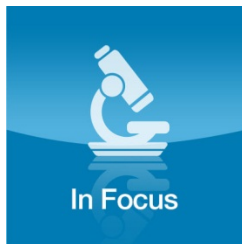
Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

January 23, 2019



RFP Calendar

HMA News

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This Week

- In Focus: Arkansas PASSE Program Readies for Full Risk Capitation
- Arizona Wins Approval for Medicaid Work Requirements
- Georgia Considers Medicaid Waiver to Expand Coverage
- Kansas Governor to Submit Medicaid Expansion Plan to Legislature This Month
- Kentucky Medicaid Plan Passport Health May Exit Market
- Maine Governor Reverses Medicaid Work Requirements
- North Carolina Audit Finds Medicaid LME/MCO Capitation Rates Were Actuarially Sound
- West Virginia Lawmakers Seek Transition to Managed Health Care for Foster Kids
- Walmart to Remain in CVS Caremark Medicaid PBM Network
- Ascension Restructures Leadership; 3 Top Executives to Depart
- New This Week on HMAIS

In Focus

Arkansas PASSE Program Readies for Full Risk Capitation

This week, our *In Focus* section reviews Arkansas' Provider-led Arkansas Shared Savings Entity (PASSE) model, scheduled to transition to full risk capitation in March 2019. The PASSE program provides care coordination to improve the health of Medicaid members with behavioral health needs or developmental/intellectual disabilities.

Background

The Arkansas Department of Human Services sought to implement an innovative care model to meet the needs of individuals with behavioral health needs or developmental/intellectual disabilities. A 2015 state analysis found that 74 percent of Medicaid claims were for the aged, blind, and disabled population. Of the approximately 2,900 individuals on the Intellectual and/or Developmental Disabilities (I/DD) waiver waitlist, 2,640 individuals accounted for $32 million in Medicaid costs. Supportive living accounted for 96 percent of spending for individuals receiving I/DD services. The cost of care was rising without improved services outcomes, there was a lack of access to quality services, and a lack of care coordination for populations with high needs.

The Arkansas Legislative Health Care Task Force reviewed multiple proposals and selected the PASSE model. The enabling legislation, Act 775, passed in March 2017.

PASSE Model

Each PASSE functions similarly to an insurance company. Under the model, local providers enter into partnerships with an administrative organization to manage the services of beneficiaries. Each PASSE must include several types of providers:

- Developmental Disabilities Services specialty provider
- Behavioral Health Services Specialty provider
- Hospital
- Physician
- Pharmacist

There is not a limit on the number of PASSEs a provider can enter.

The beneficiary is assigned a Care Coordinator, who develops a Person Centered Service Plan (PCSP) and meets members monthly face-to-face.

Phase I

In Phase I approximately 46,000 members were assessed and assigned to a PASSE. Optum conducted the independent assessments to determine eligibility. From February 1, 2018 through February 28, 2019, PASSEs are providing care coordination to members. This includes medical health services, specialty services, prevention services, health education, and medication management. Services are provided on a fee-for-service basis.

Phase II

Phase II was delayed from January 1, 2019, to March 1, 2019. Arkansas Total Care (Centene), Empower Healthcare Solutions (Beacon Health Options), and Summit Community Care (Anthem) chose to move forward with the program, while ForeverCare Health Plan (Gateway Health Plan) has pulled out. ForeverCare will transition its 7,600 members to a different PASSE.

Beginning March 1, PASSEs will accept full risk for covered Medicaid services for their members. Providers will bill the PASSEs, rather than Medicaid, for services provided. Providers will negotiate rates directly. In exchange, PASSEs will receive a global payment, an actuarially sound payment to cover the entire cost of care, for services. Beneficiary cost sharing will not be permitted.

Eligible Population

The following individuals are covered by PASSEs:

- Individuals receiving services through the DD Waiver (approximately 4,600 individuals)
- Individuals who are on the DD Waiver Waitlist (2,400 individuals)
- Individuals who are in private DD Intermediate Care Facilities (750 individuals)
- Individuals that have a Behavioral Health Diagnosis and have received an Independent Assessment that determines they need services in Tiers 2 or 3 (38,000 individuals)
  - Individuals in these tiers are eligible for targeted services provided in home/community settings or residential settings in addition to receiving counseling and medication management

Covered Services

PASSEs will cover State Plan Services, Community & Employment Supports, and Arkansas Community Independence Services. See table below for examples of included services. Please note, this is not an all-inclusive list.

State Plan Services	Community & Employment Supports	Arkansas Community Independence Services
Primary Care	Respite	Behavior Assistance
Pharmacy	Supported Living	Peer Support
Hospital Services	Supported Employment	Family Support Partners
Nursing Services	Crisis Intervention	Supportive Housing
Physical Therapy	Supplemental Support	Partial Hospitalization
Speech Therapy	Specialized Medical Supplies	Adult Rehabilitation Day Treatment
Occupational Therapy	Consultation	Planned/Emergency Respite
Inpatient Psychiatric	Environmental Modifications	Individual Life Skills Development
Outpatient Behavioral Health Counseling	Community Transition Services	Community Reintegration Program

Source: Arkansas Department of Human Services

The following services are available to PASSE members but will remain as Medicaid fee-for-service:

- Nonemergency medical transportation
- Dental benefits
- School-based services provided by school employees

For more information, please click here.

HMA Medicaid Roundup

Arizona

Arizona Awards Centene Subsidiary Correctional Health Services Contract. Centene announced on January 22, 2019, that its Centurion subsidiary has won the Arizona Department of Corrections health services contract, effective July 1, 2019, for two years, plus three optional renewal years. Centurion will provide medical, dental, and mental health services to approximately 33,700 inmates daily. Read More

Arizona Wins Federal Approval for Medicaid Work Requirements. The Centers for Medicare & Medicaid Services (CMS) announced on January 18, 2019, the approval of Medicaid work requirements in Arizona. The state will now require that certain adults, age 19 to 49, engage in at least 80 hours of work, job training, or community service per month. Native American tribes, pregnant women and medically frail individuals are exempt. Read More

Arkansas

Arkansas to Expand NEMT Contract with Southeastrans to 4 More Regions. The Arkansas Department of Human Services (DHS) announced on January 17, 2019, an agreement to expand its non-emergency medical transportation (NEMT) services contract with Southeastrans to four more regions of the state (A, B, C, and G), effective February 1, 2019. Southeastrans already provides NEMT services in Region D. Simultaneously, the state said it will cancel its existing contract with Medical Transportation Management in these four regions. Read More

Delaware

Health Care Task Force Recommends Individual Mandate to Lower Insurance Costs. *The Associated Press* reported on January 16, 2019, that a Delaware health care task force led by Democratic lawmakers has recommended that the state implement an individual mandate including a penalty to help reduce Affordable Care Act Exchange premiums. In 2016, individuals in the state paid $8 million in penalties under the federal mandate. Read More

Florida

Autism, Foster Care Providers Testify on Payment Concerns. *The News Service of Florida/News4Jax.com* reported on January 22, 2019, that Florida medical foster parents are experiencing payment delays following changes to Medicaid managed care plan contracts, according to testimony given at a state legislative hearing. The complaints, made to the state Senate Health Policy Committee on Tuesday, come as new Medicaid managed care contracts are being phased in from December 2018 through February 2019. Florida autism behavioral analysis providers expressed similar payment concerns after the Agency for Health Care Administration froze payments to behavioral analysis providers while it implemented fraud control measures. Read More

Georgia

Auditor Puts State Share of Medicaid Expansion Cost At $150 Million in FY 2020. *The Atlanta Journal-Constitution* reported on January 23, 2019, that Georgia's share of costs for Medicaid expansion would be about $150 million in 2020 and range between $188 million and $213 million by 2022, according to the state auditor. An earlier analysis by the Urban Institute projected that expansion in Georgia would generate $3 billion in matching federal funds. Advocates for Medicaid expansion are using the estimate to support their argument for expansion to nearly 500,000 Georgians. Read More

Georgia Considers Medicaid Waiver to Expand Health Care Coverage. *Georgia Health News* reported on January 17, 2019, that Georgia Governor Brian Kemp has allocated $1 million to pursue a Medicaid waiver that would expand health care coverage in the state. However, Kemp indicated that the state will not pursue a traditional Medicaid expansion as outlined in the Affordable Care Act. Kemp also plans to work with lawmakers to increase the rural hospital tax credit and address a physician shortage. Read More

Kansas

Governor Seeks to Bolster Staff for Medicaid Application Processing. *The Kansas City Star* reported on January 18, 2019, that Kansas Governor Laura Kelly's proposed budget for Fiscal Year 2020 includes $7 million to hire 313 additional state workers to take over certain Medicaid application processing functions at the state's Topeka clearinghouse beginning in July. Maximus is the state's outside vendor for Medicaid application processing functions. Read More

Governor to Submit Medicaid Expansion Plan to Legislature This Month. *The Garden City Telegram* reported that Kansas Governor Laura Kelly expects to submit a Medicaid expansion plan to the state legislature later this month. Kelly's budget proposal for fiscal year 2020 includes $14.2 million in state general funds to initiate expansion coverage to 150,000 adults. In 2017, a Medicaid expansion bill passed both chambers of legislature but was vetoed by then-Governor Sam Brownback. Read More

Kentucky

WellCare to Help Kentucky Medicaid Members Meet Work Requirements. *Modern Healthcare* reported on January 22, 2019, that WellCare Health Plans has announced a program in Kentucky aimed at helping members meet Medicaid work requirements, scheduled to take effect on April 1. The program, called WellCare Works, will roll out in Lexington and Northern Kentucky and include online job training and one-on-one coaching. An estimated 95,000 beneficiaries could lose eligibility over the next five years because of the requirements. Read More

U.S Judge May Delay Kentucky Medicaid Work Requirements Case Hearing Amidst Government Shutdown. *The Lexington Herald Leader* reported on January 18, 2019, that U.S District Judge James Boasberg may delay hearing a Kentucky Medicaid work requirements lawsuit for a week given the federal government shutdown. Attorneys for the U.S. government have requested that the case be put on indefinite hold. However, Boasberg has indicated he wouldn't agree to a longer delay unless the state was willing to postpone implementation of the new requirements, which are set to take effect April 1. Read More

Medicaid Plan Passport Health May Exit Market Following Rate Cuts. *The Louisville Courier Journal* reported on January 18, 2019, that Passport Health Plan may exit the Kentucky Medicaid managed care market following rate cuts of 4.1 percent in Jefferson County, where the plan has 310,000 Medicaid members. Passport lost $60 million in 2018 and projects up to $144 million in losses in 2019. Read More

Maine

Governor Reverses Medicaid Work Requirements, Premiums. *The Bangor Daily News* reported on January 22, 2019, that Maine Governor Janet Mills has decided to withdraw the state from a waiver program that would have applied Medicaid work requirements and monthly premiums to members. Mills has been a staunch opponent of work requirements, which were approved by federal regulators in December at the request of the administration of former Governor Paul LePage. Read More

Minnesota

Lawmakers Want Affordable Health Care, Disagree on Provider Tax. *The Twin Cities Pioneer Press* reported on January 16, 2019, that Minnesota lawmakers want to improve the state's health care system but disagree on whether to renew a two percent provider tax set to expire in 2020. While Democratic lawmakers want to renew the tax, members of the Republican-led Senate have proposed measures like allowing primary care physicians to charge a set fee for unlimited visits, price transparency, and regulating pharmacy benefit managers. Democrats have also proposed a Medicaid buy-in. Read More

Mississippi

Tobacco Use Leads to Nearly $400 Million in Annual Medicaid Costs, Report Finds. *The Daily Journal* reported on January 20, 2019, that tobacco use in Mississippi results in nearly $400 million in annual Medicaid costs in the state, according to a report commissioned by the Center for Mississippi Health Policy with The Hilltop Institute. The report found Medicaid claims costs directly and indirectly attributed to tobacco use in the state were $388 million in 2016 and $396 million in 2017. The Center recommended improved tobacco cessation support and coverage, smoke-free ordinances and laws, tobacco tax increases, and raising minimum legal age to purchase tobacco to 21 years. Read More

Nebraska

Governor Appoints Dannette Smith to Head of DHHS. Nebraska Governor Pete Ricketts announced on January 22, 2019, the appointment of Dannette Smith as chief executive of the state Department of Health and Human Services, effective February 25, 2019. Smith has previously served as director of the Virginia Beach Department of Human Services and of the Seattle Department of Human Services. She replaces Courtney Phillips, who left last year to become executive commissioner of the Texas Health and Human Services Commission. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Approves Woods Services, Legacy Treatment Services Affiliation. New Jersey announced on January 18, 2019, that it approved the affiliation of not-for-profits Legacy Treatment Services and Woods Services Inc., effective this month. Legacy, which provides crisis and addiction treatment services, will become Woods' fifth affiliate in New Jersey and Pennsylvania. Woods' affiliates treat people with complex medical and behavioral healthcare needs. Read More

Division of Aging Releases Request for PACE Applications. On January 7, 2019, the New Jersey Department of Human Services, Division of Aging issued a public notice to request applications from provider agencies interested in becoming PACE (Programs of All-Inclusive Care for the Elderly) organizations in Essex and Middlesex counties. Interested bidders should submit a letter of intent to Doas.Paceprogram@dhs.state.nj.us by April 30, 2019. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Governor Introduces FY 2020 Executive Budget Proposal. On January 15, 2019, New York Governor Andrew Cuomo introduced his Executive Budget for State Fiscal Year (SFY) 2020. The Executive Budget proposal for SFY 2020 totals $175.2 billion, of which $73.9 billion, or 42.2 percent, is spending on Medicaid. For the first time since the Medicaid Redesign Team introduced a Global Spending Cap for New York's Medicaid program, the governor has proposed increasing Medicaid spending by more than the global cap: 3.6 percent, versus the 3.1 percent allowed under the global cap.

New York's economy is fairly robust, and the budget remains balanced despite a slight decline in tax revenues. Governor Cuomo continues to limit increases in total state spending to 2 percent or less. The FY 2020 budget closes a budget gap estimated at $3.1 billion. In his State of the State address, the governor focused on the impact that President Trump's Tax Cut and Jobs Act has had on New York, largely due to capping the amount of state and local tax deductions. Further, cuts to the Medicaid Disproportionate Share Hospital funding are scheduled to begin in October 2019. Should those cuts go through, New York will see the largest reduction among all states, at $3.6 billion.

Budget Highlights:
Universal Access to Health Care
One of the most significant pieces of health care legislation likely to be considered early in the legislative session (which began on January 9) is a single-payor proposal called the New York Health Act. Assembly member Richard Gottfried has introduced the New York Health Act every legislative session for many years and is likely to reintroduce it early in this session. The newly named Chair of the Senate Committee on Health, Senator Gustavo Rivera, has indicated his support for the proposal. Governor Cuomo has indicated that while he supports a single payer concept, he has concerns about the feasibility of such a plan being implemented on a state level. His budget proposal does not directly address the single payer question; instead it proposes establishing a Commission on Universal Access to Health Care. The commission, made up of "independent health policy and insurance experts," would review options for achieving universal access to care. The commission would report back to the governor in December 2019.

Codifying the Affordable Care Act
In light of continuing threats to the Affordable Care Act (ACA), the governor proposes two important changes: codifying the consumer protections of the ACA into state law, and establishing the New York health exchange, New York State of Health, under state public health law. The budget would prohibit insurance companies from imposing pre-existing conditions clauses; it also requires health plans to offer all essential health benefits as defined by the ACA. The exchange has operated under an executive order since 2013, as the then-Republican-controlled Senate would not enact legislation establishing the exchange.

Pharmacy Costs

The budget extends the Medicaid drug cap, originally part of the SFY 2018 budget, through 2021. The legislation set a spending limit on pharmaceuticals and provided the state with enhanced authority to negotiate additional rebates with manufacturers to maintain spending within the spending limit. Manufacturers that don't reach rebate agreements are subject to Drug Utilization Review (DUR) Board referral for a value-based review and recommendations for targeted supplemental rebates. The budget proposes accelerating rebate negotiations and collections. The budget also proposes requiring pharmacy benefit managers to be licensed and registered, with mandatory reporting of any financial incentives or benefits they might have.

Fiscal Intermediaries (FIs) for Consumer-Directed Program

The budget proposes changing the way that FIs are reimbursed from a percentage of fees to a set fee per member per month. The state believes that the administrative functions performed by FIs does not vary based on the intensity of services provided, and that those fees should be standardized. The budget also proposes significant consolidation of FIs, reducing the 600 currently practicing FIs by as much as 90 percent, limiting participation to independent living centers and FI's that have been in operation since 2012.

Behavioral Health Parity

The governor proposes enhancing behavioral health parity through the hiring of additional staff dedicated to review health plan network adequacy and health plans denials to ensure compliance with New York's existing parity laws. The proposal includes a number of other initiatives, including prohibiting prior authorization for medication assistance therapy for individuals with addictions disorders, prohibiting prior authorization for inpatient services for youth during first fourteen days of inpatient care, prohibiting multiple copayments per day, and requiring that behavioral health copayments be equal to copayments for a primary care visit.

Capital Funding

The proposed budget does not include new capital funding for health care facilities, as $725 million in prior funding has not yet been awarded. The budget would allow the Department of Health to award $300 million of last year's $525 million allocation to entities that had submitted an application that was denied in prior rounds of funding.

DSRIP and System Transformation

Over the first 3 years of New York's Delivery System Reform Incentive Payment (DSRIP) program, the state has seen a reduction of 17 percent in avoidable hospitalizations. To further encourage efforts to reduce avoidable hospitalizations, and to continue efforts to strength the primary care delivery system, the budget proposes reducing inpatient payments to hospitals that have not reduced their avoidable hospitalization rates, and investing those dollars into higher fees paid to primary care and maternity providers. Read More

North Carolina

Audit Finds Medicaid LME/MCO Capitation Rates Were Actuarially Sound. Medicaid capitation rates paid to seven North Carolina Local Management Entities/Managed Care Organizations (LME/MCOs) to cover mental health, individuals with intellectual and developmental disabilities, and substance abuse programs were actuarially sound from fiscal year 2015 through 2017, according to a report from the Office of the State Auditor. LME/MCOs received an average of $2.6 billion in state and federal funds annually to manage, coordinate, facilitate and monitor care for these members. The report recommends that the state include language in future contracts "that limit the profit that a private MCO can retain." Read More

Ohio

Medicaid Report Reveals Variation in CVS Payments To Retail Competitors. *The Columbus Dispatch* reported on January 20, 2019, that Ohio Medicaid's pharmacy benefit manager, CVS Caremark, paid some of its largest retail competitors significantly less than it paid CVS pharmacies, according to an Ohio Department of Medicaid report. Findings indicate CVS pharmacies were paid 46 percent more for generic drugs than Walmart and Sam's Club and 25 percent more than Ohio-based Kroger stores. However, on average, CVS pharmacies were paid 17 percent less than Walgreens. CVS Caremark indicated a pharmacy's performance measurements impact its reimbursement rates, and rates also vary between different types of retailers that operate pharmacies. The report showed that brand-name drugs were reimbursed fairly consistently between CVS and retail competitors. Read More

Texas

Federal Appeals Court Lifts Order Blocking Texas From Removing Medicaid Funding for Planned Parenthood. *The Associated Press* reported on January 17, 2019, that the 5th U.S. Circuit Court of Appeals has overturned a lower court's preliminary injunction that had prohibited Texas from eliminating Planned Parenthood from the state's Medicaid program. The federal appeals court said U.S. District Judge Sam Sparks did not follow proper standards in issuing his decision and has returned the case to Sparks for further review. Previously, Planned Parenthood had filed a lawsuit against the state to maintain Medicaid coverage for cancer screenings, access to birth control, and other non-abortion services statewide. Read More

Judge Orders State to Reimburse Home Telemonitoring Providers. *The Statesman* reported on January 17, 2019, that Texas District Judge Darlene Byrne has ordered the state to again start reimbursing for home telemonitoring services until representatives of the state and home health agencies appear in court next week. The Texas Health and Human Services Commission (HHSC) had stopped accepting telemonitoring claims following a coding change. Approximately, 6,000 Medicaid members in Texas receive home telemonitoring services. Read More

Utah

Bill To Alter Voter-Approved Medicaid Expansion Is Revised to Limit Coverage Delays. *Deseret News* reported on January 17, 2019, that a bill proposed by Utah Senator Allen Christensen (R-North Ogden) to repeal and replace the state's voter-approved Medicaid expansion has been revised to ensure no coverage delays for individuals below 100 percent of the federal poverty level. The plan would cover 100,000 individuals, instead of 150,000 under a full expansion. Either way, expansion coverage would begin April 1. Read More

West Virginia

Lawmakers Seek Transition to Managed Health Care for Foster Kids. *The Charleston Gazette-Mail* reported on January 17, 2018, that West Virginia lawmakers have introduced House Bill 2010, which would transition 7,000 foster children to a managed health care plan beginning in July. Under the legislation, the state Department of Health and Human Resources would contract with a managed care organization. Delegate Kayla Kessinger (R-Fayette), one of the bill's sponsors, believes the transition will help improve continuity of care. Read More

National

Medicaid Innovation Accelerator Program Launching New SUD Technical Support Opportunities. The Medicaid Innovation Accelerator Program's (IAP) Reducing Substance Use Disorder (SUD) program area is launching two new technical support opportunities for state Medicaid agencies. All interested states are encouraged to attend the information session on Thursday, February 7, 2019 from 3:00 pm – 4:00 pm ET to learn more. During this information session, states will learn about the collaborative learning technical support opportunities offered through the Medicaid IAP SUD program area, including an opioid data analytics cohort and roundtable discussions focused on medication assisted treatment. During this session, IAP will also introduce states to the topics of the upcoming IAP SUD national learning webinar series. Additional information, including the Program Overviews, Expression of Interest forms, and Informational Session slides will be posted on the IAP SUD webpage the day of the webinar.

HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid IAP. HMA is providing CMCS with subject matter expert assistance for the program areas of Reducing SUD and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates.

To participate in this webinar, register here.

Federal Proposal Could Increase Out-of-Pocket Costs for Exchange Plan Members. *The New York Times* reported on January 21, 2018, that Exchange plan members could face higher out-of-pocket costs under a new policy proposed by the Trump administration. The proposal would allow insurers to not count the full co-pay for brand drugs when generics are available, meaning consumers would have to spend more before reaching their annual out-of-pocket limit. The proposal would also permit insurers to exclude coupons or other financial assistance provided by drug manufacturers if generics are available. Read More

Rural Hospitals in Texas, Other Non-Expansion States Face Heightened Risk of Closure. *The Pew Charitable Trusts* reported on January 22, 2019, that rural hospitals in states that have not expanded Medicaid are at a higher risk of closure than rural hospitals in expansion states. In the past six years, 21 rural hospitals in Texas were forced to close and 75 remain in danger of closing. Since 2014, the rate of closures of rural hospitals has significantly increased across non-expansion states, while the closure rate has decreased in states that have expanded Medicaid. Read More

MACPAC Meeting Scheduled for January 24-25. The Medicaid and CHIP Payment and Access Commission (MACPAC) announced on January 18, 2019, that its next meeting will be held January 24-25, 2019. Topics to be discussed are:

- Disproportionate Share Hospital Allotment Reductions
- Upper Payment Limit Compliance
- Program Integrity Strategies
- Financial Alignment Initiative
- Physician Acceptance of New Medicaid Patients
- Hospital Payment Recommendations
- Utilization Management of Medication-Assisted Treatment
- Third-Party Payments Read More

INDUSTRY NEWS

Ascension Restructures Leadership; 3 Top Executives to Depart. *Crain's Detroit Business* reported on January 22, 2019, that Ascension has gone through a leadership restructuring that resulted in the departure of three top executives effective June 30. Anthony Tersigni will remain chief executive but will give up the president title, which will be taken on by general counsel Joe Impicciche, who will also hold the title of chief operating officer. Executive vice president and head of Ascension Healthcare Patricia Maryland will step down effective June 30. John Doyle, president and chief executive of Ascension Holdings, and David Pryor, M.D., Ascension's chief clinical officer, will retire on June 30. Read More

Simplura Health Completes Acquisition of Personal In-Home Services. One Equity Partners portfolio company Simplura Health announced on January 23, 2019, that it has completed the acquisition of Personal In-Home Services, a West Virginia-based provider of services for the elderly. With this acquisition, Simplura expands its services to six states. Financial terms were not disclosed. Read More

Walmart to Remain in CVS Caremark Medicaid PBM Network in Multi-year Agreement. CVS Health announced on January 18, 2019, that Walmart will continue to serve as an in-network retail pharmacy for CVS Caremark Medicaid pharmacy benefit management members after the companies reached a multi-year agreement that resolved an earlier pricing impasse. Financial terms were not disclosed. Existing agreements with Medicare Part D or Sam's Club will not be affected. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Massachusetts One Care (Duals Demo)	RFP Release	150,000
2019	Hawaii	RFP Release	360,000
2019	Minnesota MA Families and Children	RFP Release	589,000
2019	MinnesotaCare	RFP Release	90,000
2019	Minnesota Senior Health Options	RFP Release	39,000
2019	Minnesota Senior Care Plus	RFP Release	16,000
2019	Louisiana	RFP Release	1,500,000
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract Awards	1,500,000
April 1, 2019	Idaho Medicaid Plus (Dual) - Bonneville, Bingham, Bannock Counties	Implementation	3,329
Late Spring 2019	Kentucky	RFP Release	1,200,000
June 28, 2019	Texas STAR+PLUS	Contract Awards	530,000
July 1, 2019	New Hampshire	Implementation	181,380
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
August 30, 2019	Texas STAR and CHIP	Contract Awards	3,400,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000

COMPANY ANNOUNCEMENTS

Crotched Mountain Community Care Wins 2018 Doyle Award for Optimizing Medicaid Outcomes

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Medicaid Managed Care Enrollment for 300 Plans in 38 States, Plus Ownership and For-Profit vs. Not-for-Profit Status, Updated Jan-19
- Arizona Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- Colorado RAE Enrollment is 1.2 Million, 2018 Data
- Iowa Medicaid Managed Care Enrollment is Up 4.9%, 2018 Data
- Indiana Medicaid Managed Care Enrollment is Down 4.6%, 2018 Data
- Kentucky Medicaid Managed Care Enrollment is Flat, Jan-19 Data
- Louisiana Medicaid Managed Care Enrollment is Up 2.1%, 2018 Data
- Mississippi Medicaid Managed Care Enrollment is Down 8.0%, 2018 Data
- Ohio Medicaid Managed Care Enrollment is Down 4.9%, 2018 Data
- Pennsylvania Medicaid Managed Care Enrollment is Down 1.3%, Nov-18 Data
- South Carolina Dual Demo Enrollment is Up 7.7%, 2018 Data
- South Carolina Medicaid Managed Care Enrollment is Up 0.8%, Jan-19 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arkansas Crisis and Forensic Mental Health Services RFQ Draft, Jan-19
- Arkansas Prior Authorization and Retrospective Reviews RFP, Proposals and Related Documents, Sep-18
- Iowa Technical Assistance and Waiver Support Services for Iowa Medicaid Contract, RFP and Scoring Sheet, Oct-18
- New Jersey MMIS RFP, Proposals, BAFOs, 2013-15

Medicaid Program Reports, Data and Updates:

- Alabama Coordinated Health Network Primary Care Providers Presentation, Jan-19
- Arkansas PASSE Presentation Slides, Dec-18
- Arizona Medicaid Advisory Committee Meeting Materials, Jan-19
- Colorado Governor's Proposed Budget, FY 2020
- Delaware Senate Concurrent Resolution 70 Study Group Final Report, Jan-19
- Florida Annual External Quality Review Reports, 2015-17
- Hawaii Department of Human Services Annual Reports, 2013-17
- Hawaii QUEST Integration Section 1115 CMS Quarterly Report, 4Q18
- Kansas Governor's Proposed Budget Report, FY 2020
- Kansas Medical Assistance Reports, FY 2014-19
- Massachusetts Medicaid Managed Care Quality Strategy Reports, 2017-18
- Maryland HealthChoice PBM Reimbursement Rates Report, Dec-18
- Montana Medicaid Expansion Dashboard, Dec-18
- Nebraska Heritage Health CAHPS Reports, 2017
- New Hampshire Medicaid Care Management (MCM) Quality Strategy Report, SFY 2019
- New Hampshire Medicaid Enrollment by Eligibility Group and County, Nov-18

- New Hampshire Medicaid Managed Care Organization Annual Reports, 2017
- New Hampshire Substance Use Disorder (SUD) Secret Shopper Survey Report, SFY 2019
- Oklahoma Medical Advisory Meeting Materials, Nov-18
- Pennsylvania Medicaid Nursing Facility Services Availability and Costs, 2017-18
- South Carolina Medicaid Enrollment by County and Plan, Dec-18
- Utah Medical Care Advisory Committee Meeting Materials, Jan-19
- Virginia Governor's Proposed Budget Amendments, Dec-18
- CMS Guidance to State Medicaid Directors – Opportunities to Better Serve Dual Eligibles, Dec-18

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