HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 15, 2020

RFP CALENDAR

HMA News

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IN FOCUS

MEDICARE AND MEDICAID TELEHEALTH COVERAGE IN RESPONSE TO COVID-19

Telehealth service expansions by Medicare and most Medicaid programs aim to rapidly increase access to care and reduce transmission, but also provide a natural experiment for policymakers.

This week, our *In Focus* section examines the extensive scope of flexibilities Federal and State governments have made to Medicare and Medicaid telehealth coverage in response to the COVID-19 national emergency. In March and April 2020, federal and state policymakers responded to the COVID-19 emergency by temporarily and aggressively expanding the definition of and

reimbursement for telehealth services—moves intended to improve access to care and reduce virus transmission. Under the Medicare and Medicaid programs, these temporary expansions have been rapid and historic in scope, and will have substantial implications for patients, providers, payers, and federal/state financing. For policymakers, this temporary expansion may serve as a natural experiment for assessing which forms of telehealth services successfully expand access to care and should become permanent healthcare policy.

Leveraging the existing telehealth models along, the easing of restrictions: Telehealth services are currently fulfilling their long-touted benefits as a clinical solution to expanding access to care. For the benefit of both COVID-positive and COVID-negative patients these services have the ability to: extend a wide variety of care types to patients anywhere and at any time, reduce virus transmission rates by enabling social distancing, and enable providers to effectively triage patients amidst periods of high demand. While the basic structure of telehealth care is a patient/provider interaction via two-way video conferencing, there are several types of telehealth services clinicians can use to serve patients in the most appropriate manner. These include audio-only interactions (i.e., telephone calls) as a virtual check in, e-visits through an online portal, e-consults between providers, remote patient monitoring, and others. Importantly, payers define telehealth services differently from one another and establish reimbursement rules that differ by service type, provider type, and other characteristics. While consistency across payers can and should be improved, offering providers a menu of technology-based interactions that are free from overarching restrictions on location of services and other limitations, allows for the most flexibility in meeting the patients' needs at the lowest cost.

Medicare coverage expanded temporarily: Congress and the Centers for Medicare & Medicaid Services (CMS) have temporarily expanded Medicare's coverage of telehealth services through three regulatory or legislative vehicles, including the Cares Act of 2020. The scope of these expansions is extensive, impacting all six forms of Medicare telehealth services (Figure 1). Among the most important of these are the changes made to 'Medicare telehealth visits'—physician office visits conducted via two-way audio/video. For this service Medicare will permit: visits to originate in urban areas and from the patients' home, Federally Qualified Health Centers and rural clinics to act as distant sites, and 80 new types of services (e.g., emergency department, hospice, home health, and therapy services). While audio-only telephone calls are not permitted for this form of telehealth, audio-only telehealth is permitted by Medicare for 'Telephone-based evaluations' and 'Virtual Check-ins'. The broad range of temporary expansions are retrospectively effective on March 1, 2020 and will remain in place until the end of the emergency. In addition, CMS is encouraging patients and providers to use the various forms of Virtual Visits implemented on a more permanent basis in the last 18 months (Virtual Check-ins and E-visits) and to be aware that, starting in 2020, Medicare Advantage (MA) plans are permitted to cover any form of Virtual Visit from anywhere. In addition, CMS will now permit telehealth encounters to be included in the risk adjustment process for setting MA plan rates.

Figure 1: Six types of Medicare Virtual Visits and their rules effective through the emergency

Types of Medicare Virtual Visit	Type of services	Linkage	Form of communication	Eligible providers
Telehealth visits	171 services	New* or established patients to clinician	Two-way audio-video (smart-phones or other)	Most clinicians, FQHCs, clinics, hospice, home health
Telephone-base evaluations	Patient evaluations		Audio-only telephones	Most clinicians, FQHCs, and clinics
Virtual check-ins	Patient triage		Audio-only telephone, two-way audio-video, email, text, online portal	Most clinicians, FQHCs, and clinics
E-visits	Patient triage	Established patients to clinicians	Online portal	Most clinicians, FQHCs, and clinics
E-consults	Any clinical consult	Clinician to clinician	Audio-only telephone, email, or two-way audio-video	Clinicians eligible to bill for E&M services
Remote Patient Monitoring	Monitoring patient vitals	Established patients to clinician	Electronic monitoring	Clinicians eligible to bill for E&M services

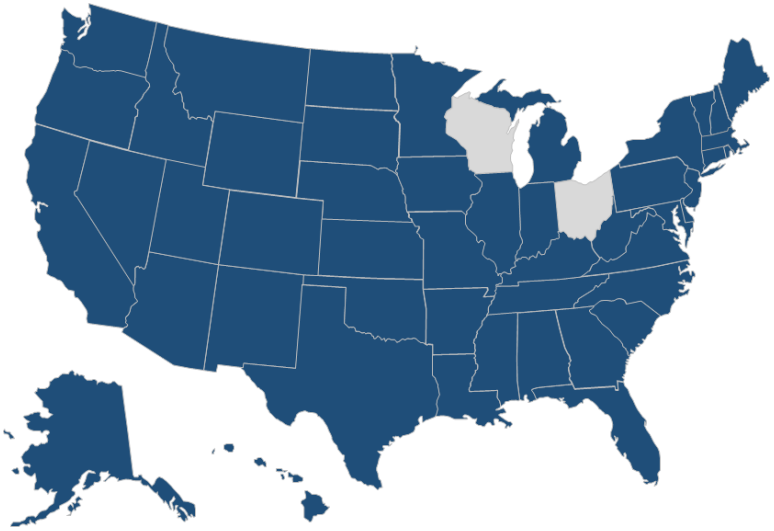
Note: *CMS has stated it will not audit claims to enforce the limitation on new patients.

Other federal policy expanded temporarily: Federal policymakers have also altered the telehealth landscape by creating flexibility under the Health Insurance Portability and Accountability Act and under the Drug Enforcement Agency (DEA). On March 17, the Secretary of Health and Human Services announced that the Office for Civil Right (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients "in good faith" through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. In addition, during the emergency the DEA is permitting DEA-registered practitioners to issue prescriptions for controlled substances to patients on whom they have not conducted an in-person medical evaluation if the prescription is issued for a legitimate medical purpose, the practitioner is acting in accordance with federal and state law, and the practitioner is using an audio-visual, real-time, two-way interactive communication system.

Medicaid policy expanded temporarily: To date, 48 states, Washington, DC, and several US territories have received approval for 1135 waivers from CMS to facilitate coverage expansion during the emergency (Figure 2). Several states are streamlining out-of-state provider Medicaid enrollment. In addition, many

governors have used executive orders to further expand the definition of telehealth and are working to facilitate the use of telehealth in several ways. A number of states—including California, New York, and Delaware—have permitted the use of audio-only telephones for physician office visits and behavioral health visits. States such as Colorado, Washington and North Carolina have expanded the scope of eligible providers and types of clinicians permitted to bill for telehealth services. And other states—including Missouri, Texas and Indiana—now allow the establishment of a patient-provider relationship via telehealth or have eliminated patient cost-sharing for telehealth visits.

Figure 2: Forty-eight states receiving 1135 waivers from CMS to expand Medicaid coverage



Will telehealth use increase significantly during the emergency? While the recent expansions of telehealth coverage allow for a significant increase in the use of this service, the extent to which patients and providers will choose to use telehealth services is unclear. Prior to the emergency, the use of telehealth under Medicare was extremely low, amounting to roughly 0.3 percent of all Physician Fee Schedule spending per year—or $30 million. During the emergency, the use of telehealth services is likely to increase in urban areas and from patients' residences. Physician offices, behavioral health clinics, FQHCs, home health agencies, and hospital systems specifically demonstrated a desire for these expansions, and subsequent relief upon their passage. In addition, increased use is likely to occur broadly across all payers, public and private.

Which of the temporary telehealth expansions will become permanent? This unfortunate emergency may serve as a natural experiment for policymakers assessing which forms of telehealth services could be expanded permanently. For many years, payers have voiced concern about the risk of fraud and misuse associated with telehealth services. By the fall of 2020, policymakers and payers will possess claims and encounter data identifying the volume of telehealth services provided in the first half of 2020, and an opportunity to survey providers and patients about their experiences with telehealth. Using these data, we will be able to determine which types of telehealth services were most beneficial to expanding access, in which locations service use grew most,

and for which types of patients use grew most. Specifically, these data may answer questions such as:

- Are patients satisfied with and seeking these services?
- Do providers want to deliver these services?
- Should payers expand originating sites (e.g., urban areas and patient residences)?
- Should home health agencies, hospice agencies, and FQHCs serve as distant sites?
- Do audio-only telephone visits pose a significant risk of misuse?

Despite the natural experiment playing out right now, it may remain unclear—due to the corresponding decrease in in-person visits—if increased telehealth use leads to more cost-effective delivery or higher costs. In either case, these temporary, and potentially permanent, expansions of telehealth services will have budgetary implications for Medicare, Medicaid, and other payers.

Link to HMA's Telehealth web page and slide decks

https://www.healthmanagement.com/what-we-do/covid-19-resources-support/telehealth/

Proposed Medicare Payment and Policy Changes for Fiscal Year 2021 for Hospice, Inpatient Psychiatric Facilities, and Skilled Nursing Facilities

Recently, the Centers for Medicare & Medicaid Services (CMS) issued proposed rules to update the Medicare payment rates and implement other policy changes for three types of Part A providers: hospice, inpatient psychiatric facilities (IPFs), and skilled nursing facilities (SNFs). CMS is publishing these proposed rules in accordance with existing statutory and regulatory requirements to update Medicare payment policies for these providers on an annual basis. This brief summarizes the proposed payment rates and key policy changes for each of these provider types.

In separate guidance, CMS issued an array of temporary regulatory waivers and new rules in response to the COVID-19 pandemic, including waiving the SNF benefit's 3-day qualifying inpatient hospital stay requirement, which allows patients to be admitted to SNFs without the typically required 3-day inpatient hospital stay, and adding flexibility in how soon beneficiaries may access a new SNF benefit period without the typical 60-day "wellness" period. CMS has introduced more flexibility for hospices to furnish services via telecommunications technology to minimize exposure risk for clinicians, patients, and the general public. For inpatient psychiatric units that are located in acute care hospitals, CMS is waiving requirements about where services are provided to allow hospitals to relocate inpatients from the distinct psychiatric unit to an acute care bed if needed. In addition, CMS is waiving the enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA) to allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at offsite locations from the hospital's campus to prevent the spread of COVID-19.

For more information on CMS's temporary regulatory waivers and new rules in response to the COVID-19 pandemic, please contact Jon Blum or Kathleen Nolan.

For all three types of providers, CMS proposes to adopt Office of Management and Budget (OMB) revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. This change is intended to make wage index values more representative of the actual costs of labor in each geographic area. CMS proposes to apply a 5 percent cap on wage index decreases for all hospice, IPF, and SNF providers for FY 2021, regardless of the circumstance causing the decrease.

The deadline for submitting comments on each of the three proposed rules is **June 9, 2020.**

HMA continues to analyze these proposed rules and will analyze the final rules when they are released by CMS. For more information, please contact Jennifer Podulka.

Hospice

The proposed rule would increase payments to hospices by 2.6 percent ($580 million) for fiscal year (FY) 2021. The 2.6 percent update is based on an

estimated 3.0 percent inpatient hospital market basket update reduced by the multifactor productivity adjustment of 0.4 percentage point. Hospices that fail to meet quality reporting requirements receive a 2-percentage point reduction to the annual market basket update for the year.

Medicare's hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments per patient made to a hospice annually. The proposed rule would set the hospice cap amount for the FY 2021 at $30,743.86, which is equal to the FY 2020 cap amount of $29,964.78 updated by the proposed FY 2021 hospice payment update of 2.6 percent.

Medicare hospice payments are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC). RHC is the most common level of hospice care, accounting for about 98 percent of all hospice days. For FY 2020, CMS increased the payment rates for the three higher intensity levels of hospice care (CHC, IRC, GIC) to better align with their estimated cost. In order to maintain budget neutrality, as required by statute, the RHC rates were adjusted by a service intensity add-on (SIA) budget neutrality factor (SBNF). This adjustment has been minimal, about 1 percent for the past four years. Because the SBNF remains stable, CMS proposes to remove the factor to simplify the RHC payment rate updates. Therefore, the RHC payment rates would typically only be updated by the wage index standardization factor and the hospice payment update percentage.

In addition, the proposed rule provides model examples of the hospice election statement and the hospice election statement addendum to reflect the changes finalized in the FY 2020 hospice final rule for elections on or after October 1, 2020. Hospices must provide Medicare beneficiaries electing hospice documents similar to these models to inform them of their rights, expected cost sharing liability, and choice of physician. CMS will publish additional guidance to further educate the hospice community on the election statement and addendum content requirements.

Inpatient Psychiatric Facilities (IPFs)

The proposed rule would increase payments to IPFs by 2.4 percent ($100 million) for FY 2021. The IPF market basket increase, which is used to update IPF payment rates, is 3.0 percent. This is adjusted by the productivity adjustment of -0.4 percentage point, resulting in the update of 2.6 percent. Additionally, total estimated payments to IPFs are estimated to decrease 0.2 percentage points due to updating the outlier threshold amount to maintain estimated outlier payments at 2 percent of total estimated payments.

Skilled Nursing Facilities (SNFs)

The proposed rule would increase payments to SNFs by 2.3 percent ($784 million) for FY 2021. This increase is attributable to a 2.7 percent market basket update that is reduced by a 0.4-percentage point multifactor productivity adjustment.

CMS proposes changes to the International Classification of Diseases, Version 10 (ICD-10) code mappings used for the Patient Driven Payment Model (PDPM) that would be effective beginning in FY 2021. Implemented on October 1, 2019, PDPM uses ICD-10 codes to classify SNF patients into case-mix payment groups, resulting in SNF prospective payment system (PPS)

payments that are driven more by patient characteristics, rather than length of stay and volume of therapy received. Under the PDPM, patients are classified into clinical categories based on the primary SNF diagnosis. For some diagnoses, the clinical classification may also be determined based on whether the patient had a major procedure during the prior inpatient stay that impacts the plan of care. CMS proposes to add this clinical classification option for diagnoses associated with certain cancers and spinal stenosis that could require a major procedure. In addition, under current clinical classifications, certain fracture codes map to surgical clinical categories. CMS proposes to change the default clinical category to "Non-Surgical Orthopedic" and include the surgical classification option.

The proposed rule also includes several minor technical changes to the SNF Value-Based Purchasing (VBP) Program, but does not include any changes to measurement, scoring, or payment policies. The SNF VBP Program scores SNFs on a single all-cause claims-based measure of hospital readmissions, as required by law, and adjusts payments under the SNF PPS. CMS proposes to:

- Align SNF VBP Program regulatory language with previously finalized policies: switching from the currently used Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) to the new Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) as soon as possible,
- Apply the 30-day Phase One Review and Correction deadline to the baseline period quality measure quarterly report: CMS has a two-phase review and corrections process for SNFs' quality measure data that will be made public; under this proposal, SNFs would have 30 days following issuance of baseline period reports to review the underlying claims and measure rate information and submit a correction request, and
- Establish performance periods and performance standards for upcoming program years: for example, the FY 2023 performance period will be FY 2021, and the baseline period will be FY 2019.

HMA Medicaid Roundup

California

California Exchange Attracts 60,000 Individuals through Special Enrollment Period. *Modern Healthcare* reported on April 14, 2020, that the California health insurance Exchange attracted 58,400 individuals during a special enrollment period in response to COVID-19. State-based Exchanges in 10 other states and the District of Columbia established similar special enrollment periods. The Trump administration has declined to open a special enrollment period for the federal Exchange, which serves 38 states. Read More

Florida

Senate Seeks to Block Medicaid Expansion Ballot Initiative. *Florida Politics* reported on April 13, 2020, that the Florida Senate submitted a six-page document to the state Supreme Court hoping to block a Medicaid expansion initiative which could appear on the 2022 ballot. According to the filing, the Senate argues that Supreme Court should not review the initiative after Governor Ron DeSantis signed a new law that increases the number of signatures required from 76,632 to 191,550. The expansion initiative collected 90,420 signatures. Read More

Illinois

Illinois Improperly Claimed $37.1 Million in Medicaid Reimbursements, OIG Report Says. *Home Health Care News* reported on April 10, 2020, that Iowa improperly claimed at least $37.1 million in federal reimbursements for payments made to home care providers, according to the U.S. Office of Inspector General (OIG). OIG recommends the state refund the money to the federal government, improve monitoring of its health home program, and better define documentation requirements. Read more

Nebraska

Nebraska Temporarily Modifies Plan for Tiered Medicaid Expansion. *Live Well Nebraska* reported on April 13, 2020, that Nebraska will require newly eligible Medicaid expansion beneficiaries to start out with "basic" coverage that doesn't include dental, vision, or over-the-counter medication coverage. The state originally wanted to offer the higher benefits to most eligibles who met certain wellness, personal responsibility, and community engagement requirements. However, the U.S. Department of Health and Human Services (HHS) is not able to review the proposal for another six months. The state hopes to offer the higher tier to new eligibles after HHS approves the plan. Implementation is expected October 1. Read More

New York

HMA Roundup – Cara Henley (Email Cara)

New York Announces Choice Model for Electronic Visit Verification. New York announced on April 13, 2020, its intention to use the Choice Model for implementing Electronic Visit Verification (EVV). The model requires providers of Medicaid-funded personal care services to choose and implement EVV systems that meet the requirements of the 21st Century Cures Act by January 1, 2021. Providers of Medicaid-funded Home Health Care Services will be required to select and implement EVV systems by January 1, 2023. Read More

New York Home Health, Hospice Providers Face Shortages of Staffing, Personal Protective Equipment. *Modern Healthcare* reported on April 8, 2020, that New York home health and hospice providers are facing shortages in staffing and personal protective equipment like masks, gloves, and gowns because of COVID-19, according to a Home Care Association of New York State survey. Staffing shortages are driven by both the virus and a lack of childcare services for workers. Read More

Ohio

Ohio Submits Section 1135 Waiver Request. *WTTE* reported on April 14, 2020, that Ohio submitted a section 1135 waiver request to federal regulators for flexibility in combating COVID-19. The waiver will bolster telehealth services, remove staffing level requirements, ease restrictions on nursing home care, allow services to be furnished in alternative settings, and remove signature requirements for providers to ensure safe distancing without compromising access to care. Read More

Oregon

Oregon Could See Medicaid Enrollment Increase by 320,000 Because of COVID-19. *The Oregonian/The Lund Report* reported on April 9, 2020, that as many as 430,000 Oregonians may lose their jobs and 320,000 may enroll in Medicaid because of the COVID-19 pandemic, according to an analysis by Health Management Associates. In a scenario where unemployment reaches 25 percent, the increase in Medicaid enrollment would cost the state $1.9 billion per year. Read More

Virginia

Virginia to Increase Medicaid Reimbursements for Nursing Homes to Cover COVID-19 Cost. *The Richmond Times-Dispatch* reported on April 10, 2020, that Virginia Governor Ralph Northam pledged to increase daily Medicaid reimbursements by $20 for each Medicaid resident in a nursing home to help cover COVID-19 costs. Read More

National

Medicare to Pay $100 for High-Volume, Rapid COVID-19 Lab Tests. The Centers for Medicare & Medicaid Services (CMS) announced on April 15, 2020, that Medicare will pay $100 for COVID-19 lab tests that use technology allowing for higher capacity and faster results, nearly double the rate of $51 for other COVID-19 tests. The higher reimbursement rate is effective April 14 and will run through the duration of the national emergency. Read More

Health Systems Criticize HHS for Tying Emergency COVID-19 Funding to Medicare Billings. *Kaiser Health News* reported on April 20, 2020, that health system executives criticized the federal government's decision to administer the first $30 billion in emergency funding based on past Medicare billings rather than on COVID-19 burden. Carlos Migoya, chief executive of Florida's Jackson Health System warned in a letter to the U.S. Department of Health and Human Services (HHS) that the improper distribution of funds "could jeopardize the very existence" of the health system. Separately, the Medicaid and CHIP Payment and Access Commission (MACPAC) also criticized HHS for not accounting "for the real and pressing concerns of safety-net providers."

CMS Allows Providers to Practice at Top of License, Across State Lines. *Modern Healthcare* reported on April 9, 2020, that the Centers for Medicare & Medicaid Services (CMS) announced it will allow providers to practice across state lines and at the top of their license in order to help hospitals across the country free up additional capacity during the COVID-19 pandemic. Read More

Supreme Court Decision in Pending PBM Case Could Limit States' Ability to Implement Other Healthcare Reforms. *Modern Healthcare* reported on April 9, 2020, that a U.S. Supreme Court decision in a pending Arkansas pharmacy benefit management (PBM) case could limit states in their ability to implement a wide range of healthcare reform policies, including group purchasing initiatives, price caps, public option plans, or single-payer healthcare. The case addresses whether an Arkansas law requiring PBMs to increase reimbursement rates to pharmacies violates federal law. Read More

Biden Unveils Proposal to Lower Medicare Eligibility Age to 60. *Modern Healthcare* reported on April 9, 2020, that presumptive Democratic presidential nominee Joe Biden unveiled a proposal that would lower the Medicare eligibility age to 60 from 65. The change would be funded by general revenues instead of the Medicare Trust Fund. Read More

Industry News

Molina, NextLevel Health Break Off Merger Talks. *Modern Healthcare* reported on April 13, 2020, that the planned acquisition of Chicago-based Medicaid plan NextLevel Health by Molina Healthcare for $50 million has been called off. NextLevel is one of two health plans only serving Medicaid members in Cook County, IL. NextLevel has about 58,000 members, or 3 percent market share, while Molina has a 10 percent share. Read More

Blue Shield of California Affiliate to Acquire Brown & Toland. *Modern Healthcare* reported on April 10, 2020, that Altais, a Blue Shield of California company, is acquiring Brown & Toland Physicians, a medical group serving 350,000 patients in the San Francisco Bay Area. Altais will provide Brown & Toland with capital and technology to help the medical group expand geographically. Brown & Toland currently practices in seven California counties. Read More

Most Private Equity-backed Physician Practices Will Not Qualify for CARES Act Bailout Funds. *Modern Healthcare* reported on April 14, 2020, that most private equity-owned physician practices will not qualify for CARES Act bailout funds, according to rules from the Trump Administration. Physician practices have been hard hit by cancellations of elective procedures. Read More

Health Agency Layoffs Tied to Patient-Driven Groupings Model Are Below Expectations. A *Home Health Care News* survey released on April 13, 2020, suggests that layoffs of home health agency therapy staff are below expectations following this year's implementation of the Patient-Driven Groupings Model (PDGM). Still, about 24 percent of home health professionals reported that their organizations have laid off therapy staff because of PDGM and about one-in-three reported their organization's therapy utilization decreased by at least 15 percent. PDGM ties therapy reimbursement to patient characteristics rather than the volume of services delivered. Read More

MHPA Names United's Catherine Anderson as Chair. *The Mining Journal* reported on April 13, 2020, that the Medicaid Health Plans of America (MHPA) has named Catherine Anderson, senior vice president of policy and strategy, UnitedHealthcare Community & State, as the chair. Anderson is joined by four new executive board members: Chris Priest (Centene), Wendy Morriarty (Horizon Blue Cross and Blue Shield of New Jersey), and Melissa Holmquist (Upper Peninsula Health Plan). Deb Bacon (Aetna Medicaid) also joins the MHPA board as an at-large member. Read More

Health Systems Search for Short-Term Liquidity Solutions. *Modern Healthcare* reported on April 10, 2020, that many health systems across the country are facing a liquidity crunch as COVID-19 decimates their most profitable revenue streams and depletes investment portfolios. Health systems are relying on advanced Medicare payments through the Coronavirus Aid, Relief and Economic Security (CARES) Act for short-term liquidity. Read More

Sentara Healthcare Completes Acquisition of Majority Stake in Virginia Premier Health Plan. *The Richmond Times-Dispatch* reported on April 9, 2020, that Sentara Healthcare completed its acquisition of an 80 percent stake in Virginia Premier Health Plan from VCU Health System. VCU retains a 20 percent stake. Sentara also owns Virginia-based Optima Health Plan. The two plans cover more than 840,000 members. Read More

Envision Healthcare Hires Houlihan Lokey to Explore Debt Rescheduling Options. *Reuters* reported on April 10, 2020, that hospital-based physician group Envision Healthcare Corporation has hired investment bank Houlihan Lokey, Inc., to explore ways to restructure its $7.5 billion worth of debt. Tennessee-based Envision, which is owned by KKR & Co., has seen revenues fall as patients avoid elective surgeries and steer clear of emergency rooms. Read More

Veronis Suhler Stevenson, NewSpring Health Capital Invest in BRC Recovery. Private equity firms Veronis Suhler Stevenson (VSS) and NewSpring Health Capital announced on April 9, 2020, an investment in Texas-based addiction treatment provider BRC Recovery Family of Programs. VSS and NewSpring also announced the formation of BRC Healthcare, which will serve as a holding company for BRC Recovery and future acquisitions. Read More

Over Half of Risk-Bearing ACOs May Leave Medicare Shared Savings Program. *Modern Healthcare* reported on April 13, 2020, that 56 percent of risk-bearing accountable care organizations (ACOs) are likely to drop out of the Medicare Shared Savings Program over concerns they will suffer financial losses related to COVID-19, according to a survey from the National Association of ACOs. The deadline for dropping out of the program without financial penalty is May 31. Currently, there are 517 ACOs in the Medicare Shared Saving Program with 11.2 million assigned beneficiaries. 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	Indiana Hoosier Care Connect ABD	Awards	90,000
May 5, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Proposals Due	*NA*
June 16, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Awards	*NA*
July 1, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Implementation	*NA*
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	West Virginia Mountain Health Trust	Implementation	400,000
September 1, 2020	Texas STAR 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
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

COMPANY ANNOUNCEMENTS

MCG Health Releases New Guidelines to Support Healthcare Organizations During COVID-19 Pandemic

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Arkansas Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Connecticut Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- District of Columbia Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Delaware Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Georgia Medicaid Management Care Enrollment is Up 1.7%, Apr-20 Data
- Georgia Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Iowa Medicaid Managed Care Enrollment is Flat, Apr-20 Data
- Illinois Dual Demo Enrollment is Down 4.1%, Mar-20 Data
- Illinois Medicaid Managed Care Enrollment is Up 0.7%, Mar-20 Data
- Indiana Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Louisiana Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Louisiana Medicaid Managed Care Enrollment is Up 0.8%, Mar-20 Data
- Maryland Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- New Jersey Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Nebraska Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Ohio Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Oregon Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Oregon Medicaid Managed Care Enrollment is Up 1.5%, Mar-20 Data
- South Carolina Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Texas Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Utah Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Virginia Medicaid Fee for Service vs. Managed Care Penetration, 2014-19
- Wisconsin Medicaid Fee for Service vs. Managed Care Penetration, 2014-19

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Maryland Maximization of Third-Party Liability Recoveries RFP & Related Documents, 2020
- Minnesota Home and Community-Based Disability Waiver Services RFP, Apr-20
- Montana CHIMES-EA Facility Management and Supportive Services RFP, Apr-20

Medicaid Program Reports, Data and Updates:

- Michigan Healthy Kids Dental 1915b Waiver, 2018
- Michigan Choice 1915 HCBS Waivers, 2019
- Michigan Children's Waiver Program 1915c HCBS Waiver, 2019
- Iowa Medicaid Health Home Providers OIG Audit, Apr-20
- Texas OIG Quarterly Reports, 2019-20

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