HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

May 20, 2020

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THIS WEEK

IN FOCUS

MEDICARE FY 2021 HOSPITAL INPATIENT PROPOSED RULE, FEDERAL FLEXIBILITIES FOR COVID-19

This week, our *In Focus* section reviews recent announcements and actions by Congress and the Centers for Medicare & Medicaid Services (CMS) that have significant financial and operational implications for the hospital industry. This brief begins with the most recent of these actions by providing a summary

of the key provisions of the CMS Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P), which includes Medicare payment updates and policy changes for the upcoming FY, with a comment deadline of July 10, 2020. Although somewhat limited in scope compared to previous proposals, this year's proposed rule includes several disruptive proposals that the hospital industry should carefully consider.

This brief also provides an analysis of the most critical regulatory flexibilities CMS and Congress created for hospitals in response to the novel coronavirus (COVID-19) pandemic. In addition, we provide a state-level analysis of the funding hospitals received as a part of the COVID-19 High-Impact Allocation. Finally, we offer a few thoughts about possible future actions policymakers could take to further assist the hospital industry.

HMA continues to monitor legislative and regulatory developments and funding opportunities that will impact the hospital sector. For more information or questions, please contact Zach Gaumer (zgaumer@healthmanagement.com) or Jennifer Podulka (jpodulka@healthmanagement.com).

FY 2021 Hospital IPPS and LTCH Proposed Rule

On May 11, 2020, CMS released the FY 2021 IPPS and LTCH Proposed Rule (CMS-1735-P). In light of the public health emergency (PHE) and recent policy changes for hospitals, the scope of the FY 2021 Proposed Rule was slightly smaller than in past years. However, the Proposed Rule contains a handful of potentially disruptive proposals. Comments on the Proposed Rule are due to CMS by July 10, 2020, with an expected publication date of 30 days before its effective date of October 1, 2020.

Payment rates: CMS estimates the overall impact of the FY 2021 IPPS Proposed Rule on general acute care hospitals will increase payments by $2.07 billion from FY 2020 to FY 2021, or 1.6 percent. Specifically, CMS proposed to increase Medicare operating payment rates by 3.1 percent, which reflects the sum of the projected hospital market basket update (3.0 percent), the statutory reduction for productivity (-0.4 percent), and statutory increase stemming from the transition of the IPPS from DRGs to MS-DRGs (+0.5 percent). Combining operating and capital payments, the FY 2021 inpatient standardized amount will be $6,448.10 per case. CMS' proposed net percent increase in Medicare IPPS payments of 1.6 percent is lower than the 3.1 percent increase in Medicare operating payment rates because other components of proposed FY 2021 payment changes will lower payments.

Uncompensated Care payments: From FY 2020 to FY 2021, uncompensated care payments will decrease by $534 million, or 6.4 percent. This reduction is a result of several changes in CMS assumptions, including the estimated share of uninsured patients (9.5 percent in 2020 and 2021) and estimated inpatient discharge volume (decrease from 2020 to 2021). In addition, CMS proposed to use uncompensated care cost data from hospitals' audited FY 2017 Cost Reports (worksheet S-10) to distribute these uncompensated care payments to hospitals.

Price transparency and use of private-sector negotiated charge data in calibrating DRG weights: In a potentially wide-sweeping proposal, CMS proposed to require hospitals to report two new variables as a part of the standard hospital

cost reporting process to enable the agency to identify MS-DRG-level payer-specific negotiated charges. This proposal builds off of the price transparency rule CMS issued in 2019 that required hospitals to publicly report their prices for many of the services they provide. Specifically, as a part of the FY 2021 IPPS Proposed Rule CMS proposed that beginning January 1, 2021, hospitals must report:

1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage payers, by Medicare Severity-Diagnostic Related Group (MS-DRG), and
2) The median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers (Medicare Advantage and other payers), by MS-DRG.

In the proposed rule, CMS requests feedback from stakeholders on its proposal to use the data described above to set MS-DRG weights beginning in FY 2024. CMS asserts any change from the current system (case-level resource-based costs to set MS-DRG weights) to the proposed system (negotiated charges) would be held budget neutral nationally. However, this change could result in changes to payments rates (and weights) of individual MS-DRGs. At this time, CMS seeks feedback and analysis from stakeholders with access to payer-specific negotiated charge data, regarding the potential impact of the use of such data on the MS-DRG relative weights.

New or revised MS-DRGS: CMS proposed to make two noteworthy changes as a part of its annual process for recalibrating MS-DRGs. Specifically, CMS proposed to create a new MS-DRG for CAR T-cell therapy (MS-DRG 018). This proposed changed has been contentiously debated in recent years because this therapy is extremely expensive. As such, the new MS-DRG will be reimbursed by Medicare at roughly $239,000 per case. CMS estimates the addition of the CAR-T MS-DRG will not cause significant changes in the weights and payment rates of other MS-DRGs for FY 2021 due to a low volume of cases in FY 2021 (116 cases). In addition, CMS proposed to create two new MS-DRGs (521 and 522) for hip procedures. For many years, hip and knee procedures were grouped in the same MS-DRGs and, therefore, were paid similarly. By splitting hip from and knee procedures the system becomes less bundled, and payment rates for these two services will be permitted to be independent of each other potentially causing them to differ over time.

Medicare Hospital Quality Programs: In recent years CMS has devoted significant effort to refine its hospital quality and value-based purchasing programs in its IPPS rulemaking, but for FY 2021 proposed policy changes are relatively minor. In general, we continue to see an effort by CMS to more closely align their programs.

- Hospital Inpatient Quality Reporting (IQR) Program: CMS proposes to progressively increase the number of quarters of Electronic Clinical Quality Measures (eCQM) data reported by hospitals. Hospitals would report two quarters of data for the FY 2023 payment determination, three quarters of data for the FY 2024, and four quarters of data FY 2025 and subsequent years. In addition, CMS proposes to begin the public display of eCQM data on the Hospital Compare website in the fall of 2022. CMS also proposed to reduce the number of hospitals selected for data validation, from 800 to 400 hospitals.

- Hospital Value-Based Purchasing (HVBP) Program: CMS provides estimated and newly established performance standards for certain measures for the FY 2023, FY 2024, FY 2025, and FY 2026 program years, however CMS does not propose to add new measures or remove measures from the HVBP Program in this proposed rule.
- Hospital Acquired Condition Reduction and Hospital Readmissions Reduction Programs: CMS proposed to more closely align the applicable performance periods and validation procedures used for this program with the Hospital IQR program.
- Hospital Star Ratings: Despite a previous announcement that CMS would update the Hospital Quality Star Rating methodology in the FY 2021 Proposed Rule, CMS proposed no changes.
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program: CMS proposed to refine two existing National Healthcare Safety Network (NHSN) measures (Catheter-Associated Urinary Tract Infection (CAUTI) and Central Line-Associated Bloodstream Infection (CLABSI)) and to begin publicly reporting the updated versions of the CAUTI and CLABSI measures in fall 2022.

COVID-19-related flexibilities for hospitals

Since the declaration of the Public Health Emergency (PHE), CMS has implemented more than 60 COVID-19-related flexibilities to support hospital efforts to respond to the pandemic. These flexibilities have largely been implemented on a temporary basis and are effective retrospectively to March 1, 2020. These flexibilities have been implemented through legislative and regulatory actions, as well as applying the 1135 waiver authority, which permits the Secretary of Health and Human Services to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program requirements to ensure that sufficient health care items and services are available during an emergency. Most of these flexibilities are temporary and are scheduled to expire at the end of the PHE.

Among the most significant of these flexibilities for hospitals are:

- *Hospital inpatient payment increase:* Medicare will increase payment rates for inpatient cases involving COVID-19 by increasing the case weight of these cases by 20 percent.
- *Temporary suspension of sequestration payment cuts:* From May through December of 2020 the statutory 2 percent reduction to Medicare fee-for-service payments will be suspended.
- *Hospital outpatient services furnished via telehealth:* Patients registered as hospital outpatients may receive certain services via telehealth. Hospitals may bill for the originating site facility fee associated with these telehealth service. Clinicians providing these services to patients registered as hospital outpatients can do so from their homes.
- *Workforce/Supervision flexibilities:* CMS has created several flexibilities to expand the healthcare workforce, such as allowing:
    - hospitals to use other practitioners (e.g., physician assistants and nurse practitioners) to the fullest extent possible
    - hospitals to use new physicians prior to full governing body approval

  - certified nurse anesthetists to provide care without the supervision of a physician, and
  - Critical Access Hospitals (CAH) to treat patients without a physician physically present.

- *Coverage and payment for COVID-19 diagnostic testing:* Hospital outpatient departments will receive payment for symptom assessment and specimen collection for severe acute respiratory syndrome coronavirus-2. In addition, Medicare will provide coverage for FDA-authorized COVID-19 serology testing for patients with known current or prior COVID-19 infection or suspected current or past COVID-19 infection.
- *Reducing Administrative Burden:* CMS has made several changes to temporarily reduce administrative requirements related to the provision of hospital services, such as:
  - granting extraordinary circumstances exceptions for quality reporting requirements
  - limiting certain discharge planning requirements
  - extending the 30-day requirement for updating the patient medical record, and
  - delaying cost reporting and wage index occupational mix data reporting.
- *Site of service flexibility:* Hospitals may provide services in other healthcare facilities and sites that would not otherwise be considered part of the hospital. For example, CMS is allowing hospitals to screen patient at offsite locations and furnish inpatient and outpatient services at temporary expansion sites. Key flexibilities include items such as:
  - allowing ambulatory surgical centers (ASC) to temporarily enroll as hospitals
  - waiving enforcement of the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to stabilized/treat patients regardless of their ability to pay
  - allowing hospitals to create new/relocate Provider-Based Departments (PBD), and to apply for a temporary extraordinary circumstances exception that enable PBDs to receive full Medicare outpatient payment rates
  - allowing general acute care hospitals to offer long-term care services ("swing-beds")
  - permitting CAHs, Medicare Dependent Hospitals, and Sole Community Hospitals to exceed their bed-size limit and length-of-stay limits
- *Medicare appeals in fee-for-service, Medicare Advantage (MA), and Part D:* CMS is allowing Medicare Administrative Contractors and other auditors to allow extensions to providers filing appeals, to process requests that do not meet all required elements, and to waive requirements for timeliness for requests for additional information to adjudicate appeals.

Federal funding to the hospitals through the COVID-19 High-Impact Allocation

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act appropriated $175 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response. To date, HHS has distributed $70 billion of these funds. Through one component of this funding allotment, the COVID-19 High-Impact Allocation, $12 billion was provided to 395 hospitals that provided inpatient care for 100 or more COVID-19 patients through April 10, 2020. These funds were distributed through the Department of Health and Human Service's Health Resources and Services Administration (HRSA) using a formula based on each hospitals' respective Medicare disproportionate share and uncompensated care payments. These 395 hospitals accounted for 71 percent of COVID-19 inpatient admissions reported to HHS from nearly 6,000 hospitals around the country.

The COVID-19 High-Impact Allocation to hospitals was highly variable by state and distributed relief to hospitals in states that were among the first to treat surges of COVID-19 patients. Ninety hospitals in New York state received a combined $5 billion, with Long Island Jewish Memorial Hospital, Tisch Hospital, New York Presbyterian, and Montefiore Hospital receiving over $150 million each. Fifty-three hospitals in New Jersey received more than $1.7 billion, including more than $200 million for Holy Name Medical Center. Thirty hospitals in Michigan received nearly $900 million. While these three states received the largest share of the COVID-19 High-Impact Allocation, other states in the top ten include Illinois ($690 million), Massachusetts ($490 million), Louisiana ($400 million), Georgia ($380 million), Pennsylvania ($320 million), Connecticut ($290 million), and Florida ($290 million).

Policymakers may act in subsequent months to address the ongoing needs of hospitals

Given the continuous flow of guidance, regulation, and legislation coming from CMS and Congress over the last few months, HMA anticipates policymakers will continue to modify regulations, create additional administrative flexibilities, and allocate funds for the hospital industry throughout 2020. Policymakers may choose to further enhance the ability of hospitals to provide additional telehealth services to patients discharged from the inpatient and outpatient settings, because only recently has CMS permitted hospital outpatient departments to provide a few services via telehealth. HHS is still establishing its policies for how to distribute more than $100 billion in appropriated provider relief funds; and Congress may pass additional legislation providing direct funding to hospitals in areas of the country that are only recently beginning to experience an increase of COVID-19 cases. This might entail additional funding to support rural hospitals and hospitals in states that did not receive significant funding through the COVID-19 High-Impact Allocation (e.g., Texas, California, Minnesota, and Colorado). Policymakers may continue to provide the hospital industry with administrative relief, such as further delaying the submission of cost reports or quality measures. In addition, CMS may choose to modify how data from calendar year 2020 are used or not used, as a part of the annual calculation of inpatient and outpatient payment rates, quality payments, and additional add-on payments, such as uncompensated care, disproportionate share hospital (DSH), indirect medical education (IME), and outlier payments.

The extent to which the COVID-19 emergency will have an impact on hospital finances throughout the rest of 2020 is unclear, but policymakers will be making ongoing changes with significant implications for the hospital industry.

HMA Updates Forecast of COVID-19 Impact on Medicaid, Marketplace, Uninsured

HMA's updated analysis projects the potential impact of the COVID-19 pandemic on health insurance coverage and cost by state through 2022. The analysis provides deeper insights into how health insurance coverage is estimated to take years to more closely resemble pre-COVID-19 coverage levels.

The analysis forecasts Medicaid enrollment could increase by 5 to 18 million by the end of the year and costs could grow by at least $11 billion in 2020. Depending on the speed of the economic recovery, Medicaid enrollment by the end of 2022 could be 1-5 million higher than year-end 2019. Total state and federal costs to cover the additional Medicaid population could range from $18 billion to $127 billion between 2020 and 2022.

A team of HMA Medicaid experts, health economists, and data analysts calculated the approximate change in health insurance coverage and cost by state as a result of the economic disruptions primarily driven by COVID-19. HMA utilized three unemployment rate scenarios – ranging from a peak unemployment rate of 20-28% – to estimate the impact on Medicaid, the ACA Marketplaces, employer provided insurance, and the uninsured.

In addition to estimates of Medicaid program costs through 2022, HMA's update includes new estimates reflecting the magnitude and duration of the economic downturn and revised assumptions regarding how enrollment could change over time. The additional analysis includes an evaluation of the more than 30 million people who have filed for unemployment insurance since February, the relationship between industry and type of health insurance, and a review of expected type and timing of insurance coverage enrollment after job loss, differentiated by state of residence, personal and family income, and family status. HMA released its initial analysis April 3.

HMA's updated analysis projects that Marketplace enrollment will edge up 1-5 million by the end of 2020. The combination of the Medicaid and Marketplace enrollment increases this year, juxtaposed with a projected decline in employer-sponsored coverage of 5-27 million, helps explain why the increase in the number of people uninsured (1-5 million by year's end) is not steeper. A disproportionate share of the newly uninsured are in non-expansion states. Enrollment in the individual Marketplace is projected to see significant turnover, as people will both enter and exit due to job losses and have associated changes in income.

HMA Updated Estimates of COVID Impact on Health Insurance Coverage, May 2020

HMA Medicaid Roundup

California

Prospect Medical Group to Acquire Assets of 3 California Physician Practices. *Modern Healthcare* reported on May 18, 2020, that Los Angeles-based Prospect Medical Group plans to acquire certain assets of CalCare IPA, Los Angeles Medical Center IPA, and Vantage Medical Group. The addition of the three physician practices in Southern California would double Prospect's network to more than 20,000 physicians and add about 130,000 new members, most of whom are enrolled in Medicaid. Prospect owns or manages 25 physician groups across six states and serves 500,000 members. Read More

Governor Proposes Major Medicaid Cuts in Pared Down Budget. *Kaiser Health News* reported on May 14, 2020, that California Governor Gavin Newsom proposed major cuts to Medicaid as part of a revised budget aimed at addressing the state's $54 billion deficit. Cuts include eliminating certain optional benefits, such as adult podiatry care, eyeglasses, speech therapy, and hearing exams. The budget proposal also includes a one-time $5.9 million investment for the state Department of Public Health, $1.3 billion in one-time funding from the federal government for local public health departments, and $4.8 million in annual ongoing funds for public health infrastructure expansions. Read More

Florida

Florida AHCA Relaxes Assessment Payment Deadline for Long-Term Care Providers. *WUSF/News Service of Florida* reported on May 15, 2020, that Florida Agency for Health Care Administration (AHCA) Secretary Mary Mayhew issued an emergency order delaying the deadline for long-term care providers and facilities for individuals with intellectual and developmental disabilities (I/DD) to pay March and April health-quality assessments. Nursing homes will have until June 20, 2020 to pay over $72 million in state assessments. Facilities serving I/DD populations will have until June 15. Read More

Hawaii

Medicaid Enrollment Hits 348,000 as Applications Spike. *Honolulu Civil Beat* reported on May 18, 2020, that Medicaid enrollment in Hawaii hit 348,000 as of May, compared to 327,000 at the beginning of March. Applications are up about 40 percent. Kauai and Maui have seen the biggest increase in applications, 85 percent and 53 percent respectively, compared to the same time last year. Read More

Illinois

Illinois Hospitals Have Begun Receiving $75 Million in New Medicaid Stability Payments. *WAND* reported on May 12, 2020, that Illinois hospitals have begun receiving $75 million in new Medicaid stability payments to help fight the COVID-19 pandemic. Payments are being issued in installments until July 1, 2020, through the state's Medicaid managed care organizations (MCOs). Additionally, a Hospital Assessment Program proposal would bring nearly $250 million more annually to hospitals throughout the state. If the proposal receives federal approval, the new program would operate from July 1, 2020, until the end of 2022. Read More

Kansas

Medicaid Director Adam Proffitt Resigns. *Modern Healthcare/The Associated Press* reported on May 14, 2020, that Kansas Medicaid director Adam Proffitt will resign effective June 5, 2020. Proffitt, who was appointed in May 2019, will join the private sector. An interim Medicaid director will be announced at a later date. Read More

Louisiana

Baymark Health Services Acquires Louisiana-based Opioid Treatment Provider. Baymark Health Services announced on May 15, 2020, that its subsidiary AppleGate Recovery has acquired Louisiana-based Medication Assisted Recovery Centers (MARC), an office-based opioid treatment (OBOT) program with two locations near New Orleans. AppleGate Recovery now operates eight clinics providing medication-assisted treatment (MAT) and recovery services in Louisiana. Additionally, MARC co-founder Dan Forman will join AppleGate Recovery as regional director, operations. Read More

Louisiana Allows 64,000 Ineligible Medicaid Members to Remain Enrolled. *The Advocate/The Associated Press* reported on May 13, 2020, that the Louisiana Department of Health is allowing more than 64,000 ineligible Medicaid recipients to remain enrolled. The decision is in response to a federal COVID-19 aid requirement that prohibits states from ending Medicaid coverage except under certain limited circumstances such as death or moving to another state. The requirement will end when the federal public health emergency declaration expires. Read More

Maine

Maine Group Homes for I/DD Struggle with COVID-19 Outbreaks. *The Bangor Daily News* reported on May 15, 2020, that providers of group homes for individuals with intellectual and developmental disabilities (I/DD) are the latest sites of COVID-19 outbreaks in Maine. At least 20 individuals have been infected in one group home since the beginning of April, and providers have financially struggled and encountered difficulty obtaining personal protective equipment for staff and residents. Read More

Michigan

Michigan Budget Is Further Strained by Rising Medicaid Enrollment. *The Detroit News* reported on May 14, 2020, that the Michigan state budget is being further strained by rising Medicaid enrollment. In the past two months, Medicaid enrollment in Michigan rose by 110,000, with a projected annual cost of as much as $500 million. That's on top of a previously projected budget shortfall of up to $3 billion. Read More

Nebraska

Nebraska Is on Track to Implement Medicaid Expansion October 1. The Nebraska Department of Health and Human Services (DHHS) announced on May 15, 2020, that the state is on track to implement a voter-approved Medicaid expansion program on October 1. The program will begin to accept applications on August 1. Newly eligible Medicaid expansion beneficiaries will start out with "basic" coverage, which does not include dental, vision, or over-the-counter medication coverage. About 94,000 Nebraskans are eligible. Read More

New Jersey

New Jersey Medicaid to Seek Substance Use Care Management State Plan Amendment. On May 19, 2020, New Jersey announced its intent to seek federal approval for a Medicaid State Plan Amendment to cover care management services for individuals with a primary substance use disorder with a co-occurring psychiatric severe mental illness or chronic condition. Comments are due to the state Department of Human Services, Division of Medical Assistance and Health Services, in 30 days. The announcement is an update to a notice published in September 2019.

New Jersey Medicaid to Cover EPSDT Well Visits via Telehealth. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services, informed providers on May 14, 2020, that it would begin covering NJ FamilyCare pediatric and adolescent well visits for members under 21 years of age via telehealth for claims with dates of service on or after March 23, 2020. The policy was enacted in response to the COVID-19 State of Emergency in order to continue meeting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program goals. Visit limitations must be clearly documented in the medical record and provided in-person as soon as feasible.

New York

HMA Roundup – Cara Henley (Email Cara)

New York City Health + Hospitals Receives $699 Million in Federal COVID-19 Hot Spot Funding. *Crain's New York* reported on May 18, 2020, that NYC Health + Hospitals received $699 million in federal COVID-19 hot spot funding, the second largest amount among New York hospitals, according to the state Department of Health and Human Services. Northwell Health led with $795 million, and New York–Presbyterian was third at $698 million. The

funding, which was announced May 1, was split among 395 hospitals in New York, New Jersey, Connecticut, Pennsylvania, Massachusetts, Michigan, and Louisiana. Read More

New York Safety Net Hospitals Face Dire Financial Outlook. *Politico* reported on May 16, 2020, that heads of many of New York's 29 not-for-profit, safety net hospitals say they may not be able to continue to operate once the COVID-19 crisis subsides. Federal relief funds have favored larger health systems and the loss of revenues from delayed procedures will be impossible to make up, hospital administrators say. Read More

Oklahoma

Lawmakers Approve Separate Measures to Boost Medicaid Funding. *Modern Healthcare* reported on May 15, 2020, that Oklahoma lawmakers gave final approval to two measures aimed at boosting Medicaid funding. The House approved a bill that increases the state's hospital fee from 2.5 percent to 4 percent to help fund Governor Kevin Stitt's proposed Soonercare 2.0 Medicaid expansion, which is scheduled to take effect July 1, 2020. The Senate approved a resolution for a public vote on whether to divert some tobacco settlement money to Medicaid. Read More

Oklahoma Suspends Premiums for Insure Oklahoma Members. The Oklahoma Health Care Authority announced on May 15, 2020, that it will suspend premiums for Insure Oklahoma Individual Plan beneficiaries for the months of April, May, and June 2020 in response to COVID-19. Insure Oklahoma is the state's premium-assistance program for low-income people whose employers offer health insurance. Read More

Senate Confirms Kevin Corbett to Head OHCA. On May 14, 2020, the Oklahoma Senate confirmed Governor Kevin Stitt's executive nomination of Kevin Corbett to head the Oklahoma Health Care Authority (OHCA). Corbett has been leading the roll out of Governor Stitt's SoonerCare 2.0 plan scheduled for July 1, 2020. Corbett previously served as a senior partner and risk advisory practice leader with Ernst & Young. Read More

Utah

Utah Medicaid Program Could Save $3.4 Million a Year with Statewide PDL, Audit Finds. *The Deseret News* reported on May 13, 2020, that the Utah Department of Health could save the state Medicaid program up to $3.4 million per year if it were to adopt a statewide preferred drug list (PDL), according to a new audit report. Utah's Medicaid program received about $138 million in prescription manufacturer rebates in 2018, but the audit found that the state did not sufficiently verify that all rebates were received. The auditors found that the state could provide more oversight over rebates "to ensure pricing is matching the lowest price index and rebates are billed and received correctly." Read More

Washington

Governor Affirms Support for Public Option. On May 19, 2020, Washington Governor Jay Inslee affirmed his support of the state's Cascade Care public option in a letter to state regulators. "While Cascade Care may take a preliminary approach in its initial year, we fully expect it to flourish in future years," Inslee wrote to Washington State Health Care Authority director Sue Birch and Washington State Health Benefit Exchange chief executive Pam MacEwan. Washington is the first state to pass legislation creating a public option. Read More

National

State Medicaid Budget Cuts Could Hit Providers Hardest. *Modern Healthcare* reported on May 19, 2020, that providers could bear the brunt of Medicaid cuts being considered in several states. That is because federal COVID-19 relief funds came with rules that prevent states from restricting eligibility, increasing premiums, or kicking beneficiaries off of Medicaid rolls. States already planning Medicaid cuts include New York, California, Colorado, Ohio, Alaska, and Georgia. Read More

State-based Exchanges Take Lead in Driving Enrollment During COVID-19 Pandemic. The Commonwealth Fund reported on May 19, 2020, that state-based health insurance Exchanges have taken the lead in driving enrollment during the COVID-19 pandemic, opening up special enrollment periods, launching advertising and outreach campaigns, and tapping consumer networks to facilitate the enrollment process. The federal Exchange, meanwhile, declined to offer a special enrollment period. Read More

CMS Issues Guidance to Ensure Safe Reopening of Nursing Homes. On May 18, 2020, the Centers for Medicare & Medicaid Services (CMS) issued guidance on the safe reopening of nursing homes, including infection prevention and control, testing, and surveillance. CMS is also recommending that states inspect nursing homes significantly impacted by COVID-19 prior to reopening. Read More

1199SEIU, Home Care Providers Urge Congress for Additional Support.*Crain's New York* reported on May 18, 2020, that 1199 Service Employee International Union (SEIU) United Healthcare Workers East president George Gresham and dozens of chief executives of home care providers are asking Congress to increase federal medical assistance percentages for home and community based services (HCBS). Gresham is also asking Congress to require state Medicaid agencies to provide pass-through funding for worker support and to reimburse providers for costs associated with COVID-19. The group is urging Congress to approve these measures so that HCBS providers remain financially stable and can retain workers to care for COVID-19-positive patients returning home from hospitals or nursing homes. Read More

MHPA Praises House Lawmakers for Passing Additional FMAP Increase. On May 15, 2020, the Medicaid Health Plans of America (MHPA) released a statement praising House lawmakers for an additional increase in the Medicaid Federal Medical Assistance Percentage (FMAP) as part of the latest phase of COVID-19 response legislation. The increase brings total FMAP enhanced funding to 14 percent. The legislation also put a moratorium on the proposed Medicaid Fiscal Accountability Regulation (MFAR) during the pandemic, lifted the Medicaid payment exclusion for incarcerated populations, and provided additional support through the Public Health and Social Services Emergency Fund for hospitals and health care providers that have been acutely impacted by COVID-19. Read More

CMS Guidance Offers States Medicaid Managed Care Rate Flexibility in Response to COVID-19. On May 14, 2020, the Centers for Medicare & Medicaid Services (CMS) released guidance providing states temporary Medicaid managed care rate flexibility in response to COVID-19. The guidance gives states the options to adjust Medicaid managed care capitation rates to reflect temporary increases in provider rates tied to fee-for-service rate increases; require managed care plans to make retainer payments to maintain provider capacity; and utilize state directed payments to require Medicaid plans to temporarily increase provider payments. CMS will also consider state requests to retroactively amend or implement risk mitigation strategies for the purposes of responding to COVID-19. Read More

Medicaid Providers Face Growing Financial Pressure. *Kaiser Health News* reported on May 18, 2020, that Medicaid providers are facing growing financial pressure and are at risk of closure without an immediate infusion of emergency relief funds. Medicaid providers are at the bottom of the list for CARES Act distributions, and states are still waiting for federal approval to make retainer payments to keep Medicaid providers afloat. Read More

Medicaid Expansion States See Greater Decline in Cancer Deaths Than Non-Expansion States, Study Says. *The Hill* reported on May 15, 2020, that states that expanded Medicaid under the Affordable Care Act (ACA) saw a 29 percent decrease in cancer deaths, compared to a 25 percent decrease in non-expansion states, according to a study from the American Society of Clinical Oncology. The study looked at data for three years prior to expansion and three years after. The study also found that Medicaid expansion particularly benefited Hispanic cancer patients, who make up a larger proportion of the population in expansion states compared to non-expansion states. Read More

States Expect Medicaid Enrollment, Spending Growth to Accelerate Because of COVID-19, Survey Finds. The Kaiser Family Foundation reported on May 15, 2020, that states are projecting higher rates of growth in Medicaid enrollment and spending in fiscal 2020 and 2021, driven by COVID-19, according to a survey released by Kaiser Family Foundation and Health Management Associates. For fiscal 2020, nearly all states with enrollment projections and over half of states with spending projections anticipate growth rates to exceed pre-pandemic estimates. For fiscal 2021, nearly all states with projections anticipate growth rates will exceed fiscal 2020 rates for both enrollment and spending and that a Medicaid budget shortfall is "almost certain" or "likely" for fiscal 2021. Read More

Medicaid MCOs Eye Revenue, Enrollment Growth. *Modern Healthcare* reported on May 9, 2020, that Medicaid managed care organizations like Molina Healthcare and Centene Corporation are eyeing membership growth, driven by surging unemployment tied to COVID-19. Overall, the nation's largest for-profit health plans appear to be largely immune to COVID-19, with first quarter 2020 results suggesting that the pandemic has had little impact on profitability. Read More

Medicaid Plan Profit Margin Dips to 0.1% In 2019. An analysis by HMA Information Services, a division of Health Management Associates, shows that Medicaid managed care plans in 34 states and Washington, DC, posted a net underwriting margin of 0.1 percent in 2019, down 40 basis points from 0.5 percent in 2018. Overall, margins have fallen consistently since hitting a four-year high of 2.4% in 2015. The data include financial information for nearly 220 Medicaid managed care plans, with total membership of 37 million in 2019. Not included are Medicaid plans in California and Arizona, which don't report financial information through NAIC.

Medicaid Providers Receive Very Little of CARES Act Distributions. *Bloomberg Law* reported on May 13, 2020, that Medicaid providers have seen very little of the $175 billion in federal assistance set aside by Congress in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Matt Salo, executive director of the National Association of Medicaid Directors, warns that even though disproportionate share hospitals and nursing homes have received some money, many other Medicaid providers have largely been neglected, including pediatricians, primary care physicians, OB-GYNs, opioid treatment facilities, non-emergency medical transportation providers, and health clinics. Read More

Industry News

OptumHealth Acquires Post-Acute Care Software Company naviHealth. *MedCity News* reported on May 19, 2020, that Optum Health has acquired naviHealth, which offers a software platform to help manage post-acute care. Terms were not disclosed. In 2018, Cardinal Health Inc. sold a 55 percent stake in naviHealth to private equity firm Clayton, Dubilier & Rice for $650 million. Cardinal retained a 45 percent stake at that time. Read More

Bain Capital Invests in Broadstep Behavioral Health. Broadstep Behavioral Health announced on May 20, 2020, that it had received a significant investment from Bain Capital Double Impact. The funds will go toward expanded services and additional staff. Broadstep serves 1,300 individuals with intellectual and developmental disabilities in 86 facilities across Illinois, New Jersey, North Carolina, South Carolina, and Wisconsin. Read More

Baymark Health Services Acquires Louisiana-based Opioid Treatment Provider. Baymark Health Services announced on May 15, 2020, that its subsidiary AppleGate Recovery has acquired Louisiana-based Medication Assisted Recovery Centers (MARC), an office-based opioid treatment (OBOT) program with two locations near New Orleans. AppleGate Recovery now operates eight clinics providing medication-assisted treatment (MAT) and recovery services in Louisiana. Additionally, MARC co-founder Dan Forman will join AppleGate Recovery as regional director, operations. 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 Episodes of HMA Podcast Series, "HOPE: Behavioral Health and COVID-19 Response" Available

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Arizona Medicaid Managed Care Enrollment is Up 4.0%, May-20 Data
- California Medicaid Managed Care Enrollment is Flat, Apr-20 Data
- California Dual Demo Enrollment is Down 1.1%, Apr-20 Data
- Colorado RAE Enrollment is Up 8.5%, Apr-20 Data
- Idaho SNP Membership at 10,181, Mar-20 Data
- Indiana SNP Membership at 44,215, Mar-20 Data
- Louisiana SNP Membership at 72,202, Mar-20 Data
- Maryland Medicaid Managed Care Enrollment Is Up 1.2%, Mar-20 Data
- Maryland SNP Membership at 10,565, Mar-20 Data
- Michigan Medicaid Managed Care Enrollment is Up 2.1%, Apr-20 Data
- Michigan Dual Demo Enrollment is Down 1.2%, Apr-20 Data
- Nebraska SNP Membership at 8,476, Mar-20 Data
- New Jersey SNP Membership at 53,233, Mar-20 Data
- Texas Medicaid Managed Care Enrollment is Down 3.2%, 2019 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Hawaii Fiscal Agent and Pharmacy Benefits Manager Services RFP and Award, 2019
- Maryland Resoliciting for Coding and Data Entry Services MS-IFB and Related Documents, 2020
- Mississippi Medicaid Pre-Admission Screening & Resident Review (PASRR) IFB, May-20

Medicaid Program Reports, Data and Updates:

- Medicaid Plan Profit Margin Dips to 0.1% In 2019
- Special Needs Plans (SNP) Enrollment by State and Plan, Mar-20 Data
- California Budget Update Presentation and Reports, FY 2020-21
- Colorado Children's Health Plan Plus Caseload by County, Apr-20
- New Hampshire Medical Care Advisory Committee Meeting Materials, Apr-20
- Oklahoma Medical Advisory Meeting Materials, May-20
- South Carolina Medical Care Advisory Committee Meeting Materials, May-20

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