HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

KEY TAKEAWAYS FROM CMS INNOVATION CENTER STRATEGY REFRESH

This week, our *In Focus* section shares HMA's takeaways from the Centers for Medicare & Medicaid Services (CMS) white paper on the CMS Innovation Center Strategy Refresh: *Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*.

The Strategy Refresh, released October 20, 2021, provides a comprehensive overview of lessons from the Innovation Center's first decade, goals, and next steps in five identified strategic areas. It also shares new models or concepts that the Innovation Center is exploring. Several of the Innovation Center's articulated approaches are reflective of recommendations in the Issue Brief, *Center for Medicare and Medicaid Innovation: Recommendations for Future Direction*, written by Health Management Associates (HMA) experts Jennifer Podulka, Yamini Narayan, and Lynea Holmes. The Strategic Refresh also highlights the imperative to include payers beyond Medicare, importantly Medicaid and commercial insurers, in models to achieve person-centered accountable and equitable care.

The five strategic objectives include:

- Driving accountable care that results in all Medicare enrollees and most Medicaid enrollees in a care relationship with accountability for quality and total cost of care by 2030.
- Embedding health equity in all models through mandatory reporting of demographic and, as appropriate, social determinants of health data, and including underserved populations and safety net providers in new models.
- Supporting innovation by strengthening patient engagement and person-centered measures across all models.
- Facilitating approaches and specific targets that address price and affordability for high-value care, including new approaches to cost-sharing and drug prices.
- Pursuing more collaborative and ongoing partnerships with a broader group of stakeholders to improve quality, achieve equitable outcomes and reduce healthcare costs, and allow for multi-payer alignment in new models by 2030.

Source: The Centers for Medicare & Medicaid Services

As laid out in the strategy document, all stakeholders will be engaged and included in the Innovation Center's work in the decade ahead. For some partners, this will happen directly through participation in a model. For others, the Innovation Center is expecting transformation as expectations are reshaped

with input from all stakeholders, broader dissemination of actionable tools and information occurs, and patient engagement becomes more common throughout the healthcare system. The Innovation Center intends to use the new objectives to streamline and reduce the number of ongoing models in a way that drives toward health equity, simplicity in design and participation, and affordability in and outside of the model.

Our top takeaways from the strategy document include:

1. **Health equity will be embedded in all of CMS and the Innovation Center's work** – from rethinking and developing models to its pursuit of tools and opportunities that are more inclusive of underserved populations and providers. CMS will apply a health equity lens to streamline and reduce competing models, address misaligned incentives, and include populations that could benefit from accountable and value-based healthcare delivery.

2. **Future models will focus on integrating whole-person care, and several are likely to include a total cost of care approach.** The Innovation Center points to behavioral health, palliative care, and care for people with complex needs and serious illness as areas that can be explored for greater integration with primary care and provide significant opportunity to improve care and outcomes while reducing overall costs. It plans to test payment and regulatory flexibilities for model participants that can support the provision of home or community-based care. The strategy also signals that the Innovation Center is further along in its thinking about models that test affordability and cost structures for prescription drugs in Medicare.

3. **A variety of new engagement opportunities and tools, such as dashboards, could be available to assist a broader group of stakeholders in becoming accountable care entities**. In particular, the Innovation Center intends to be more purposeful in its engagement strategy to gather ongoing input from safety net providers and others who have not previously participated in the Innovation Center's models. This approach could enable the Innovation Center – and partners – to be more supportive of accountable care and innovation for specific populations, for example the Medicare and Medicaid dually eligible population and individuals who can benefit from home and community-based services.

4. **A tailored approach to facilitate provider participation in new – and possibly existing -- models will be employed, where possible**. In particular, the Innovation Center shared its intent to support and work with providers regardless of their starting point, current capacity to obtain and use actionable data, and financial constraints that may impede them from assuming risk and advancing higher quality care for the individuals they serve. Beyond participation, stakeholders must also be prepared to demonstrate their success which will become clearer as CMS updates quality and outcomes measures for reporting.

5. **Medicare alone cannot drive healthcare transformation**. While the Innovation Center's strategy commits to strengthening Medicare-specific alternative payment models (APMs), it also calls for collaboration with states, particularly state Medicaid programs, and commercial payers. Multi-payer alignment has proved challenging for

CMS over the past ten years, but the lessons learned and articulated openness for renewed communication with states and payers could provide a new pathway for making progress on system transformation. The Innovation Center is also positioning itself to drive greater collaboration within CMS as well as other partners within the Department of Health and Human Services administering public healthcare programs, including the Food and Drug Administration (FDA), the Indian Health Service (IHS), and the Administration for Community Living (ACL).

The Innovation Center will soon hold listening sessions with stakeholders and reinvigorate its work with and input from the Learning Action Network (LAN). If the Innovation Center is successful in changing the focus of conversations and opportunities for collaboration, this could lead to higher expectations for Medicaid and Medicare fee-for-service providers and plans, as well as commercial payers.

HMA staff have extensive experience in assessing the implications of Innovation Center opportunities. If your organization is interested in assessing its opportunities, contact Andrea Maresca, Sarah Barth, or Jennifer Podulka to learn how our expert team can assist with a data-based consultation.

HMA Medicaid Roundup

Arkansas

Governor Anticipates Federal Renewal of Medicaid Expansion Waiver. *The Arkansas Times* reported on November 2, 2021, that Arkansas Governor Asa Hutchinson expects federal regulators to renew the state's Arkansas Works Medicaid expansion program. The program, which expires at the end of this year, uses Medicaid funds to pay for Exchange plans for most beneficiaries. Among the changes proposed in the renewal, Medicaid eligibles who do not actively choose an Exchange plan or do not access services will be enrolled in traditional Medicaid. Read More

California

California Medicare Plan Received $1 Billion in False Claims Payments, DOJ Complaint Alleges. *Becker's Hospital Review* reported on October 27, 2021, that Kaiser Permanente received nearly $1 billion in false Medicare Advantage claim payments from 2009 to 2018, according to a Department of Justice complaint. The complaint is the result of six whistleblower lawsuits filed against Kaiser under the False Claims Act. Kaiser said it will "strongly defend against the lawsuits." Read More

Colorado

Colorado Opioid Treatment Programs Fail to Meet Federal, State Requirements, Audit Finds. *Open Minds* reported on October 28, 2021, that more than two-thirds of opioid use disorder treatment services for Medicaid beneficiaries in Colorado failed to meet the state and federal requirements, according to a federal audit covering the two-year period ending September 30, 2018. The audit, by the U.S. Office of the Inspector General, covered claims submitted to Medicaid managed care plans for 1.5 million opioid treatment program services. Read More

District of Columbia

District of Columbia to Increase Oversight of Medicaid Procurements. The District of Columbia will increase oversight and monitoring of Medicaid managed care procurements, according to testimony on October 29, 2021, from George Schutter, chief procurement officer. Schutter noted that DC has selected a contracting officer and has convened an integrated procurement team that meets weekly. DC is expected to release a request for proposals (RFP) before Thanksgiving, with contract approval expected by June 2022 and implementation in October 2022. A previous RFP failed to treat all bidders equally, according to an administrative law judge. Read More

Florida

Florida County Will Lobby for Inmate Medicaid Reform to Cover Hospital Stays Over 24 Hours. *The Daytona Beach News-Journal* reported on November 1, 2021, that Volusia County, FL, plans to lobby state lawmakers to allow Medicaid to cover county jail inmate hospital stays exceeding 24 hours in order to receive federal matching funds. While inmates typically lose Medicaid coverage, the federal government allows exemptions for hospital stays of 24 hours or more. Florida, however, does not allow such exemptions. Read More

Maryland

Maryland Announces Medicaid Rate Increases for HCBS. The Maryland Department of Health announced on November 2, 2021, Medicaid rate increases for home and community-based services (HCBS) as part of the state's fiscal 2022 budget bill. Increases are 5.5 percent for most HCBS developmental disability providers, 5.4 percent for most HCBS behavioral health and Applied Behavior Analysis providers, and 5.2 percent rate community-based long-term services and support providers. Funding comes from the American Rescue Plan Act. Read More

Massachusetts

Massachusetts Identifies $56.6 Million in Potentially Improper Medicaid Payments Related to Dual Eligibles in Hospice. *Morgan Lewis* reported on November 2, 2021, that Massachusetts may have made up to $56.6 million in improper overpayments for services related to dual eligible hospice patients that should have been covered by the hospices, according to an audit from the Massachusetts Office of the State Auditor and the Office of Inspector General. The audit also found that MassHealth had inaccurate information in its Medicaid Management Information System for approximately 56 percent of claims related to dual-eligible members receiving hospice services. Read More

Minnesota

Minnesota Awards Medicaid Contract to For-Profit Managed Care Plan for First Time. *The Star Tribune* reported on November 1, 2021, that UnitedHealthcare is the first for-profit health maintenance organization to be awarded a Medicaid managed care contract in Minnesota, according to a recent state award announcement. In 2017, the state legislature passed a law allowing for-profit managed care plans to compete in the Medicaid market for the first time in 40 years. Read More

Minnesota Releases Names of Award Winners for Twin Cities Medicaid Managed Care Procurement. The Minnesota Department of Human Services released on November 1, 2021, the names of award winners of the Twin Cities metro area Medicaid managed care procurement: Blue Plus, HealthPartners, Hennepin Health, Medica, UCare, and UnitedHealthcare. The contracts are valued at $3.87 billion and cover approximately 600,000 metro area children, parents, and pregnant women in the state's Medicaid and MinnesotaCare programs. Read More

New Hampshire

New Hampshire Releases RFI for Medicaid Management Information System. The New Hampshire Department of Health and Human Services released on October 27, 2021, a request for information to help develop a long-term procurement strategy to replace the state's Medicaid Management Information System with a modular system. Responses are due on November 30, 2021. Read More

House Committee Approves Comprehensive Medicaid Dental Bill. *The New Hampshire Union Leader* reported on October 28, 2021, that the New Hampshire House Health, Human Services, and Elderly Affairs Committee approved a bill that would create a comprehensive dental benefit for adult Medicaid beneficiaries. The same proposal was dropped from the state budget in June 2021. The committee estimated that state costs would be $7 million per year and federal costs would be roughly $20 million. Read More

New Jersey

New Jersey Receives Approval to Extend Postpartum Coverage to 12 Months. The Centers for Medicare & Medicaid Services announced on October 28, 2021, that New Jersey has received approval to extend postpartum coverage from 60 days to a full year. The approval is granted through June 30, 2022. Read More

New York

Governor Nominates Commissioner of Office for People with Developmental Disabilities. New York Governor Kathy Hochul announced on November 1, 2021, the nomination of Kerri Neifeld as commissioner of the Office for People with Developmental Disabilities. Neifeld will serve as acting commissioner pending confirmation by the state Senate. Hochul also appointed Jihoon Kim as deputy secretary for Human Services and Mental Hygiene. Read More

Lawmakers Hold Hearing on Effectiveness, Sustainability of Medicaid. *CBS 6 News* reported on November 1, 2021, that New York Assembly Health Committee held a hearing on the efficacy and sustainability of the state's Medicaid program. Key topics included the effect of the Medicaid global cap, potential Medicaid managed care carve-outs, and the impact of managed care on access to care. Read More

Ohio

Ohio Medicaid Director Testifies that PBMs are Improperly Collecting Clawbacks. *The Columbus Dispatch* reported on October 28, 2021, that pharmacy benefit managers (PBMs) are collecting millions of dollars from pharmacies in violation of the spirit of a state law banning clawbacks, according testimony from Ohio Medicaid director Maureen Corcoran to the legislature's Joint Medicaid Oversight Commission. The clawbacks occur after the state has closed the books on prescription drug purchases, she said, which means that the actual cost of Medicaid drug transactions recorded by the state and reported to the federal government is inflated. Separately, Corcoran said that the data Ohio Medicaid relies on to set its payment rates is likely incorrect. Read More

Ohio Seeks Rate Hike to Boost Medicaid Plan Payments to Substance Abuse Treatment Providers. The Centers for Medicare & Medicaid Services announced on October 28, 2021, that the Ohio Department of Medicaid submitted an amendment to its Section 1115 Waiver for Substance Use Disorder Treatment, seeking to increase Medicaid plan per member per month rates to substance use disorder treatment providers. Public comments will be accepted until November 27. Read More

Oregon

Oregon Publishes Final Concept Papers for Upcoming 1115 Waiver Renewal. The Oregon Health Authority (OHA) announced on November 2, 2021, the publication of the final policy concept papers for the state's upcoming Section 1115 Demonstration waiver renewal. OHA plans on using this waiver to advance health equity by maximizing equitable access to coverage, streamlining coverage transitions, moving to a value-based global budget, and focusing on community-led equity investments. OHA will release a draft application to the Centers for Medicare & Medicaid Services in early December, with a public comment period beginning on December 7. Read More

Oregon Suspends Further Enrollment in Medicaid CCO For Failing to Take Sufficient Corrective Action. *The Lund Report* reported on November 1, 2021, that the Oregon Health Authority (OHA) has suspended all new Medicaid enrollment in Trillium Community Health Plan/Centene, effective December 1, due to failure to adequately improve network development, health equity and language access, community engagement, and intensive care coordination as part of a corrective action plan. Trillium, which is an Oregon Coordinated Care Organization (CCO) serving more than 50,000 members, must complete the required actions in three months to avoid sanctions and potential termination of its CCO contract. Read More

Pennsylvania

Jefferson Health Acquires Temple Health Stake in HealthPartners Plans for $305 Million. Jefferson Health announced on November 1, 2021, the acquisition of Temple Health's 50 percent ownership interest stake in HealthPartners Plans (HPP) for $305 million. HPP was previously owned by a consortium of hospitals, including Einstein Health Network and Temple Health. Temple will remain in HPP's provider network. HPP serves 290,000 members in 13 Pennsylvania counties through Medicaid, CHIP, Medicare Advantage, and Dual-Eligible Special Needs plans. Read More

South Carolina

AmeriHealth Caritas Launches Medicare Advantage D-SNP in South Carolina. AmeriHealth Caritas announced on October 27, 2021, that it will offer a Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP) through its Select Health of South Carolina operation. The D-SNP, called First Choice VIP Care, will begin service in 42 counties on January 1, 2022. Read More

Tennessee

Tennessee Clinic Claimed $4.7 Million from State Medicaid Agency for Overreported Visits, Audit Finds. The Tennessee Comptroller of the Treasury reported on October 28, 2021, that Grove Primary Care Clinic overreported 44,342 patient visits resulting in $4.7 million in reimbursements from TennCare from 2014 to 2019, according to a recent audit. Grove operated clinics in Henderson, Middleton, and Scotts Hill, all of which have since been closed. Grove is now under investigation by the Tennessee Attorney General's Office. Read More

Wisconsin

Wisconsin Transitions Medicaid NEMT Business to Veyo. The Wisconsin Department of Health Services, November 1, 2021, transitioned its Medicaid non-emergency medical transportation (NEMT) business to Veyo, under a contract effective November 1. Veyo replaced former NEMT vendor MTM. All existing NEMT users will remain eligible. Read More

National

Uninsured Rate Remains Stable in 2020, Federal Data Show. *Health Payer Intelligence* reported on November 2, 2021, that the uninsured rate remained stable in 2020, with increases in Medicaid and Exchange enrollment offsetting decreases in employer-sponsored coverage, according to a brief from the federal Office of Health Policy. The brief notes that Medicaid enrollment increased by 11.6 million from February 2020 to April 2021. Read More

MACPAC Raises Questions About Accuracy of Data Used to Monitor UPL Compliance. Medicaid and CHIP Payment and Access Commission (MACPAC) released an Issue Brief in November 2021, which raises questions on the accuracy of data used to monitor state Medicaid upper payment limit (UPL) compliance between 2016 and 2019. MACPAC found inconsistencies between data submitted on CMS-64 expenditure reports and in state UPL demonstrations for physicians, hospitals, and nursing homes. The accuracy of reporting may improve, MACPAC says, given that CMS has standardized reporting processes and is updating its financial management data systems. Read More

Democrats Agree on Plan to Allow Medicare to Negotiate Some Drug Prices. *CQ News* reported on November 2, 2021, that Senate Democrats reached an agreement to allow Medicare to negotiate prices with manufacturers on a limited number of drugs in the Part B outpatient and Part D retail drug programs as part of the pending budget reconciliation bill. Medicare would be able to negotiate prices for 10 drugs per year in 2023, with prices taking effect in 2025, and increasing to 20 drugs per year. Drugs become eligible for price negotiation after being on the market nine years for small-molecule drugs and 12 years for biologics. Read More

House Democrats Consider 12.5 Percent Cut to DSH Payments in Non-Expansion States. *Modern Healthcare* reported that House Democrats are considering cutting disproportionate share hospital (DSH) payments by 12.5 percent in non-expansion states as part of an updated version of President Biden's Build Back Better framework. The proposal is aimed at convincing hold-out states to implement Medicaid expansion. The DSH cut would be rescinded if a state decides to adopt Medicaid expansion. Read More

Patient Advocates Ask States to Extend Telehealth Flexibilities. *Modern Healthcare* reported on November 1, 2021, that the Alliance for Connected Care, ALS Association, and National Organization for Rare Disorders led an effort of more than 230 organizations to convince state governors to preserve and expand state medical licensure flexibilities for telehealth until the public health emergency ends. Almost 30 states have already let emergency declarations lapse. Flexibilities were put in place after federal regulators suspended rules requiring providers to be licensed where a patient is located to bill telehealth services to Medicaid and Medicare. Read More

CMS Issues Final Rule on Value-Based Home Health Services. The Centers for Medicare & Medicaid Services (CMS) issued on November 2, 2021, a final rule aimed at incentivizing Medicare quality of care improvements through a nationwide expansion of the Home Health Value-Based Purchasing Model. The model is aimed at serving the elderly and individuals with disabilities. The rule also targets CMS data collection efforts to better identify and address health disparities among dual eligibles, individuals with disabilities, the LGBTQ+ community, religious minorities, individuals in rural areas, and others affected by poverty or inequality. Read More

Medicaid Expansion Had No Overall Effect on Administrative Spending, Study Finds. *Health Affairs* found that Medicaid expansion had "no overall effect" on administrative spending in states that expanded. While states with small expansions saw some increases in administrative spending, states with large expansions saw some decreases. Overall, administrative spending as a percentage of total spending was lower in Medicaid expansion states than in non-expansion states. Read More

Democrats Are Still Pushing to Close Medicaid Coverage Gap in Non-Expansion States. *The New York Times* reported on November 1, 2021, that Democrats continue to seek a solution to the Medicaid coverage gap for some 2.2 million Americans in non-expansion states, proposing subsidized Exchange plans for four years as part of the pending budget bill. The proposed Exchange plan coverage would be comparable to Medicaid, including minimal fees for doctor visits and transportation to medical appointments. Read More

CMS Report Breaks Down Medicaid Enrollment Data for Key Programs as of July 2019. The Centers for Medicare & Medicaid Services reported on October 29, 2021, that total Medicaid enrollment topped 78.7 million as of July 1, 2019, with comprehensive Medicaid managed at more than 55.1 million, Primary Care Case Management at more than 2.6 million, managed long-term services and supports at more than 464,000, dental at more than 10.3 million, transportation at more than 13.5 million, and PACE at more than 51,000. Read More

Democrats Remain Committed to Passing Legislation that Allows Medicare to Negotiate Drug Prices. *CQ News* reported on October 28, 2021, that Congressional Democrats remain committed to passing legislation that allows Medicare to negotiate prescription drug prices, even though it was left out of the Biden administration's $1.75 trillion framework for the proposed reconciliation bill. The framework does call for repealing a rule that requires pharmacy benefit managers and insurance companies to share drug manufacturer rebates with patients at the pharmacy counter. Read More

HHS to Repeal Rule Calling for Review of All Existing Regulations. *Modern Healthcare* reported on October 28, 2021, that the U.S. Department of Health and Human Services is moving to repeal a regulation finalized in the final days of the Trump Administration requiring the department to review its regulations every 10 years and sunset those not assessed. The Biden Administration previously delayed enforcement of the rule by one year in March. Read More

Democrats Seek Compromise on Plan to Close Medicaid Coverage Gap. *CNN* reported on October 27, 2021, that Senate Democrats are seeking a compromise on a plan to cover individuals in the Medicaid coverage gap in non-expansion states. Instead of a national expansion program, lawmakers are considering a proposal to subsidize Exchange plans for individuals in the coverage gap, according to U.S. Senator Tammy Baldwin (D-WI). The coverage gap impacts approximately 2 million people in 12 states that have not yet implemented Medicaid expansion. Read More

Build Back Better Framework Would Extend Exchange Premium Subsidies, Increase HCBS Spending. The White House released on October 28, 2021, a framework for the proposed Build Back Better plan, which includes the extension of Affordable Care Act premium tax credits through 2025, increased spending for home and community-based services, Medicare hearing coverage, and reduced Exchange plan premiums. Read More

Industry News

Centene Sells Majority Stake in U.S. Medical Management to Venture Capital, Private Equity Firms. Centene announced on November 3, 2021, the sale of a majority stake in its U.S. Medical Management (USMM) subsidiary to Rubicon Founders; Valtruis, a WCAS company; Oak HC/FT; and HLM Venture Partners. USMM is a network of home and community-based service providers. Centene will retain a minority stake in the company. Read More

AmeriHealth Caritas Promotes Rebecca Engelman to EVP, Medicaid Markets. AmeriHealth Caritas announced on October 28, 2021, that Rebecca Engelman has been promoted to executive vice president, Medicaid markets. Previously, she served as regional president for AmeriHealth Caritas. Read More

Centene to Put PBM Business Out to Bid. *Axios* reported on October 27, 2021, that in 2022 Centene will start the bidding process for a pharmacy benefit manager (PBM), with the new contract effective 2024. Centene had used CVS Caremark as its PBM until 2018, when it shifted the role inhouse. Centene spends $30 billion annually on prescription drugs. Read More

Sevita Acquires Help at Home Services in 7 States. Sevita announced on October 27, 2021, the acquisition of Chicago-based Help at Home supportive living and day center services in seven states. Help at Home serves seniors and individuals with disabilities. All acquisitions were finalized on October 25, 2021. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
Summer 2021- Delayed	Rhode Island	RFP Release	276,000
Fall 2021	Missouri	RFP Release	756,000
November 2021	District of Columbia	RFP Release	230,000
November 5, 2021	Louisiana	Awards	1,600,000
November 8, 2021	Tennessee	Awards	1,500,000
December 1, 2021	Delaware	RFP Release	240,000
December 22, 2021	Iowa	RFP Release	745,000
Dec. 2021 - Feb. 2022	Texas STAR+PLUS	RFP Release	538,000
2022	Georgia	RFP Release	1,800,000
First Quarter 2022	Indiana MLTSS	RFP Release	*NA*
January 2022	Minnesota MA Families and Children, MinnesotaCare	RFP Release	543,000
January 1, 2022	Minnesota MA Families, Children; MinnesotaCare (metro)	Implementation	548,000
January 1, 2022	Nevada	Implementation	600,000
January 1, 2022	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2022	North Dakota Expansion	Implementation	19,800
January 7, 2022	Indiana Hoosier Healthwise and HIP	Awards	1,200,000
February 2022	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
February 2022	California GMC - Sacramento, San Diego	RFP Release	1,091,000
February 2022	California Imperial	RFP Release	75,000
February 2022	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
February 2022	California San Benito	RFP Release	7,600
February 18, 2022	Minnesota Senior Health Options, Senior Care Plus	Proposals Due	64,000
February 18, 2022	Minnesota Special Needs BasicCare	Proposals Due	63,000
May 9, 2022	Minnesota Senior Health Options, Senior Care Plus	Awards	64,000
May 9, 2022	Minnesota Special Needs BasicCare	Awards	63,000
June 2022	Texas STAR Health	Awards	43,700
July 1, 2022	Ohio	Implementation	2,450,000
July 1, 2022	Rhode Island	Implementation	276,000
July 1, 2022	North Carolina - BH IDD Tailored Plans	Implementation	*NA*
July 1, 2022	Missouri	Implementation	756,000
July 1, 2022	Louisiana	Implementation	1,600,000
Early 2022 -Mid 2022	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	Awards	1,640,000
Early 2022 -Mid 2022	California GMC - Sacramento, San Diego	Awards	1,091,000
Early 2022 -Mid 2022	California Imperial	Awards	75,000
Early 2022 -Mid 2022	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Awards	286,000
Early 2022 -Mid 2022	California San Benito	Awards	7,600
Fourth Quarter 2022	Indiana MLTSS	Awards	*NA*
Sep. 2022 - Nov. 2022	Texas STAR+PLUS	Awards	538,000
Sep. 2022 - Nov. 2022	Texas STAR & CHIP	RFP Release	3,700,000
January 1, 2023	Tennessee	Implementation	1,500,000
January 1, 2023	Minnesota MA Families and Children, MinnesotaCare	Implementation	543,000
January 1, 2023	Minnesota Senior Health Options, Senior Care Plus	Implementation	64,000
January 1, 2023	Minnesota Special Needs BasicCare	Implementation	63,000
January 7, 2022	Indiana Hoosier Healthwise and HIP	Awards	1,200,000
Mar. 2023 - May 2023	Texas STAR & CHIP	Awards	3,700,000
Mar. 2023 - May 2023	Texas STAR Kids	RFP Release	166,000
Sep. 2023 - Nov. 2023	Texas STAR Kids	Awards	166,000
Sep. 2023 - Nov. 2023	Texas STAR Health	Implementation	43,700
Sep. 2023 - Nov. 2023	Texas STAR+PLUS	Implementation	538,000
2024	Indiana MLTSS	Implementation	*NA*
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
Jun. 2024 - Aug. 2024	Texas STAR & CHIP	Implementation	3,700,000
Dec. 2024 - Feb. 2025	Texas STAR Kids	Implementation	166,000

HMA News

HMA Webinar to Feature Veteran Medicaid Directors. On November 8, 2021, HMA will host a webinar featuring a panel of three veteran Medicaid directors who are now members of the HMA consulting team: Beth Kidder (Florida), Bill Snyder (South Dakota), and Matt Wimmer (Idaho). They will provide a frank assessment of the many challenges, opportunities, and competing priorities facing state Medicaid leaders and share their thoughts on how Medicaid directors will likely approach a wide variety of pressing issues. The panel will be moderated by HMA chief operating officer Chuck Milligan. Register Here

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Georgia Medicaid Management Care Enrollment is Up 11.4%, Nov-21 Data
- Louisiana Medicaid Managed Care Enrollment is Up 6.4%, Sep-21 Data
- North Carolina Medicaid Managed Care Enrollment is More Than 1.6 Million, Aug-21 Data
- Oklahoma Medicaid Enrollment is Up 15.4%, Sep-21 Data
- Oregon Medicaid Managed Care Enrollment is Up 6.9%, Jul-21 Data
- Utah Medicaid Managed Care Enrollment is Up 11.1%, Aug-21 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Massachusetts Dental Third-Party Administrator RFR, Proposals, and Contracts, 2015-20
- Massachusetts One Care Model Contract Extensions, 2019-21
- New Hampshire Medicaid Enterprise Systems MMIS Modular Implementation RFI, Oct-21
- Pennsylvania Medicare Improvements for Patients and Providers Act (MIPPA) Contracts, 2020-21

Medicaid Program Reports, Data and Updates:

- Hawaii Department of Human Services Annual Reports, 2013-19
- Iowa Plan for HCBS Implementation of the American Rescue Plan Act, 2021
- Kansas Plan for HCBS Implementation of the American Rescue Plan Act, 2021
- Michigan Plan for HCBS Implementation of the American Rescue Plan Act, 2021
- Mississippi Medicaid Managed Care Preliminary Rate Certifications, 2022
- New Hampshire Plan for HCBS Implementation of the American Rescue Plan Act, 2021
- North Carolina Plan for HCBS Implementation of the American Rescue Plan Act, 2021
- Ohio Joint Medicaid Oversight Committee Meeting Materials, 2017-21
- Oregon Trillium CCO Non-Compliance with Corrective Action Plan Letter, Nov-21
- South Dakota Plan for HCBS Implementation of the American Rescue Plan Act, 2021

- Texas Mental Health Condition and Substance Use Disorder Parity Strategic Plan, Aug-21
- Utah Plan for HCBS Implementation of the American Rescue Plan Act, 2021

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