HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 9, 2020

RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

CMS FINALIZES POLICY TO USE HOSPITAL NEGOTIATED CHARGE DATA TO SET PAYMENT RATES

This week, our *In Focus* section reviews the policy changes included in the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Final Rule (CMS-1735-F). This year's IPPS Final Rule includes several important policy changes that will change hospitals' administrative procedures and may alter hospitals' Medicare margins, beginning as soon as October 1, 2020.

HMA continues to monitor legislative and regulatory developments that will impact the hospital sector. For more information or questions about the policies described below, please contact Zach Gaumer or Eric Hammelman.

Key Provisions of the FY 2021 Hospital IPPS and LTCH Final Rule

On September 2, 2020, CMS released the FY 2021 IPPS and LTCH Final Rule. The scope of the FY 2021 Proposed Rule was slightly smaller than in past years, due to the demands of the COVID-19 public health emergency. However, this final rule finalized several significant and potentially disruptive policies stakeholders will need to understand and adjust to quickly.

Price transparency and use of private-sector negotiated charge data in calibrating DRG weights: CMS finalized much of their controversial policy to require hospitals to report payer-negotiated charge data and then use these data to calculate inpatient Medicare Severity-Diagnostic Related Group (MS-DRG) payment weights.

CMS had originally proposed that hospitals report two new forms of MS-DRG-level data as a part of their annual cost reporting process:

1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage payers, by 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.

However, CMS chose only to finalize the requirement that hospitals report Medicare Advantage (MA) negotiated charge data, and not the negotiated charge data associated with third-party payers. Therefore, hospitals will be required to report these MA negotiated charge data, by MS-DRG, on all cost reports submitted from January 1, 2021, forward.

In addition, CMS finalized its proposal to use the MA negotiated charge data to calculate MS-DRG payment weights, beginning in FY 2024. CMS will use the relative payment differences determined by the negotiated charge data to update MS-DRG payment weights, including a budget neutral adjustment to ensure aggregate payments made under the current system (case-level resource-based costs used to set MS-DRG weights) are equal to estimated payments made under the new system. In implementing this new methodology CMS asserted they will: 1) implement payment weights in FY 2024 without a transition period; 2) make MA negotiated charge data publicly available prior to implementation; 3) and consider modifications to their methodology between now and FY 2024.

Hospital systems and other stakeholders will now race to determine the impact of using MA negotiated charge data on setting hospital inpatient MS-DRG payment weights. While CMS has stated it will ensure aggregate inpatient spending will not decline as a result of this new methodology, it is likely to cause significant fluctuations in payment rates by individual MS-DRG, at least initially. Because the mix of MS-DRGs varies by hospital, we anticipate this new methodology will also have a wide-ranging differential impact on individual hospitals. Therefore, before this methodology is implemented stakeholders will need to understand which MS-DRGs will experience reductions in Medicare payment rates and how their overall revenues will change. In addition, although it did not finalize the collection of third-party

negotiated charge data, CMS has now sent a strong message to stakeholders that it may consider using negotiated charge data from commercial payers to set MS-DRG weights in the future. Therefore, hospitals and other stakeholders will also need to understand the impact these data may have on MS-DRG weights and inpatient payment rates.

Payment rates: CMS estimates the overall impact of the FY 2021 IPPS Final Rule on general acute care hospitals will increase payments by $3.5 billion from FY 2020 to FY 2021, or 2.7 percent. Specifically, CMS will increase Medicare operating payment rates by 2.9 percent, reflecting the sum of the projected hospital market basket update (2.4 percent), the statutory reduction for productivity (0.0 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 $6,427 per case. CMS' finalized net percent increase in Medicare IPPS payments of 2.7 percent is lower than the 2.9 percent increase in Medicare operating payment rates because other components of proposed FY 2021 payment changes will lower payments.

New or revised MS-DRGs: After several years of debate CMS finalized the creation of a new MS-DRG for CAR T-cell therapy (MS-DRG 018). This new MS-DRG will be reimbursed by Medicare at roughly $240,000 per case and CMS estimates Medicare spending for this new MS-DRG will amount to $34 million in FY 2021.

New Technology Add-on Payments (NTAP): CMS finalized a significant expansion of approved NTAP technologies for FY 2021, continuing a multi-year effort to create new opportunities for new technologies to receive additional payments. For FY 2021 CMS will pay add-on payments for 24 NTAP drugs or devices. CMS estimates this expansion will result in approximately $870 million in NTAP payments in FY 2021, more than 10 times higher than the $91 million of NTAP payments in FY 2015.

Uncompensated Care Payments: Amounting to $8.3 billion, the FY 2021 uncompensated care (UC) payments will be roughly equivalent to UC payments in FY 2020. One element in calculating the size of the UC payment pool is that CMS typically uses the estimated total number of uninsured individuals in the US. However, this year the Agency noted that due to the COVID-19 economic crisis it used a modified estimate that accounted for recent changes in unemployment. In addition, CMS finalized the use of UC cost data from hospitals' audited FY 2017 Cost Reports (worksheet S-10) to distribute these payments to hospitals. This is the second consecutive year CMS has used a single year of UC cost data to distribute UC payments, and rather than the 2015 UC cost data used to distribute 2020 UC payments the Agency will use 2017 UC cost data to distribute 2021 UC payments.

Wage Index: CMS finalized the use of new geographic delineations created by the U.S. Office of Management and Budget (OMB). This policy change will result in numerous counties changing their urban and rural geographic designations or changing from one urban designation to another. Hospitals located in the effected geographic areas will experience increases and decreases in their wage index and therefore increases or decreases in their Medicare payment rates. CMS stated: 34 counties will be defined as urban when previously they were rural, 47 counties will be defined as rural when previously they were urban, and 19 counties will move from one urban geographic designation to a different urban geographic designation. Hospitals and health systems will need to understand whether their geographic designations may change and the extent to which they will be impacted by this policy financially.

Link to Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Final Rule

HMA Medicaid Roundup

Arizona

Arizona Nursing Home to Pay More than $11 Million in Billing Fraud Settlement. *The Arizona Republic* reported on September 3, 2020, that long-term care nursing facility Hacienda HealthCare will pay Arizona more than $11 million in a settlement over inflated Medicaid billings. Additionally, two former Hacienda executives were indicted on multiple fraud charges related to inflated expense reports and false bills from 2013 to 2018. Read More

Arkansas

Arkansas Medicaid Work Requirements Restricted Access to Care, Did Not Increase Employment. On September 8, 2020, *Health Affairs* released a study that analyzes Medicaid work requirements implemented in Arkansas from June 2018 through April 2019. The study found that work requirements did not increase employment and more than half of individuals ages 30–49 who had lost coverage delayed care because of cost. After a federal judge put the policy on hold, most of the Medicaid coverage losses in 2018 were reversed in 2019 after the court order. More than 70 percent of people surveyed were not aware of the work requirements. Read More

District of Columbia

District of Columbia Council Finalizes Medicaid Managed Care Contracts; Approves Transition of Individuals With Complex Care Needs to Managed Care. On September 3, 2020, the D.C. Council finalized the new Medicaid managed care contracts and approved the transition of current fee-for-service members with complex care needs to Medicaid managed care. These enrollees will be distributed to the recently awarded health plans: AmeriHealth Caritas, CareFirst BlueCross BlueShield, and MedStar Family Choice. The transition is scheduled for October 1. The council previously debated not transitioning the members due to the pandemic. Read More

Florida

Florida AHCA Secretary Mary Mayhew to Leave Post October 2. *Florida Politics* reported on September 4, 2020, that Florida Agency for Health Care Administration (AHCA) Secretary Mary Mayhew will leave her position to run the Florida Hospital Association as chief executive officer, effective October 2. The Governor's Office has already started the search process to replace her and hopes to name a successor before Mayhew departs. Read More

Medicaid Is Flagged For 'Potential Irregularities' Related to Controlled Substances. *CBSMiami/NSF* reported on September 2, 2020, that Florida Medicaid paid $3.7 million between April 2017 and February 2019 for opioids, controlled substances, and other prescription drugs for beneficiaries who had not recently been hospitalized or seen a physician, according to an audit from the Florida auditor general. Overall, the audit flagged "potential irregularities" associated with as many 36,411 claims totaling $5.45 million. Florida Agency for Health Care Administration Secretary Mary Mahyew noted that systematic program improvements will be made if deemed necessary. Read More

Georgia

Georgia Submits 1332 Waiver to Abandon ACA Health Insurance Exchanges. *The Pew Charitable Trusts* reported on September 2, 2020, that Georgia submitted a 1332 waiver proposal to federal regulators to opt out of the federal HealthCare.gov insurance Exchange, without creating a state-based marketplace to replace it. More than 450,000 individuals in the state use the Exchange to purchase health insurance. Under the proposal, individuals would have to purchase insurance on the open market similar to before the Affordable Care Act. The public comment period ends September 16, after which the Centers for Medicare & Medicaid Services (CMS) will issue a decision. Read More

New Hampshire

Vermont Is Hit With Lawsuit by NH Hospitals Over Medicaid Reimbursement Rates. *The New Hampshire Business Review* reported on September 1, 2020, that Vermont faces a federal lawsuit filed by three New Hampshire hospitals on the state border for paying Medicaid reimbursement rates that are substantially lower than rates paid to Vermont hospitals. The lawsuit also names Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS) and Alex Azar, secretary of the U.S. Department of Human Services. The three hospitals — Alice Peck Day Memorial Hospital, Cheshire Medical Center and Valley Regional Hospital — are all part of Dartmouth-Hitchcock Health System. Read More

New Mexico

New Mexico ACA Co-op to Close at the End of 2020. *Kaiser Health News* reported on September 9, 2020, that New Mexico Health Connections, one of four remaining not-for-profit health insurance co-ops established through the Affordable Care Act (ACA), will close its doors at the end of the year. This decision comes as Health Connections reported a loss of nearly $60 million from 2015 to 2017. Only three of the original 23 co-ops will remain. Read More

New Mexico Sees a 7 Percent Increase in Medicaid Enrollment. *The Albuquerque Journal/Associated Press* reported on September 5, 2020, that Medicaid enrollment in New Mexico increased by seven percent since the start of the COVID-19 pandemic. Federal legislation increased federal matching rates 6.2 percent for Medicaid. However, state Medicaid officials warn that the boost is inadequate for increasing demand for medical services and changes to the federal public health emergency declaration could cost the state as much as $150 million in general funds. Read More

New York

New York Medicaid Spending to Grow 6 Percent in Fiscal 2021. *City and State New York* reported on September 3, 2020, that New York Medicaid spending is expected to increase by 6 percent to $80.3 billion in fiscal 2021, according to an analysis by the Empire Center for Public Policy. Medicaid enrollment in New York rose by about 4 percent from February to May, the largest increase since the Affordable Care Act took effect in 2014. The state is also seeing growing coverage of more costly home care services. Read More

Oklahoma

Oklahoma to Transition Majority of Insure Oklahoma Members to Medicaid Expansion. The Oklahoma Health Care Authority announced on September 3, 2020, plans to transition about 21,000 members of its Insure Oklahoma premium assistance program to the newly created Medicaid expansion program, effective July 1, 2021. The transition applies to members with incomes below 138 percent of poverty which accounts for nearly three-quarters of the Insure Oklahoma membership. The Insure Oklahoma program will continue to cover individuals with incomes from 138 to 200 percent of poverty. Read More

Oregon

Oregon Files Notice of Noncompliance Against Medicaid CCO. *The Lund Report* reported on September 3, 2020, that the Oregon Health Authority (OHA) filed a notice of noncompliance against Centene-Trillium Community Health Plan, giving the coordinated care organization 30 days to submit a correction plan that addresses lingering concerns over Medicaid provider network capacity and the ability to reach multilingual communities in the Portland area. Last month, OHA approved Trillium's application to expand into the Portland-area counties of Clackamas, Multnomah, and Washington. The correction plan will need to be approved by state regulators. Read More

Pennsylvania

Pennsylvania Updates New Guidance for Nursing Homes. *WGAL* reported on September 3, 2020, that Pennsylvania Secretary of Health Rachel Levine has announced new guidance for nursing homes. Two of the changes deal with the frequency of COVID-19 testing for staff and residents and compassionate caregivers providing care to residents in facilities if there are two or more documented changes in a resident's condition. Compassionate caregivers can include family and others who play a role in the patient's physical, emotional, and mental health. The updated testing guidance follows guidelines and data from the Centers for Medicare & Medicaid Services. Read More

Texas

Texas Physicians, Advocates Renew Calls for Medicaid Expansion. *The Houston Chronicle* reported on September 2, 2020, that Texas healthcare providers, associations, and advocates have renewed calls for Medicaid expansion in response to COVID-19, which has resulted in an estimated 659,000 adults losing employer-sponsored health coverage. Medicaid expansion in Texas would cover more than 1 million individuals. Read More

National

Senator McConnell Calls for Vote on Stripped Down COVID-19 Relief Legislation. *Modern Healthcare* reported on September 8, 2020, that Senate Majority Leader Mitch McConnell (R-KY) plans to hold a vote on a stripped down COVID-19 relief bill as early as this week. The bill protects providers from lawsuits related to COVID-19, allows states the option to extend reduced additional federal unemployment benefits, revives the small business loan program, provides $16 billion for state COVID-19 testing, and allocates $31 billion for vaccine, therapeutic and diagnostic development and stockpiling. Healthcare providers are disappointed that the bill does not relax Medicare loan repayment terms, set aside an additional $100 billion in grants, ensure telehealth flexibilities through the end of 2021, or establish a national fund for testing reimbursement. Read More

Congress Remains Deadlocked on New COVID-19 Relief Package. *The Hill* reported on September 7, 2020, that Congress remains divided over a stalled COVID-19 relief bill, which experts say is crucial to the country's economic recovery following the pandemic. While Republicans insist that $150 billion in state and local aid is enough to compensate for local and state government budget shortfalls, Democrats are calling for $900 billion. The broader package would renew expanded unemployment payments that expired in July, provide funds for reopening schools, revive the small business loan program, and bolster the public health response. Read More

HRSA Considers Penalties On Drug Manufacturer 340B Drug Discount Policies. *Modern Healthcare* reported on September 4, 2020, that the Health Resources and Services Administration (HRSA) is evaluating potential sanctions on drugmakers that continue to restrict 340B drug discounts and curtail the use of contract pharmacies in the 340B drug discount program. Drugmaker Eli Lilly most recently limited discounts to in-house pharmacies and imposed additional conditions on discounts for their insulin products. HRSA noted that recent actions by drug manufacturers could limit access to drugs for vulnerable populations. Read More

Medicaid IAP Hosting National Webinar: Data-Informed Strategies to Address Maternal Mortality and Severe Maternal Morbidity in Medicaid. The CMS Medicaid Innovation Accelerator Program (IAP) is hosting a national webinar on Tuesday, September 15, 2020, from 2:30 pm – 4:00 pm ET to highlight state and national efforts to build capacity to examine maternal mortality (MM) and severe maternal morbidity (SMM) in Medicaid and to use analytic insights to inform initiatives to address MM and SMM. Participants from a related Medicaid IAP technical assistance opportunity will share their experiences of developing data analytic strategies to address MM and SMM. National experts, Elliott Main, MD, from the California Maternal Quality Care Collaborative and Joia Crear-Perry, MD, from the National Birth Equity Collaborative, will also discuss considerations related to conducting data analyses of MM and SMM and how to use those findings to drive action in Medicaid. This webinar will be relevant to all Medicaid agencies and is designed to encourage active participation with a portion of the webinar reserved for facilitated question-and-answers. *HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with IBM Watson Health to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates.* Register here.

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2020	Ohio	RFP Release	2,360,000
October 1, 2020	Washington DC	Implementation	224,000
Fall 2020	Oklahoma	RFP Release	800,000
3Q2021	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
3Q2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
3Q2021	California Imperial	RFP Release	75,000
3Q2021	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
3Q2021	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
July 1, 2021	North Carolina - Phase 1 & 2	Implementation	1,500,000
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Georgia Medicaid Management Care Enrollment is Up 15.9%, Aug-20 Data
- Georgia Medicaid Management Care Enrollment is Up 17.8%, Sep-20 Data
- Louisiana Medicaid Managed Care Enrollment is Up 7.4%, Jul-20 Data
- Michigan Medicaid Managed Care Enrollment is Up 4.2%, May-20 Data
- Minnesota Medicaid Managed Care Enrollment is Up 15.1%, Sep-20 Data
- Missouri Medicaid Managed Care Enrollment is Up 21.2%, Aug-20
- New York CHIP Managed Care Enrollment is Down 0.5%, Jul-20 Data
- Pennsylvania Medicaid Community HealthChoices Enrollment at 368,731, Jun-20 Data
- Pennsylvania Medicaid Managed Care Enrollment is Up 7.9%, Jul-20 Data
- Wyoming Medicaid Spending Down 2.3% to $554 Million, 2019 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- New Jersey D-SNP Contracts, 2016-20
- Tennessee Pharmacy Benefits Management RFP and Related Documents, 2018
- Wyoming Fraud, Waste, and Abuse Analytics and Case Tracking Solution RFP and Contract, 2017-18

Medicaid Program Reports, Data and Updates:

- Arizona AHCCCS Population Demographics, Sep-20
- Georgia Section 1332 Waiver Application, 2019-20
- Indiana Medicaid Advisory Committee Meeting Materials, Aug-20
- Indiana Medicaid Managed Care Demographics by Age, Aid Category, and Program, 2016-19, Jul-20
- Pennsylvania Department of Human Services Monthly Data Report, Jun-20
- Tennessee Medicaid Managed Care Enrollment by Age, Gender, County, 2015-19, Jul-20
- Vermont Blueprint for Health Annual Reports, 2015-19
- Vermont Medicaid and Exchange Advisory Board Meeting Materials, Aug-20
- Washington Medicaid Wraparound with Intensive Services (WISe) Annual Dashboards, 2016-20

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