce a state-level version of the recently repealed federal Health Insurance Tax (HIT) that would be used to fund New Jersey's reinsurance program enacted in 2018 and provide $200 million to fund annual subsidies for qualifying state residents purchasing health insurance through the state-level exchange.
4) **Protecting Women's Health Care and Family Planning Services.** The proposed budget includes close to $20 million for family planning services including a new family planning benefit for individuals not previously covered by Medicaid.
5) **Mental Health and Addiction Services.** Increase rates for Substance Use Disorder Long-Term Residential Services and Integrated Care Management Services, maintaining opioid epidemic initiatives at the existing $200 million funding level with an additional $15 million to support new initiatives.
6) **Developmental Disabilities.** Add $10 million to increase day program rates in addition to wage increases for Direct Service Providers.

The 2021 Budget in Brief including the Governor's budget address can be found here.

Ohio

Ohio Health System ProMedica Posts Profit. *The Blade* reported on March 3, 2020, that Ohio not-for-profit health system ProMedica posted net income of $51 million in fiscal 2019, compared to a loss the year earlier. The company attributed the improvement to the acquisition of HCR ManorCare in 2018. ProMedica also reported a fiscal 2019 loss in its insurance line, largely from its Paramount Medicaid business. Read More

Oklahoma

Lawmakers Disagree on Funding Sources for Proposed Medicaid Expansion. *The Oklahoman* reported on March 2, 2020, that Oklahoma lawmakers are divided on how to finance the state's proposed Medicaid expansion, which would come to about $150 million. Proposals include raising the Supplemental Hospital Offset Payment Program (SHOPP) fee, using funds from the state's Tobacco Settlement Endowment Trust, and tapping into state savings. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Senate Appropriations Committee Holds Budget Hearing with DHS. On February 26, 2020, Pennsylvania Department of Human Services (DHS) Secretary Teresa Miller attended this year's budget hearing with the Senate Appropriations Committee. Highlights from this hearing include Secretary Miller reiterating that Governor Tom Wolf will not support President Trump's Medicaid block grants or work requirements. State Senator Art Haywood (D-Philadelphia) noted reports that the Trump administration may change Medicare Advantage financing for hospitals regarding the assessment program for high Medicaid-utilization hospitals. Secretary Miller responded that DHS has submitted comments, noting DHS does not expect an immediate impact in Pennsylvania and has concerns about long-term effects.

Tennessee

Governor Names Stephen Smith as Medicaid Director. *Modern Healthcare* reported on March 3, 2020, that Tennessee Governor Bill Lee named Stephen Smith as director of the state's Medicaid program TennCare, replacing Gabe Roberts. Smith currently serves as deputy director and chief of state of TennCare. Read More

Texas

Texas Is Not Ruling Out Medicaid Expansion Through A Block Grant Waiver. *The Texas Tribune* reported on February 27, 2020, that a spokesman for Texas Governor Greg Abbott, who is a longtime Medicaid expansion opponent, did not rule out expansion through the Trump administration's Healthy Adult Opportunity waiver. Expansion would cover approximately 1.5 million Texans. Read More

Washington

Washington Issues Exchange Public Option Plan RFA. The Washington State Health Care Authority (HCA) issued a request for applications (RFA) on February 27, 2020, for the procurement of Cascade Care public option plans offered through the state's health insurance Exchange. The state intends to award one or more contracts for public option plans in each county for coverage beginning January 1, 2021. The contract will run for two years with two optional two-year extensions. Letters of intent are due March 13, while Phase 1 and Phase 2 responses from applicants are due April 17 and May 22, respectively. Read More

West Virginia

West Virginia Proposes $1.25 Billion Opioid Settlement with Drug Makers. *The New York Times/The Associated Press* reported on March 2, 2020, that West Virginia has proposed an opioid settlement in which drug makers would pay $1.25 billion to the state, local governments, hospitals, and other entities. The proposal would not apply to Purdue Pharma and Mallinckrodt. West Virginia has already settled lawsuits with drug distributors AmerisourceBergen, Cardinal Health, and McKesson. Read More

Senate Approves Medicaid Dental Coverage for Adults. *WVNews* reported on February 26, 2020, that the West Virginia Senate passed a bill to expand dental coverage to more than 300,000 Medicaid beneficiaries age 21 or over. Coverage would include diagnostic and preventative dental services and restorative dental services, with a $1,000 annual limit per member. Read More

National

CMS Faces Pushback Over Plan to End Automatic Re-Enrollments for Certain Exchange Members. *Modern Healthcare* reported on March 3, 2020, that insurers, providers, trade associations, and employer groups warned the Centers for Medicare & Medicaid Services (CMS) that its proposed 2021 rule to end automatic re-enrollment for certain Exchange members would result in widespread confusion and increase the number of uninsured. The proposal would cut tax credits for subsidized exchange members in $0 premium plans unless they actively re-enroll. Of the 1.8 million individuals auto-enrolled in Exchange plans in 2019, about 270,000 were in zero premium plans. Read More

Supreme Court to Hear Case Challenging Affordable Care Act in 2020. *Modern Healthcare* reported on March 2, 2020, that the U.S. Supreme Court has agreed to hear a case concerning the constitutionality of the Affordable Care Act in the fall 2020 term. However, the court will likely not decide on the case until after the 2020 presidential election. Read More

States Face Tradeoffs in Rolling Out Medicaid Value-Based Payments, MACPAC Research Shows. *Modern Healthcare* reported on February 27, 2020, that state Medicaid programs are facing policy trade-offs and other challenges in rolling out value-based payment reform, according to research by the Medicaid and CHIP Payment and Access Commission (MACPAC). For example, prescriptive approaches can provide standardization, but allow less room for managed care organizations to customize payments to meet the needs of providers. In contrast, more flexible approaches can increase administrative burdens for providers and create difficulties in evaluating which models are working. Read More

Hospitals, Nursing Homes to Be Hardest Hit by Proposed Medicaid Fiscal Accountability Rule, Comments Suggest. *Stateline/The Associated Press* reported on February 28, 2020, that many of the 4,200 comments submitted to the Centers for Medicare & Medicaid Services (CMS) on the Trump administration's proposed Medicaid Fiscal Accountability Regulation warned of hospital and nursing home closures because of diminished Medicaid funding. Read More

Industry News

PharMerica's BrightSpring Health Services Acquires Advanced Home Care. *Home Health Care News* reported on March 3, 2020, that PharMerica's BrightSpring Health Services announced the acquisition of the home health and specialty infusion businesses of Advanced Home Care. The home health business will become part of BrightSpring's Adoration Home Health and Hospice, while the infusion business will join PharMerica's Amerita division. Read More

Flexpoint Ford Acquires MGA Homecare. On March 4, 2020, home healthcare provider MGA Homecare announced it has been acquired by private equity firm Flexpoint Ford. MGA Homecare provides services to pediatric patients throughout Arizona, Colorado, and Texas. MGA also named Bradley Bennett as chief executive. Read More

Anthem Acquires Beacon Health Options, Announces Mental Health America Partnership. Anthem, Inc. announced on March 2, 2020, that it has completed its acquisition of the largest independently held behavioral health organization Beacon Health Options, which serves more than 36 million people across the nation. Beacon will operate as a wholly-owned subsidiary of Anthem. Separately, Anthem's philanthropic organization, Anthem Foundation, announced a $100,000 grant to Mental Health America (MHA), the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness. Read More

Clairvest Acquires 50 Percent of Childsmiles Group. Clairvest Group, Inc. and Clairvest Equity Partners V announced on March 2, 2020, the acquisition of a 50 percent stake in The Childsmiles Group LLC, a dental provider with five practices across New Jersey. Childsmiles will use the funds for expansion. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
2020	Louisiana	RFP Rebid Release	1,500,000
January - March 2020	Ohio	RFP Release	2,360,000
February 1, 2020 (DELAYED)	North Carolina - Phase 1 & 2	Implementation	1,500,000
February 2020 (DELAYED)	Texas STAR and CHIP	Awards	3,400,000
April 30, 2020	Indiana Hoosier Care Connect ABD	Awards	90,000
May 5, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Proposals Due	*NA*
June 16, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Awards	*NA*
July 1, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Implementation	*NA*
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	West Virginia Mountain Health Trust	Implementation	400,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR Kids - Dallas Service Area	Implementation	21,000
October 1, 2020	Washington DC	Implementation	224,000
December 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
2021	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	RFP Release	1,640,000
2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
2021	California Imperial	RFP Release	75,000
2021	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	286,000
2021	California San Benito	RFP Release	7,600
January 2021	Nevada	RFP Release	465,000
January 1, 2021	Kentucky Rebid	Implementation	1,200,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

COMPANY ANNOUNCEMENTS

MCG Health Publishes 24th Edition of Industry-Leading, Evidence-Based Care Guidelines

Medicare Compliance: How CMS Policy Changes Impact Utilization and Case Management

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Kansas Medicaid Managed Care Enrollment is Down 2.9%, 2019 Data
- Maryland Medicaid Managed Care Enrollment Is Flat, Jan-20 Data
- Michigan Dual Demo Enrollment is Up 0.7%, Feb-20 Data
- Michigan Medicaid Managed Care Enrollment is Up 0.5%, Feb-20 Data
- Minnesota Medicaid Managed Care Enrollment is Down 0.5%, Mar-20 Data
- Mississippi Medicaid Managed Care Enrollment is Down 0.6%, Jan-20 Data
- New Mexico Medicaid Managed Care Enrollment is Flat, Feb-20 Data
- North Carolina Medicaid Enrollment by Aid Category, Feb-20 Data
- Utah Medicaid Managed Care Enrollment is Up 9.5%, Jan-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Hawaii Med-QUEST Health Care Services for the Organ and Tissue Transplant (SHOTT) Program RFP, Feb-20
- Maryland Modern Electronic Health Records for MDH Healthcare Facilities RFP, Feb-20
- Massachusetts One Care Amended, Restated RFR, Responses and Related Documents, Jun-19
- Minnesota Prepaid Health Care to Special Needs BasicCare Enrollees in Morrison, Todd, and Wadena Counties RFP, Mar-20
- Mississippi Children's Health Insurance Program (CHIP) RFQ, Proposals, Award, and Related Documents, 2018
- Mississippi External Quality Review Organization IFB and Award, 2020
- South Dakota Medicaid Delta Dental Contract, SFY 2020
- South Dakota Medicaid Dental Adjudication, Administrative Services RFP, Feb-20
- Washington Cascade Care Public Option Plans RFA, Feb-20

Medicaid Program Reports, Data and Updates:

- HHS Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs Report, Feb-20
- Arkansas Monthly Enrollment and Expenditures Report, Jan-20
- Arizona AHCCCS Population Demographics, Mar-20
- Arizona Medicaid Advisory Committee Meeting Materials, Jan-20
- Georgia Medicaid Managed Care Rate Certifications, FY 2019-20
- Indiana Medicaid Managed Care Demographics by Age, Aid Category, and Program, 2016-19, Jan-20
- Louisiana Medicaid Financial Forecast Reports, SFY 2018-20, Jan-20
- Maryland Medicaid Eligibles by Age, Race, Gender, by Month, CY 2019
- Mississippi Medicaid Fact Sheet, 2020
- Oklahoma Medical Advisory Meeting Materials, Jan-20
- Oregon Medicaid Advisory Committee Meeting Materials, Feb-20

- Pennsylvania Medical Assistance Advisory Committee (MAAC) Meeting Materials, Feb-20
- Pennsylvania OVR MLTSS Subcommittee Meeting Materials, Feb-20
- TX HHSC Medicaid Rate Setting Reports, FY 2019

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