HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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THIS WEEK

IN FOCUS

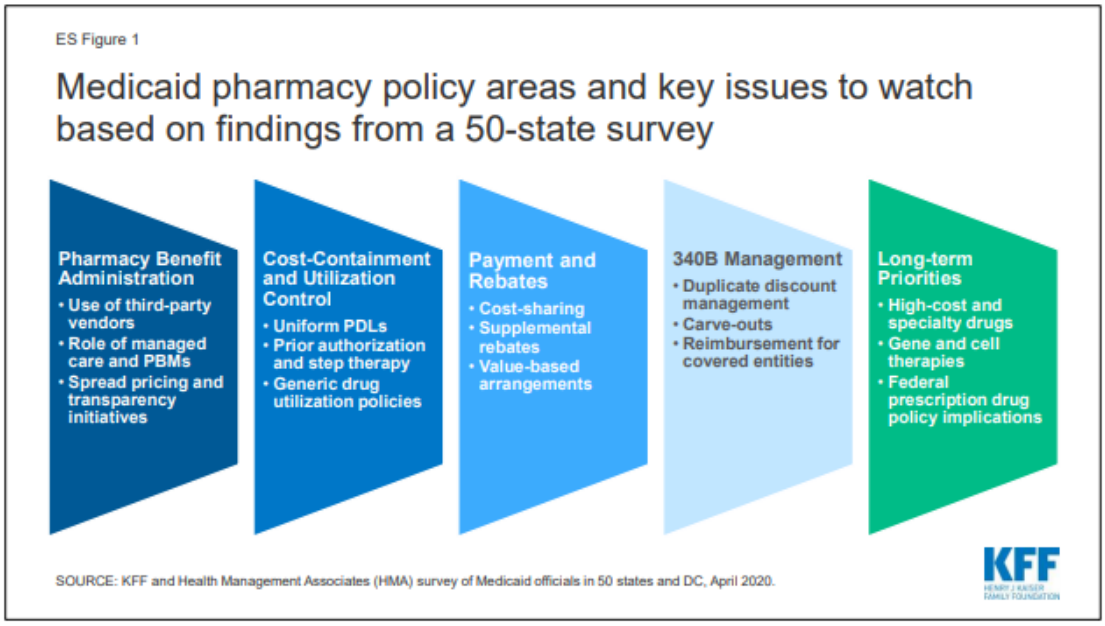
50-STATE SURVEY OF MEDICAID PHARMACY DIRECTORS

This week, our *In Focus* section reviews key takeaways from the report, *How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020*, prepared by Kaiser Family Foundation (KFF) and Health Management Associates (HMA). The report was written by HMA Managing Principal Anne Winter and Principals Kathleen Gifford and Linda Wiant with Rachel Dolan, Marina Tian, and Rachel Garfield from KFF.

Medicaid provides health coverage for millions of Americans, including many with substantial health needs who rely on Medicaid drug coverage for both acute problems and for managing ongoing chronic or disabling conditions. Though the pharmacy benefit is a state option, all states provide pharmacy benefit coverage. States administer the benefit in different ways but within federal guidelines regarding, for example, pricing, utilization management, and rebates. Due to federally required rebates, Medicaid pays substantially lower net prices for drugs than Medicare or private insurers. After a sharp spike in 2014 due to specialty drug costs and coverage expansion under the Affordable Care Act (ACA), Medicaid drug spending growth has slowed, similar to the overall US pattern; however, state policymakers remain concerned about Medicaid prescription drug spending as spending is expected to grow in future years. Due to Medicaid's role in financing coverage for high-need populations, it pays for a disproportionate share of some high-cost specialty drugs. In addition, Medicaid is required to cover the "blockbuster" drugs increasingly entering the market as a result of the structure of the pharmacy benefit. Policymakers' actions to control drug spending have implications for beneficiaries' access to needed prescription drugs.

To better understand how the Medicaid pharmacy benefit is administered across the states, KFF and Health Management Associates conducted a survey of all 50 states and the District of Columbia (DC) in 2019. Highlights from the full survey are below (ES Figure 1).

ES Figure 1



What entities play a role in administering Medicaid pharmacy benefits?

States may administer the Medicaid pharmacy benefit on their own or may contract out one or more functions to other parties. The administration of the pharmacy benefit has evolved over time to include delivery through managed care organizations (MCOs) and increased reliance on pharmacy benefit managers (PBMs). In addition, drug utilization review (DUR) boards and pharmacy and therapeutics (P&T) committees play oversight and administrative roles in Medicaid pharmacy benefits.

All but one state reported outsourcing some or all functions to one or more vendors as of July 1, 2019. The most commonly outsourced functions reported were claims payment, utilization management, and drug utilization review. Of the 44 states that reported outsourcing the claims payment function, 23 reported that their fiscal intermediary processes pharmacy claims.

States are exploring pharmacy policy reforms to adapt to the growth in managed care and the growing role of pharmacy benefit managers (PBMs). States reported enacting or considering policy changes such as drug carve-outs, PBM pass-through pricing, and transparency reporting requirements. While most states that contract with MCOs reported that the pharmacy benefit was carved in to managed care coverage, two states reported plans to carve out the pharmacy benefit in FY 2020, one state has announced that a carve-out would be effective in FY 2021, and other states reported carve-outs were under consideration. Fifteen states also reported carving out one or more drugs or drug classes, often as part of a fiscal risk mitigation strategy.

States are taking action to prevent or monitor spread pricing within MCO-PBM contracts. State use of external vendors for administering the pharmacy benefit, particularly the use of pharmacy benefit managers (PBMs), has generated considerable policy debate about costs and prices in Medicaid, particularly as it relates to oversight and regulation. Spread pricing refers to the difference between the payment the PBM receives from the MCO and the reimbursement amount it pays to the pharmacy. In the absence of oversight, some PBMs have been able to keep this "spread" as profit. As of July 1, 2019, 11 MCO states prohibited PBM spread pricing and five states reported plans to eliminate spread pricing in FY 2020. One state also reported that a spread pricing prohibition would take effect in January 2021. Twenty-six MCO states also reported they will have transparency reporting requirements in place in FY 2020.

How are states managing use and cost in their programs?

Managing the Medicaid prescription drug benefit and pharmacy expenditures remains a policy priority for state Medicaid programs, and state policymakers remain concerned about Medicaid prescription drug spending growth. Because state Medicaid programs are required to cover all drugs from manufacturers that have entered into a federal rebate agreement (in both managed care and FFS settings), states cannot limit the scope of covered drugs to control drug costs. Instead, states use an array of payment strategies and utilization controls to manage pharmacy expenditures.

Most states (46 of 50 reporting states) reported having a preferred drug list (PDL) in place for fee-for-service (FFS) prescriptions as of July 1, 2019. PDLs allow states to drive the use of lower cost drugs and offers incentives for providers to prescribe preferred drugs. In recent years, a growing number of MCO states have adopted uniform PDLs requiring all MCOs to cover the same drugs as the state. Sixteen MCO states reported having a uniform PDL for some or all classes and eight states plans to establish or expand a uniform PDL in FY 2020.

Most states reported that prior authorization (PA) was always (16 states) or sometimes (30 states) imposed on new drugs. Over two-thirds of the responding states (35) report reviewing comparative effectiveness studies when determining coverage criteria, and the vast majority of responding states (45 of 50) require biosimilar drugs to undergo the same review process as other

drugs. While states often impose PA on high-cost specialty or non-preferred drugs, a number of states have legislation protecting drug classes or categories from the use of these tools in some or all circumstances.

How are states addressing payment for prescription drugs?

Medicaid payments for prescription drugs are determined by a complex set of policies at both the federal and state levels that draw on price benchmarks to set both ingredient costs and determine rebates under the federal Medicaid drug rebate program (MDRP). States set policies on dispensing fees paid to pharmacies and beneficiary cost-sharing within federal guidelines, while federal regulations guide payment levels for ingredient costs. The final cost to Medicaid is then offset by any rebates received under the federal MDRP. In addition, states or managed care plans may negotiate with manufacturers for supplemental rebates on prescription drugs or form multi-state purchasing pools when negotiating supplemental Medicaid rebates to increase their negotiating power.

Forty-six states report negotiating for supplemental rebates in addition to federal statutory rebates. Approximately two-thirds of these states (30 states) have entered into a multi-state purchasing pool to enhance their negotiating leverage and collections.

A small, but growing number of states are employing alternative payment methods to increase supplemental rebates through value-based arrangements (VBAs) negotiated with individual pharmaceutical manufacturers. States are pursuing these alternative payment methods as a response to high-cost, breakthrough therapies. Two states reported having a VBA in place as of July 1, 2019 and an additional eight states reported plans to submit a VBA State Plan Amendment to CMS or implement a VBA in FY 2020.

States reported a variety of strategies to avoid receiving duplicate discounts on 340B drugs dispensed by safety net providers. The 340B program offers discounted drugs to certain safety net providers that serve vulnerable or underserved populations, including Medicaid beneficiaries. States cannot receive Medicaid rebates for drugs acquired through the 340B program. Strategies to avoid duplicate discounts include relying on the Medicaid exclusion file, prohibiting contract pharmacies and using claims indicators.

States reported continued challenges related to new, expensive breakthrough drugs, particularly those approved on an accelerated pathway. More than two-thirds of the responding states reported that developing policies and strategies related to new high-cost therapies was a top priority. Because of the structure of the MDRP, states are required to cover all drugs approved by the FDA, even if the drug demonstrates limited clinical efficacy.

Looking Ahead

States' management of the pharmacy benefit in FYs 2019 and 2020 reflects efforts to respond to an increasingly changing prescription drug landscape within the flexibility of federal guidelines. Drug pricing has been prominent in national policy debates and lawmakers at both the state and federal levels continue to show interest in efforts to control costs that may have implications for the Medicaid program.

Federal prescription drug policy changes have implications for states. States reported concerns related to enacted legislation such as the SUPPORT and 21st

Century Cures Acts as well as monitoring proposed federal statutory and regulatory efforts related to drug pricing, drug reimportation, gene and cell therapies, and PBM contracting reforms. Some federal efforts propose policy changes to Medicaid while others focus on Medicare and commercial insurance but may have implications for Medicaid.

States continue to explore MCO pharmacy policy reforms and view them as a high priority. State priorities include a focus on increasing oversight, implementing uniform PDLs and improving data collection related to managed care.

States remain concerned about prescription drug spending growth and continue to explore policies to ensure fiscal sustainability. States reported developing PA policies for gene and cell therapies, exploring value-based arrangements, and carving out high-cost drugs from managed care.

For more information please contact HMA Managing Principal Anne Winter or Principals Kathleen Gifford and Linda Wiant.

Link to Report

HMA Medicaid Roundup

California

Plan to Offer Medicaid to Undocumented Seniors is in Doubt. *KQED* reported on April 29, 2020, that a California plan to provide Medicaid to undocumented seniors is in doubt given the economic impact of COVID-19. In January, Governor Gavin Newsom proposed covering 27,000 undocumented adults 65 and older. The state has covered undocumented children since 2016 and this year began covering undocumented young adults up to age 25. Read More

Colorado

Public Option Bill Is Tabled Until 2021, Lawmakers Say. *Modern Healthcare* reported on May 5, 2020, that Colorado lawmakers tabled a public option bill until next year. Lawmakers said the COVID-19 pandemic is preventing consumers, providers, and other stakeholders from commenting on the proposal. Under the bill, provider reimbursement rates would be based on Medicare, and there would be a minimum medical loss ratio of 85 percent. Read More

Illinois

Illinois Hospital Files Federal Lawsuit Claiming Inadequate State Oversight of Medicaid Plans. *Modern Healthcare* reported on April 29, 2020, that Chicago safety net provider St. Anthony Hospital filed a federal lawsuit against Illinois, claiming that inadequate state regulatory oversight of Medicaid managed care plans is resulting in late payment and improper claims denials. The lawsuit claims that St. Anthony is owed more than $22 million for care provided to Medicaid members. Read More

Kansas

Advocates Say Medicaid Expansion Would Provide Benefits to COVID-19 Patients Over Long-Term. *KSN* reported on April 29, 2020, that Medicaid expansion advocates in Kansas are pushing the legislature to pass a bipartisan bill that would extend coverage to 130,000 individuals. Supporters point to the long-lasting health effects of COVID-19, which they say expansion can help cover. Read More

Maine

Maine Experiences Surge in Medicaid Enrollment. *The Bangor Daily News* reported on May 6, 2020, that Maine experienced a surge in Medicaid enrollment from February through April. Enrollment in the state's MaineCare Medicaid program increased 18 percent in the period. Medicaid expansion enrollment alone rose 15 percent. Read More

Missouri

House Lawmakers Consider Medicaid Work Requirements. *The Missourian* reported on May 5, 2020, that Missouri House Republicans have proposed a bill to add Medicaid work requirements. The measure, sponsored by Budget Committee Chairman Cody Smith (R-Carthage), would amend Missouri's constitution to require able-bodied Medicaid beneficiaries to work at least 80 hours per month and would also stop Medicaid payments for hospital services provided to non-Missouri residents. Read More

Advocates Gather Enough Signatures to Put Medicaid Expansion on November Ballot. *The Hill* reported on May 1, 2020, that Medicaid expansion advocates in Missouri submitted nearly 350,000 signatures, more than twice the required amount, to put full expansion on the ballot in November. Read More

New Hampshire

Nursing Homes Struggle with Staffing Shortages, PPE Costs, Bed Vacancies. *The Concord Monitor* reported on April 30, 2020, that many nursing homes across New Hampshire are struggling with staffing shortages, bed vacancies, retention of nurses, and the ability to pay employees during the COVID-19 pandemic. Brendan Williams, the president of the New Hampshire Health Care Association, notes that even with the 3.1 percent bump in rates to Medicaid providers, nursing homes are encountering difficulty buying personal protective equipment (PPE). Read More

New York

HMA Roundup – Cara Henley (Email Cara)

Governor Announces 35 Counties Approved to Resume Elective Outpatient Treatments. Amid the ongoing COVID-19 pandemic, New York Governor Andrew Cuomo announced on April 29, 2020, that 35 upstate counties have been approved to resume elective outpatient treatments. The Governor previously announced that the state will allow elective outpatient treatments to resume in counties and hospitals without significant risk of COVID-19 surge in the near term and issued specific criteria via Executive Order. The counties now eligible are: Allegany, Broome, Cattaraugus, Chautauqua, Chenango, Delaware, Dutchess, Essex, Franklin, Fulton, Genesee, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Putnam, Saratoga, Schoharie, Schuyler, St. Lawrence, Steuben, Sullivan, Tompkins, Ulster, Wayne, Wyoming and Yates. Read More

New York Behavioral Health Agencies Face Operational and Financial Challenges Due to COVID-19, Survey Finds. On April 29, 2020, that the Coalition for Behavioral Health released results of a member survey providing insight into how community-based behavioral health providers have been affected by the COVID-19 pandemic. According to the survey, an average of 82 percent of programs are now being delivered by telehealth. Programs have a median of three sites open for face-to-face services, including residential and congregate care programs. Programs reported needing 180,000 pieces of PPE, including 62,000 disposable masks, 40,000 reusable masks, and 82,000 pairs of gloves. The Coalition shared that agencies have struggled to purchase these necessary supplies and have faced weeks long shipping and custom delays. Over 3,000 essential staff are working in face-to-face programs. Through April 24, 2020, 17 essential workers have died from possible or confirmed COVID-19 illness, and 800 reported COVID-19 symptoms or indicated they have cared for a family member with COVID-19 symptoms. Additionally, at least 59 clients have died from possible or confirmed COVID-19 illness. Individual agencies also reported loss in revenue ranging from $45,000 to $2.4 million since the state of emergency was declared. The Coalition estimates a total loss of over $63 million to the sector. Twenty-one percent of agencies reported that they have already furloughed or laid off some staff. Read More

Providers to Receive Nearly $6 Billion in Federal Aid. New York State hospitals are slated to receive over half of the money distributed by the Department of Health and Human Services (HHS) as part of the COVID-19 High Impact Allocation. HHS is distributing $10 billion to 395 hospitals that provided inpatient care for 100 or more COVID-19 patients through April 10, 2020. New York hospitals will receive approximately $5 billion. HHS is distributing an additional $2 billion to hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. New York hospitals treating low-income and uninsured patients will receive an additional $686 million. HHS is also providing funding to rural acute general hospitals and critical access hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers. New York rural providers will receive $264 million out of a $10 billion total distribution. Read More

North Carolina

North Carolina Gets COVID-19 Relief Package, But Not Medicaid Expansion. *The News & Observer* reported on May 2, 2020, that North Carolina lawmakers passed a COVID-19 relief package that does not include a temporary Medicaid expansion for the uninsured. However, the bill includes funding for health care, medical research, testing, and personal protective equipment. Read More

Pennsylvania

HMA Roundup – Amanda Glickman (Email Amanda)

Pennsylvania Partners with Edifecs to Provide MMIS EDI Module Services. The Pennsylvania Department of Human Services selected Edifecs, Inc., a global health information technology solutions company, to implement its electronic data interchange (EDI) solution. The Edifecs model will help the state modernize and achieve the Medicaid Management Information Systems (MMIS) 2020 Platform vision of Timely, Accurate, Complete, Outcomes (TACO). Read More

DOH Faces Class-Action Lawsuit for Nursing Homes Oversight. *WPVI-TV* reported on May 4, 2020, that a class-action lawsuit alleges the Pennsylvania Department of Health (DOH) lacks oversight of long-term care facilities amid the COVID-19 outbreak. The lawsuit seeks to compel the state to provide adequate oversight of nursing homes. DOH Secretary Levine indicated that the state is following guidelines by the Centers for Medicare & Medicaid Services (CMS) and continues to conduct complaint inspections. Read More

Texas

Texas Taps Stephanie Stephens as Medicaid Director. The Texas Health and Human Services Commission on April 30, 2020, announced that Stephanie Stephens would become Medicaid director, effective May 4, 2020. Stephens, who will replace Stephanie Muth, is currently acting deputy state Medicaid director. Read More

Virginia

Governor Signs Order Making Medicaid Services More Accessible. *The Smith Mountain Eagle* reported on May 3, 2020, that Virginia Governor Ralph Northam signed an executive order making certain Medicaid services more accessible during the COVID-19 crisis. The order eliminates copays in the Family Access to Medical Insurance Security (FAMIS) program; streamlines the process for admitting individuals to a nursing facility; and allows personal care, respite, and companion providers to work for up to 60 days while background checks are conducted. Read More

West Virginia

Governor Approves $20 Daily Reimbursement Increase for Nursing Homes. *WOWK* reported on May 4, 2020, that the West Virginia Department of Health and Human Resources will submit a Emergency State Plan Amendment to increase daily nursing home reimbursement by $20 retroactive to February 1. The increase, which was approved by the Governor, will raise total nursing home reimbursements by $13.6 million. Read More

National

HHS Signals Approach to Distributing CARES Act Funds to Medicaid Providers. *Modern Healthcare* reported on May 5, 2020, that the Centers for Medicare & Medicaid Services (CMS) has asked states to submit provider-level Medicaid payment information, which could be used to divvy up $28 billion in remaining CARES Act funding. The National Association of Medicaid Directors has asked federal regulators to distribute grants to Medicaid providers by May 11, 2020. Funds will go to providers that solely serve Medicaid and to cover COVID-19 costs for the uninsured. Read More

AHA Estimates Revenue Losses for Hospitals, Health Systems to Top $200 Billion. *Modern Healthcare* reported on May 5, 2020, that hospitals and health systems are asking Congress for additional emergency funding as revenue losses stemming from COVID-19 are expected to top $200 billion from March through June. According to the American Hospital Association (AHA), the bulk of the projected revenue losses are from canceled surgeries and outpatient treatments. Read More

Nursing Homes Seek State Protection Against Potential Lawsuits Arising From COVID-19. *The Associated Press* reported on May 4, 2020, that nursing homes are lobbying states for some protection against lawsuits arising from the COVID-19 pandemic. Fifteen states have already implemented some degree of protection: Alabama, Arizona, Connecticut, Georgia, Illinois, Kentucky, Massachusetts; Michigan, Mississippi, New Jersey, New York, Nevada, Rhode Island, Vermont and Wisconsin. Read More

Home Health Providers Hiring Newly Unemployed Workers. *Home Health Care News* reported on May 3, 2020, that home care providers are hiring hundreds of caregivers, including newly unemployed workers from the service, hospitality, and retail industries, as well as newly unemployed surgical center workers. Read More

Hospitals Want $100 Billion in Medicare Advance Payments Forgiven. *Modern Healthcare* reported on May 1, 2020, that hospitals and providers are asking Congress to forgive $100 billion in Medicare accelerated and advance payments. If that request is denied, providers want to increase the amounts of the advances, extend repayment deadlines, lower interest rates, and decrease the rate at which the Centers for Medicare & Medicaid Services (CMS) can recoup payments. Read More

CMS to Provide Optional Year Extension for ACOs. On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that it will forgo the annual application cycle for the Medicare Shared Savings Program for 2021 and give Accountable Care Organizations (ACOs) whose participation is set to end this year the option to extend for an additional year. CMS will also make adjustments to the financial methodology to account for COVID-19 costs. There are 517 ACOs serving more than 11 million beneficiaries. Read More

CMS Announces Commission to Assess Nursing Home Response to COVID-19. The Centers for Medicare & Medicaid Services (CMS) announced on April 30, 2020, an independent commission to assess the nursing home response to COVID-19. The commission, which is expected to convene in late May, will consist of industry experts, family members, providers, clinicians, advocates, state and local authorities, and others. Read More

State Medicaid Directors Criticize HHS for Tilting Emergency Funding Distributions Away from Medicaid. *The Los Angeles Times* reported on April 30, 2020, that state Medicaid directors warned Health and Human Services (HHS) Secretary Alex Azar that the federal response to COVID-19 has drastically weakened Medicaid programs across the country by tilting payments to providers that serve commercial and Medicare patients. HHS based emergency assistance initially on past Medicare billings and then on a provider's total revenues. Read More

CMS Issues Second Round of Regulatory Waiver Flexibilities to Address COVID-19. On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a second round of waiver flexibilities and regulatory rule changes to support the healthcare system and expand COVID-19 diagnostic testing for Medicare and Medicaid beneficiaries. Changes include allowing hospitals to provide services in non-hospital healthcare facilities; removing barriers for hiring and retaining physicians, nurses, and other healthcare professionals; easing administrative burden; and further expanding telehealth. Read More

States Face Budget Shortfalls Driven in Part by Soaring Medicaid Enrollment. *Governing* reported on April 27, 2020, that without federal aid, states and localities face potential budget shortfalls as high as 40 percent, driven by declining revenues and growing demand for services like Medicaid. State and local governments are asking for additional direct federal aid of anywhere from $250 billion to $500 billion. Read More

Industry News

Molina Healthcare to Acquire Magellan Complete Care for $820 Million. On April 30, 2020, Molina announced that it has entered into a definitive agreement to acquire Magellan Complete Care from Magellan Inc. for $820 million. Magellan Complete Care serves 155,000 Medicaid managed care and Managed Long-Term Services and Supports members in six states, including Arizona, Massachusetts, New York, and Virginia. Revenues in 2019 topped $2.7 billion. The deal is expected to be completed in early 2021.

Health Care Service Corporation Names Maurice Smith CEO. *Modern Healthcare* reported on May 5, 2020, that Health Care Service Corporation (HCSC) named Maurice Smith chief executive, effective June 1. Smith is currently president of HCSC and previously served as chief executive of HCSC's Blue Cross Blue Shield of Illinois. Read More

Clearview Capital Company Acquires OH Office-based Opioid Treatment Provider. Clearview Capital announced on May 5, 2020, that its portfolio company Community Medical Services (CMS) acquired IHP-Med-Psych-Solutions, Inc./Restorative Health and Recovery, an Ohio office-based opioid treatment provider. CMS provides medication-assisted treatment for opioid use disorder in 40 treatment facilities in nine states. The deal closed on April 13, 2020. Read More

Tenet Healthcare Reports Increase in 1Q20 Net Income, Decline in Volume. *Modern Healthcare* reported on May 4, 2020, that Dallas-based health system Tenet Healthcare Corporation reported $94 million in net income in the first quarter of 2020, compared to a $20 million loss a year earlier. Hospital admissions declined 4.5 percent in the first quarter, revenues were flat, and earnings before interest, taxes, depreciation and amortization fell 6 percent. The company said it received $345 million in grants from the CARES Act and $1.5 billion in accelerated Medicare payments. Read More

Bright Health Acquires CA-based Universal Care Health Plan. Bright Health announced on May 4, 2020, that it has completed the acquisition of California-based Universal Care, a special needs health plan that operates under the name Brand New Day. Brand New Day serves Medicare eligible seniors and special needs populations across 12 counties in California. Read More

Consonance Capital Partners Completes Sale of Turn-Key Health to CareCentrix. Private equity firm Consonance Capital Partners announced on May 4, 2020, that it has completed the sale of Turn-Key Health to CareCentrix. Turn-Key is a community-based palliative care company. Terms were not disclosed. Read More

The Columbus Organization Acquires Certain Assets of Community Support Network. The Columbus Organization announced on May 1, 2020, that it has acquired the support coordination assets of Florida-based Community Support Network. The acquisition adds 1,000 individuals with intellectual and developmental disabilities in the Suncoast Region. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2020	Ohio	RFP Release	2,360,000
February 1, 2020 (DELAYED)	North Carolina - Phase 1 & 2	Implementation	1,500,000
April 30, 2020 (DELAYED)	Indiana Hoosier Care Connect ABD	Awards	90,000
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
July 1, 2020	Washington Integrated Managed Care (Expanded Access)	Proposals Due	*NA*
July 24, 2020	Washington Integrated Managed Care (Expanded Access)	Awards	*NA*
September 1, 2020	Texas STAR Kids - Dallas Service Area	Implementation	21,000
October 1, 2020	Washington DC	Implementation	224,000
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
January 1, 2021	Washington Integrated Managed Care (Expanded Access)	Implementation	*NA*
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

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Colorado RAE Enrollment is Up 6.3%, Mar-20 Data
- Indiana Medicaid Managed Care Enrollment Is Up 3.7%, Mar-20 Data
- MLRs at Indiana Medicaid MCOs Average 88.6%, 2019 Data
- MLRs at Kansas Medicaid MCOs Average 89.6%, 2019 Data
- MLRs at Kentucky Medicaid MCOs Average 90.5%, 2019 Data
- North Carolina Medicaid Enrollment by Aid Category, Apr-20 Data
- New York CHIP Managed Care Enrollment is Up 2.5%, Mar-20 Data
- New York Medicaid Managed Care Enrollment is Down 0.5%, Mar-20 Data
- Ohio Dual Demo Enrollment is Up 5.9%, Apr-20 Data
- Pennsylvania Medicaid Managed Care Enrollment is Up 0.5%, Feb-20 Data
- Rhode Island Dual Demo Enrollment is Down 7.6%, Apr-20 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.1%, Mar-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arkansas PASSE Model Contract, 2019-21
- District of Columbia Integrating Medicaid Payment Strategies Consultant Services RFQ, Apr-20
- Florida Enterprise Data Warehouse ITN, 2019-20
- Massachusetts Non-Emergency Humans Service Transportation Broker Services RFR, Amendments, and Model Contract, Nov-19
- North Dakota Medicaid DUR Board, Prior Authorization, and Academic Detailing Services RFP, May-20

Medicaid Program Reports, Data and Updates:

- Arkansas Monthly Enrollment and Expenditures Report, Mar-20
- Arizona AHCCCS Population Demographics, May-20
- Colorado Children's Health Plan Plus Caseload by County, Mar-20
- District of Columbia Medicaid MCO External Quality Review Annual Technical Reports, 2014-19
- Florida Healthy Kids Corporation Board of Directors Meeting Materials, 2019-20
- New Hampshire Medical Care Advisory Committee Meeting Materials, Mar-20
- New Mexico Medicaid Advisory Committee and Subcommittee Meeting Materials, Apr-20
- South Carolina 1915c HCBS Waivers Appendix K Documents and Approval, Apr-20
- Texas Medicaid and CHIP COVID-19 Stakeholder Update, Apr-20
- Utah Medical Care Advisory Committee Meeting Materials, Apr-20

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