HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

CMS INTRODUCES NEW MEDICARE DIRECT CONTRACTING MODEL OPPORTUNITY

This week, our *In Focus* section looks at a new Medicare model, Direct Contracting, introduced by the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The new model will build on and continue testing potential reforms to the Medicare program encompassed by accountable care organizations (ACOs), Medicare Advantage (MA), and private sector risk-sharing arrangements. The payment model options may appeal to a broad

range of physician and provider groups and other organizations because they are expected to introduce flexibility in health care delivery, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in traditional fee-for-service (FFS) Medicare or CMS Innovation Center models. However, there will be substantial financial risk—and reward—for participants based on a new, complex methodology, so organizations interested in this new model should carefully consider the possible outcomes from participating in Direct Contracting versus other options. CMS has announced that 51 organizations will participate in the model's trial Implementation Period, which runs from October 1, 2020, through March 31, 2021. The agency has stated that it expects to announce additional Direct Contracting pathways in the future and that the next round of applications for participation in the second performance year will open in early 2021.

CMS's Direct Contracting model will test a set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in FFS Medicare (Figure 1). CMS has provided significant flexibility in terms of who can qualify as a Direct Contracting Entity (DCE); providers have the option to organize into participant groups as they see fit. The following are examples of organization types that may be eligible: ACOs or ACO-like organizations, networks of individual practices (e.g., IPA), hospital systems, integrated delivery systems, partnerships of hospital systems and medical practices, Medicaid managed care organizations (MCOs), other payers, and skilled nursing facilities (SNFs).[i] The specific requirements are that the DCE:

Is a legal entity identified by tax identification number (TIN) formed under applicable state federal, or tribal law, and authorized to conduct business in each state that contracts with CMS for the Direct Contracting Model

- Is responsible for receiving shared savings and paying shared losses to CMS
- Is capable of administering payments to DCE Participant Providers, and if applicable, Preferred Providers
- Establishes, reports, and ensures DC Participant provider compliance with health care quality criteria, including quality performance standards
- Fulfills other DCE functions identified in the Participation Agreement

[i] During the Implementation Period, DCEs and their DC Participant Providers and Preferred Providers can participate in both the Direct Contracting Model and the Medicare Shared Savings Program (MSSP). During each performance year starting with 2021, DCEs and their DC Participant Providers may not simultaneously participate in the MSSP. The determination of whether such an overlap exists will be made at the tax identification number (TIN) level prior to the start of each performance year. This requirement does not apply to Preferred Providers.

Figure 1. There are three types of DCEs

DCEs must have arrangements with Medicare-enrolled providers or suppliers, who agree to participate in the model and contribute to the DCE's goals pursuant to a written agreement. DCEs form relationships with two groups of providers or suppliers:

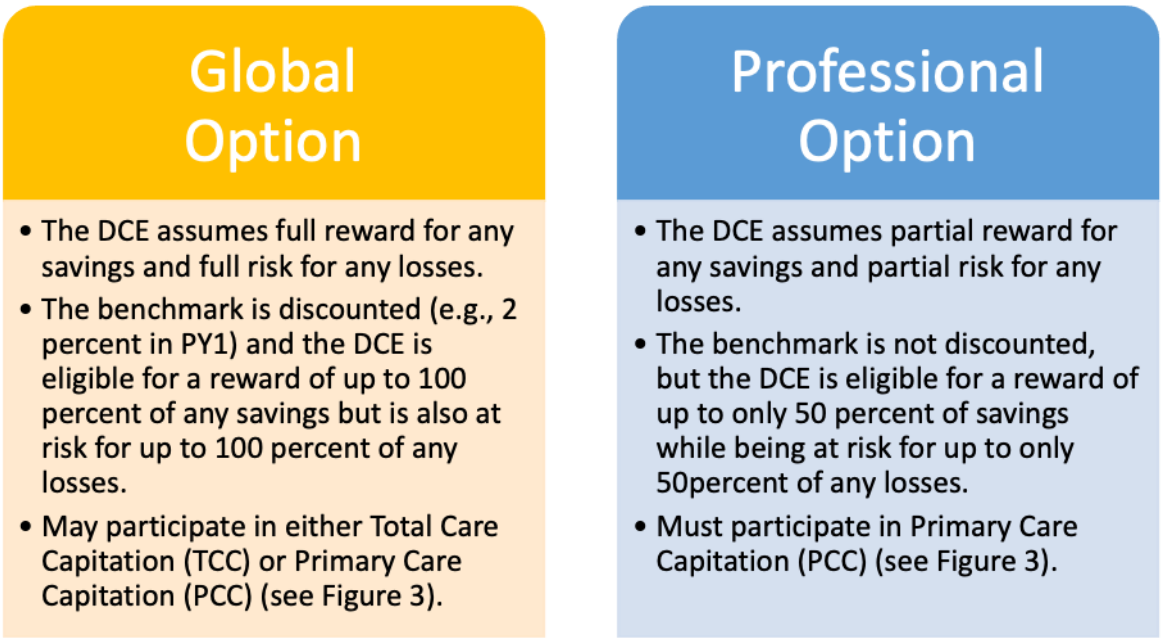
- DC Participant Providers
  - Are used to align beneficiaries to the DCE
  - Are required to accept payment from the DCE through their negotiated payment arrangement with the DCE
  - Report quality

- Preferred Providers
  - Are not used to align beneficiaries to the DCE
  - Can elect to accept payment from the DCE through a negotiated payment arrangement with the DCE
- Both Participant Providers and Preferred providers
  - Continue to submit claims to Medicare and accept claims reduction
  - Are eligible to receive shared savings
  - Have the option to participate in benefit enhancements or patient engagement incentives

Initial participants will gain experience with beneficiary attribution or "alignment" to participant organizations during the Implementation Period that started October 2020. The first PY is scheduled to begin in April 2021 and will be followed by five additional PYs. The Innovation Center will expect beneficiaries to be aligned with the DCE primarily voluntarily. Under voluntary alignment, beneficiaries choose to align to a DCE by designating a Participant Provider as their primary clinician. The other alignment option is similar to that of ACO claims-based alignment with CMS aligning beneficiaries based on where they receive the plurality of their primary care services, as evidenced in claims data.

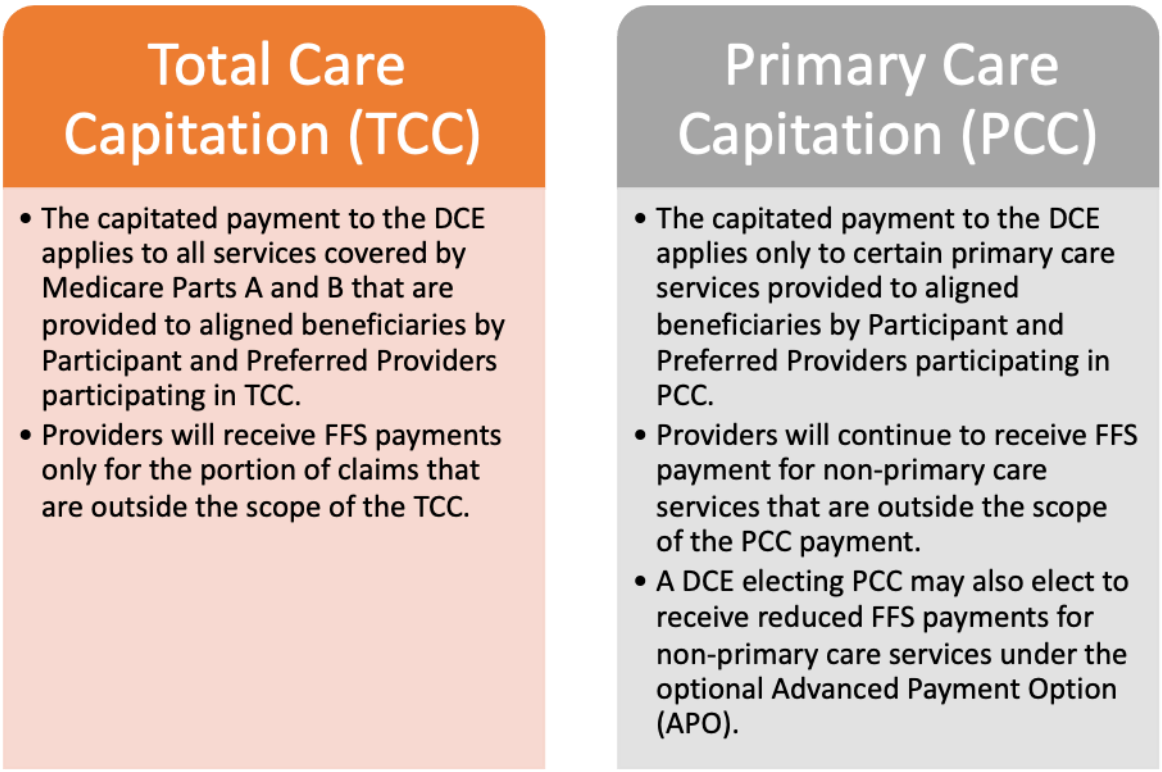
Direct Contracting offers options for both risk-sharing arrangements and risk mitigation strategies. The two risk-sharing arrangements are the Global Option and the Professional Option (Figure 2). Direct Contracting includes two risk mitigation strategies available for DCEs: risk corridors and stop-loss reinsurance. Risk corridors determine the percentage of the savings or losses that are retained by the DCE. Optional stop-loss protects DCEs from financial liability for individual beneficiary expenditures above the stop-loss "attachment points" (i.e., dollar thresholds at which stop-loss protection begins).

Figure 2. There are two Direct Contracting risk-sharing arrangements



Direct Contracting offers two payment mechanisms in which DCEs are paid a monthly capitated amount based on claims reductions made for Participant Providers and Preferred Providers. All DCEs must participate in one of the capitation payment mechanisms (Figure 3). A DCE electing PCC may also elect to accept claims reduction through the optional Advanced Payment Option (APO). The APO is available only to Preferred and Participant Providers of a DCE electing PCC. It is up to each individual provider to decide whether they want to pursue claims reduction via the APO, and each provider may choose the desired percent reduction for relevant FFS claims (1 percent–100 percent). Because APO applies to non-primary care services (i.e., services for which PCC does not apply), APO is complementary to PCC in that APO and PCC will never apply to the same service.

Figure 3. There are two Direct Contracting payment mechanisms



The impact of decisions made about TCC versus PCC vary depending on the PY and whether providers have opted to be Participant or Preferred Providers (Table 1).

Table 1. Overview of Direct Contracting payment mechanisms

Payment Mechanism Elected by the DCE	Participant Providers	Preferred Providers
TCC	Must Participate 100% Claims Reduction, all PYs	Optional for all PY's If selected, 1%–100% Claims Reduction, all PYs
PCC	Must Participate starting PY2 PY1: Primary Care Claims Reduction 1%–100% (optional) PY2: Primary Care Claims Reduction 5%–100% PY3: Primary Care Claims Reduction 10%–100% PY4: Primary Care Claims Reduction 20%–100% PY5: Primary Care Claims Reduction 100% PY6: Primary Care Claims Reduction 100%	Optional for all PYs If selected, 1%–100% Claims Reduction for Primary Care Claims, all PYs
APO (only available if PCC is also elected)	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs

The elections that organizations interested in participating as a DCE make for each of these model characteristics include: type of DCE, selection of Participant and Preferred providers, risk-sharing arrangements, payment mechanisms, and additional choices can have a substantial impact on potential shared savings and losses. HMA staff have extensive experience evaluating the most optimal pathway, understanding unique organizational risks, and assessing the implications of these decisions for the Direct Contracting model relative to other opportunities, including additional Innovation Center models. HMA also assists clients with the implementation process, including conducting assessments of organizational readiness. If your organization is interested in learning more about Direct Contracting, contact Jennifer Podulka.

HMA Medicaid Roundup

California

Legislative Analyst Projects 14.2 Percent Increase in Fiscal 2022 Medicaid Spending. The California Legislative Analyst's Office released on November 18, 2020, its annual *Fiscal Outlook,* which projects that fiscal 2022 Medicaid spending will increase 14.2 percent to $25.9 billion. From fiscal 2022 to fiscal 2025, Medicaid spending is projected to increase by $8.6 billion, driven by expiration of the enhanced federal Medicaid match next year, a significant increase in Medicaid enrollment and per capita costs, and the expiration of the managed care tax midway through fiscal 2023.

California Delays Implementation of Medi-Cal Rx Until April 2021. The California Department of Health Care Services announced on November 16, 2020, a three-month delay in the full implementation of Medi-Cal Rx, a state initiative to transition Medicaid pharmacy benefits from managed care to fee-for-service. Implementation, which was originally scheduled for January, is now set for April 2021. Read More

Illinois

Illinois Medicaid Unveils Healthcare Transformation Proposal. *Modern Healthcare* reported on November 16, 2020, that the Illinois Department of Healthcare & Family Services (DHFS) unveiled a plan to transform healthcare delivery in the state by allocating $150 million annually to initiatives that improve patient outcomes, reduce health disparities, emphasize preventive care, and prevent reductions in access to services or jobs. The funding, which would come from the $3.5 billion Illinois hospital assessment program, requires state legislative approval. Read More

Kentucky

Kentucky Submits Waiver to Treat SUD in Prisons for Justice-Involved Populations. *The Bottom Line* reported on November 16, 2020, that Kentucky submitted to the Centers for Medicare & Medicaid Services (CMS) an 1115 Medicaid demonstration waiver that would allow the use of Medicaid dollars to treat substance use disorder (SUD) for justice-involved individuals in state prisons and jails. The waiver would apply to individuals with a primary diagnosis of SUD and would allow SUD treatment to continue after incarceration. If approved, the waiver would make Kentucky the first state Medicaid program in the country to allow federal funds to be spent on incarcerated populations. Read More

Judge Orders Mediation of State Medicaid Managed Care Procurement Dispute. *The Louisville Business First* reported on November 12, 2020, that a Kentucky judge ordered the state and several health plans to resolve an ongoing Medicaid managed care procurement dispute through mediation. Franklin Circuit Court Judge Phillip Shepherd gave the parties 30 days to agree on a mediator and a mediation schedule. If they fail to agree, the judge will appoint a mediator. Shepherd previously ordered the state to grant Anthem a Medicaid managed care contract after determining there were flaws in the state's procurement process. UnitedHealthcare and Humana filed separate appeals to block Anthem from obtaining a contract. Read More

Kentucky Medicaid Contract Winner UnitedHealth Files Motion to Block Anthem, Molina from Participating. *Louisville Business First* reported on November 11, 2020, that UnitedHealthcare (UHC) of Kentucky filed a motion with Franklin Circuit Court Judge Phillip Shepherd seeking to block Anthem and Molina Healthcare from the state's Medicaid managed care program and the reassignment of their approximately 470,000 Medicaid members to UHC. The insurer argued that Shepherd's order to include Anthem as a sixth Medicaid managed care plan not only violates state law and the terms of the procurement, but also does not leave enough Medicaid members for UHC to run a viable business. UHC and Humana have separately appealed Shepherd's order to the Kentucky Court of Appeals. Read More

Michigan

Michigan PACE Market Attracts Attention of CO-Based Provider. *Crain's Detroit Business* reported on November 15, 2020, that in-home care provider InnovAge is lobbying for passage of a Michigan Senate bill that would allow the company to offer a Program of All-Inclusive Care for the Elderly (PACE) plan in metro Detroit. The plan would compete with PACE of Southeast Michigan, which is run by Presbyterian Villages of Michigan and Henry Ford Health System. Under the proposed bill, InnovAge would need to prove there is an unmet need in the market. The company is promising to invest $30 million in the construction of health and wellness centers in southeast Michigan to serve PACE members. InnovAge currently offers PACE and in-home care services in California, Colorado, New Mexico, Pennsylvania, and Virginia, and seeks to expand into Florida and Kentucky. Read More

Mississippi

Hospitals Support Medicaid Expansion in State Legislative Hearings, Suggest Managed Care Changes. *Y'all Politics* reported on November 17, 2020, that the Mississippi Hospital Association (MHA) supported Medicaid expansion and called for the removal of Medicaid managed care plans during state legislative hearings. In the event that Medicaid plans are reauthorized this year, MHA president Tim Moore recommended that the state standardize and expedite credentialing and clinical guidelines, require plans to pay no less than the fee-for-service Medicaid rate, tackle plan administrative fees before cutting provider payments, and contract with at least one not-for-profit, provider-sponsored Medicaid plan. Moore also said that health plans are not sharing data with providers as required by state law and that financial audits and use of alternative payment methods and incentives have not happened either. Read More

Missouri

Missouri to Release Medicaid Managed Care RFP Around July 1, 2021. Missouri announced at its November 12, 2020, MO HealthNet Oversight Committee meeting that the state will release a request for proposals (RFP) for its MO HealthNet Medicaid managed care program around July 1, 2021. Awards will be made no later than January 2022, with an effective date of July 1, 2022. The state also discussed plans for the implementation of a voter approved Medicaid expansion, which is required to take effect on July 1, 2021, as directed by the state constitutional amendment. Read More

North Carolina

North Carolina Releases RFA for Behavioral Health, Intellectual/Developmental Disability Tailored Plans. The North Carolina Department of Health and Human Services (DHHS), on November 13, 2020, released a request for applications for Behavioral Health and Intellectual/Developmental Disability (BH IDD) Tailored Plans as part of the statewide effort to transition to Medicaid managed care. Plans will serve populations with severe behavioral health conditions, IDD, and traumatic brain injury (TBI), beginning July 1, 2022, across seven regions. Only existing Local Management Entity-Managed Care Organizations (LME/MCOs), which currently cover behavioral health members in the state, can apply for the first round of BH IDD Tailored Plan contracts. BH IDD Tailored Plans will also be responsible for managing these services to non-Medicaid underinsured and uninsured populations. Applications are due February 2, 2021, with contract awards expected on June 11, 2021. BH IDD Tailored Plans are one of the four types of integrated Medicaid managed care plans the state will contract with to serve Medicaid and NC Health Choice beneficiaries. The other three are Standard Plans, the Statewide Specialized Foster Care Plan, and the Eastern Band of Cherokee Indians Tribal Option. Standard plans will serve less severe behavioral, IDD, and TBI populations.

Ohio

Hospital System, Health Plan File Lawsuit in Network Access Dispute With ProMedica's Paramount. *Modern Healthcare* reported on November 11, 2020, that Ohio health system ProMedica was hit with a federal lawsuit for allegedly directing its Paramount Health Care plan to cut off member access to McLaren St. Luke's hospital for commercial and Medicare Advantage lives. The lawsuit, which was filed by co-plaintiffs McLaren and WellCare (Centene), alleges that the move was made by ProMedica to protect its market share in Ohio after McLaren acquired St. Luke's. The lawsuit also says that ProMedica ended network contracts in Michigan between its own hospitals and McLaren's health plan. Read More

Oklahoma

Oklahoma to Launch Health Information Exchange in 2021. *EHR Intelligence* reported on November 13, 2020, that Oklahoma will launch a statewide Health Information Exchange (HIE) in 2021, according to Governor Kevin Stitt. The HIE will allow providers to exchange and access patient data in hopes of improving care quality, boosting public health reporting, and reducing healthcare costs. Senator Greg McCortney (R-Ada) introduced legislation that requires all state health organizations to use the statewide HIE. Read More

Oregon

Oregon CCO Struggles to Build Medicaid Enrollment, Provider Network in Portland. *The Lund Report* reported on November 16, 2020, that Medicaid coordinated care organization (CCO) Centene/Trillium Community Health Plan has enrolled fewer than 4,000 members after expanding into the Portland-area counties of Clackamas, Multnomah, and Washington earlier this year. Trillium is also struggling to meet a state directive to enhance its provider network as a condition of continuing to operate in the Portland market. Trillium has state permission to enroll up to 55,000 Medicaid beneficiaries in the tri-county area. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Rate of Uninsured Children Rises to 4.6 Percent, Report Finds. *The Pittsburgh Post-Gazette* reported on November 16, 2020, that the rate of uninsured children in Pennsylvania rose to 4.6 percent in 2019, representing about 128,000 individuals, according to the Pennsylvania Partnerships for Children. The highest uninsured rates were largely in rural counties, the report said. Read More

Tennessee

Tennessee Medicaid Enrollment Grows By More Than 83,000. *The Chattanooga Times Free Press* reported on November 14, 2020, that Medicaid enrollment in Tennessee increased by more than 83,000 people since March, including the addition of more than 34,000 children. Enrollment is expected to continue to rise as more people lose employer-sponsored health insurance and federal rules continue to restrict the state from disenrolling Medicaid beneficiaries. Read More

Virginia

Virginia Drops Plan to Give Bonuses to Medicaid Staff. *The Richmond Times-Dispatch* reported on November 16, 2020, that the Virginia Department of Medical Assistance Services (DMAS) withdrew its offer to provide one-time bonuses to staff members less than a month after it was approved by Secretary of Health and Human Resources Dan Carey. The bonuses, which were in recognition for the work employees had done in response to COVID-related Medicaid enrollment growth, would have come out of the department's general fund. The bonuses would have amounted to $477,000 for the department's 585 eligible employees. Read More

Washington

Washington Health Plan Settles Medicare Advantage Whistleblower Lawsuit. *Modern Healthcare* reported on November 16, 2020, that Kaiser Permanente settled a Medicare Advantage whistleblower lawsuit for nearly $6.4 million. According to the Department of Justice, the lawsuit alleged that Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative) claimed its members were sicker than they were in order to boost capitated payments. Read More

National

CMS Releases Final Rule Revising Several Provisions of Medicaid and CHIP Managed Care Regulations

On November 13, 2020, the Centers for Medicare and Medicaid Services (CMS) released a final rule (Final Rule) revising several sections of the Medicaid and Children's Health Insurance Program (CHIP) managed care rules, which were most recently amended in 2016. This much anticipated rule finalized several provisions proposed by CMS in their Notice of Proposed Rulemaking (NPRM) in November 2018. While CMS has made some minor modifications to the provisions set forth in the NPRM, the Final Rule is substantially the same as the 2018 proposal. CMS has noted the Final Rule "strengthens provisions in the 2016 rule taking into consideration the comments [CMS] received, giving states greater flexibility to establish appropriate payment for Medicaid and CHIP services and to set standards that effectively address the healthcare needs specific to their state, while ensuring appropriate beneficiary protections." The Final Rule makes several non-substantive, technical corrections to the current

regulations as well as several more substantive revisions. The key provisions of the revised regulations in the Final Rule are summarized below.

Most provisions in the Final Rule are effective December 14, 2020.

Payment Provisions

The Final Rule maintains the regulatory requirement that states phase out pass-through payments to hospitals, physicians and nursing facilities in existing managed care programs. However, a new option has been developed for states transitioning services and populations from fee-for-service (FFS) to managed care. States with new or expanded managed care programs that are currently making supplemental payments under FFS will be permitted to require health plans to make pass-through payments to hospitals, nursing facilities or physicians for up to three years. To exercise this option, a state must have been making supplemental payments to these providers during the "12-month period immediately two years prior to the first year of the transition period." The Final Rule establishes a formula to determine the maximum aggregate amount of permissible pass-through payments to ensure the payments are less than or equal to the supplemental payments made via FFS.

The Final Rule maintains the 2016 regulatory framework that states may only direct health plan payments to providers under certain conditions, while modifying the CMS approval process for directed payments. This includes eliminating the requirement that advanced approval is required to direct health plans to reimburse at Medicaid State Plan rates. Additionally, CMS has finalized their proposal to permit multi-year versus annual approval when states require health plans to implement value-based purchasing models, participate in delivery system reform or performance improvement initiatives. Of note, CMS did not adopt the NPRM proposal to remove the prohibition on states to direct the amount or frequency of expenditures made by health plans. CMS indicated that the original proposal to eliminate the provision was intended to alleviate concern that it could be a barrier to states seeking innovative payment models. However, the rule was finalized to continue prohibition as CMS determined the 2016 final rule struck the appropriate balance between the need for autonomy by health plans and flexibility for state Medicaid agencies.

Capitation Rate Setting Provisions

CMS has made several modifications to the capitation rate setting processes. With implementation of the 2016 regulations, CMS stopped permitting the certification of rate ranges and instead required each rate cell to be certified as actuarially sound. In response to stakeholder feedback on this topic, including concern that this requirement reduces states' ability to receive the best rates through competitive procurement and increases administrative cost and burden, CMS has determined that they will allow states to develop and certify a rate range when a series of requirements are met.

To avoid cost-shifting to the federal government, the 2016 regulations require that proposed differences among capitation rate cells be based on valid rate development standards rather than on the rate of federal financial participation (FFP) associated with the covered population. For example, under the current regulations, CMS would not approve rate cells that set minimum provider payment requirements only for populations with a higher FFP, unless supported by valid rate development standards. This requirement

is maintained with clarifying language added prohibiting differences in the "assumptions, methodologies or factors" used to develop rates based on the FFP associated with the covered population "in a manner that increases Federal costs." To determine if rate setting methods increase cost to the federal government and vary by FFP, all managed care contracts and programs within a state will be compared. While CMS considered inclusion of a non-comprehensive list of prohibited rate development practices, the Final Rule does not include such a list.

Further, the Final Rule prohibits states from retrospectively adding or modifying risk-sharing arrangements. Additionally, since 2014, CMS has issued annual capitation rate review guidance; the Final Rule codifies this practice and commits CMS to publishing "at least annually" such sub-regulatory guidance.

Quality Provisions

CMS maintains the Medicaid managed care quality rating system (QRS) established in the 2016 regulations but has made a series of modifications intended to better balance the interests of standardization and state flexibility. CMS will develop a framework for a Medicaid QRS, in consultation with states and other stakeholders, including the identification of the performance measures, a subset of mandatory performance measures, and a methodology, that aligns where appropriate with the Medicare Advantage 5-Star Rating System and other related CMS quality rating approaches. They have noted the "where appropriate" is intended to account for differences between the populations served. States may implement an alternative QRS, and, while CMS proposed elimination of the requirement that states receive advanced CMS approval to utilize an alternative state QRS, the Final Rule maintains the requirement. An alternative QRS will be required to include the mandatory measures identified in the CMS-developed framework and yield information "substantially comparable" to what is yielded by the CMS framework "to the extent feasible" to enable meaningful comparison of performance across states with vastly different programs. CMS acknowledges that this will need to take into account factors such as "differences in covered populations, benefits, and stage of delivery system transformation." CMS has also finalized language committing itself to, after engaging states and other stakeholders, issuing sub-regulatory guidance to describe the criteria and process for CMS determining if an alternative QRS system is "substantially comparable" to the QRS developed by CMS.

Network Adequacy Provisions

Under the Final Rule, the current requirement for states to develop time and distance standards for network adequacy is replaced with a more flexible requirement to set a quantitative minimum access standard for specified health care and long-term services and supports (LTSS) providers. CMS has indicated these changes enable states to choose from a variety of quantitative network adequacy standards, including minimum provider-to-enrollee ratios, maximum travel time or distance to providers, or maximum wait times for an appointment. In making this change, CMS notes they believe the more flexible standards ensure that states use the most effective and accurate standards for their respective programs.

Current regulations also specify the provider types for which states are required to establish network adequacy standards, which includes "specialist,

adult and pediatric." Under the Final Rule, CMS clarifies that "specialist," for purposes of this requirement is defined at a state level rather than a federal level to allow flexibility for states to determine the definition that best suits their respective program and managed care contract.

Beneficiary Information Requirements

CMS has also made several modifications to beneficiary information requirements, including striking the current requirement that taglines in prevalent non-English languages, large print and alternative formats be provided for all written materials. To respond to reported state and health plan concerns that these requirements increase document length and reduce the use of effective formats to communicate with beneficiaries, CMS is now requiring this information only on materials which are "critical to obtaining services." Further, under the Final Rule, modifications are made to the requirements for provider directories, most notably that health plans will no longer be required to update paper provider directories monthly if they have a "mobile-enabled, electronic provider directory." Additionally, the timelines for health plans to notify enrollees of provider terminations are modified, replacing the current 15-day standard with the requirement to notify beneficiaries the later of 30 days prior to the effective date or within 15 days after receipt or issuance of the termination notice. States have the option of continuing to require contracted health plans to meet the more stringent beneficiary information requirements currently in effect or to revise their respective requirements to meet the new federal standards.

Grievances and Appeals Provisions

CMS has finalized several revisions to regulations governing managed care grievances and appeals. First, CMS clarifies that health plans are not required to generate adverse benefit determination notices to enrollees for claims denied solely for not meeting the definition of a "clean claim." This is intended to reduce administrative burdens for health plans as well as enrollee confusion. Additionally, the Final Rule eliminates the current requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted to reduce barriers for enrollees, decrease the economic and administrative burden on managed care plans, and expedite the appeals process.

Finally, CMS has revised the timeframe for managed care enrollees to request a State Fair Hearing to be no less than 90 calendar days and no greater than 120 calendar days from the date of the health plan's notice of resolution. CMS revised the current "no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution" language to balance the interests of allowing states that wish to align managed care with the FFS filing timeframe to do so while not jeopardizing the enrollee's ability to gather information and prepare for a hearing.

CHIP

CMS has finalized several revisions, clarifications, and technical corrections to the CHIP managed care regulations. This includes clarifying language to confirm the compliance effective date for CHIP regulations under the 2016 final rule is required as of the first day of the state fiscal year beginning on or after July 1, 2018, regardless of whether or not the managed care contract in effect is a multi-year contract entered into a previous fiscal year or is a new contract effective for the first state fiscal year beginning on or after that date.

While technical revisions are made to several sections of the CHIP regulations, the most notable revisions relate to the grievance and appeals section, which, until now, generally cross-referenced the Medicaid regulations in their entirety. This section of the CHIP regulations has been amended in order to better describe the requirements under CHIP.

Miscellaneous Provisions

While there had been speculation prior to the 2018 NPRM that CMS would propose changes to the medical loss ratio (MLR) calculation, they proposed and finalized only minor technical corrections to this section. While CMS did not propose to modify the current 15-day limit on capitation payment for stays in an institution for mental disease (IMD), they did solicit comments on this topic. However, the rule was finalized with no changes with CMS noting the availability of section 1115 waiver authority for longer lengths of stay in an IMD and indicating that data that becomes available through approved section 1115 substance use disorder (SUD) demonstrations may potentially be used to inform future decision-making in this area.

The 2016 regulations require health plans that cover Medicare-Medicaid dually eligible enrollees to sign a Coordination of Benefits Agreement (COBA) and participate in the automated crossover claim process administered by Medicare, to the extent the state enters into a COBA agreement with Medicare for FFS. CMS noted they received significant feedback that, prior to the 2016 rule, states had effective processes in place to identify and send appropriate crossover claims to their health plans and that discontinuance of these processes has added unnecessary costs and burden to the state and health plans and has created some confusion and delays in provider payments. As a result, CMS has removed the requirement that health plans must enter into a COBA directly and instead will require health plan contracts to specify the methodology by which the state will ensure that the health plans receive all appropriate crossover claims, allowing states to determine the method that best meets the needs of their respective program.

Further, current regulations require that contracts between a state and health plan provide for the submission of all enrollee encounter data that the state is required to submit to CMS. CMS has added language clarifying that allowed and paid amount must be included in the encounter data due to the importance of these data for proper monitoring and administration of the Medicaid program, principally for capitation rate setting and review, financial management and encounter data analysis. This does not change requirements, rather it more explicitly states the expectation of the existing requirements.

Most provisions in the Final Rule are effective December 14, 2020. Additionally, two provisions relating to actuarial soundness and pass-through payments will be effective with contract rating periods starting on or after July 1, 2021. Finally, states will be required to come into compliance with two provisions relating to quality strategies and external quality reports for respective submissions of those documents made on or after July 1, 2021.

You can view the final rule here.

State Tax Revenues Fall $28 Billion from March through September, Report Finds. The Urban Institute reported on November 17, 2020, that state tax revenues fell $28 billion, or about 4.8 percent, in the seven months from March through September 2020, compared to the same period a year earlier, according to preliminary data from 47 states. While tax revenues rose 2.8 percent for the month of September alone year-over-year, most states are forecasting large revenue shortfalls for fiscal 2021.

Biden Can Impact Healthcare Even Without a Senate Majority. *The Associated Press* reported on November 13, 2020, that President-elect Joe Biden has some leeway on healthcare even if Republicans maintain control of the Senate. Initiatives Biden could impact include prescription drug costs, surprise medical bills, and promoting Exchange coverage. Less likely would be policies such as a public health insurance option or empowering Medicare to negotiate prescription drug prices. Read More

Exchange Members Qualify for $1.7 Billion in MLR Rebates Through October 2020, CMS Data Show. *Modern Healthcare* reported on November 11, 2020, that Exchange plan members qualified for $1.7 billion in medical loss ratio (MLR) rebates through October 2020, according to data from the Centers for Medicare & Medicaid Services (CMS). Small group rebates amount to $423 million, and large group $317 million. Rebates are expected to be high in 2021 as well, driven by low utilization of healthcare services during the COVID-19 pandemic. Read More

Industry News

Sun Capital Partners Affiliate Acquires Florida-based Miami Beach Medical Group. Private investment firm Sun Capital Partners announced on November 18, 2020, that its affiliate has signed a definitive agreement to acquire Florida-based Miami Beach Medical Group (MBMG), a primary care group focused on Medicare Advantage (MA). MBMG contracts with 10 health plans and operates a management services organization with 74 independent physicians serving more than 1,750 MA patients in the area. Terms of the deal were not disclosed. Read More

Purdue Pharma Receives Court Approval for $8.34 Billion Opioid Settlement. *The Wall Street Journal* reported on November 17, 2020, that Judge Robert Drain of the U.S. Bankruptcy Court in New York approved a $8.34 billion settlement between Purdue Pharma and the U.S. Department of Justice to settle multiple lawsuits related to the drug makers role in the opioid crisis. Members of the Sackler family, which owns Purdue, will make a related $225 million payment to Justice to resolve civil charges. The deal requires Purdue to plead guilty to three felonies concerning its marketing and distribution of OxyContin and support government programs addressing the opioid crisis. After filing for Chapter 11 bankruptcy, Purdue will transform into a public benefit trust. The deal was opposed by two dozen states, including New York, New Jersey, California, and Illinois. Read More

VillageMD to Acquire Complete Care Medical, Open Village Medical Clinics Across Phoenix. Primary care provider VillageMD, through its Village Medical subsidiary, announced on November 17, 2020, an agreement to acquire Phoenix, AZ-based provider Complete Care Medical. Village Medical now has eight clinics in Phoenix, with plans to open another 17 by summer 2021. Village Medical also offers primary care services in Atlanta, GA and Houston, TX. Read More

AccentCare, Seasons Hospice to Merge. *Home Health Care News* reported on November 16, 2020, that Texas-based AccentCare and Illinois-based Seasons Hospice & Palliative Care will merge, creating a post-acute care company with more than 225 sites across 26 states and serving more than 175,000 patients and families each year. Terms of the deal have not been disclosed. AccentCare chief executive Steve Rodgers will remain chief executive of the combined organization, while Seasons chief executive Todd Stern will lead the hospice department and serve as executive vice chair. Read More

Centauri Health Solutions Acquires Ivy Ventures. Arizona-based healthcare technology company Centauri Health Solutions announced on November 16, 2020, its acquisition of Ivy Ventures, a Virginia-based referral management and data analytics company. The addition of Ivy marks Centauri's fourth acquisition in the hospital sector in less than 12 months. The combined organization will be led by Centauri chief executive and co-founder Adam Miller, with Ivy's founding partners Roger Johnson and Douglas Wetmore, and partners Milan diPierro and Barrett Clark, joining Centauri's management team. Read More

Arsenal Capital Partners Acquires FL-based Best Value Healthcare Primary Care Group. Private equity firm Arsenal Capital Partners announced on November 17, 2020, the acquisition of Florida-based Best Value Healthcare, a primary care group focused on Medicare Advantage. Best Value currently has operations in central and south Florida. Terms of the deal were not disclosed. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November 20, 2020	Ohio	Proposals Due	2,450,000
December 2020	Hawaii Quest Integration	RFP Release	340,000
December 15, 2020	Oklahoma	Proposals Due	742,000
December 23, 2020	North Dakota Expansion	Proposals Due	19,800
Late 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
Late 2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
Late 2021	California Imperial	RFP Release	75,000
Late 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
Late 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	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
January 1, 2021	Washington Integrated Managed Care (Expanded Access)	Implementation	*NA*
January 8, 2021	Hawaii Community Care Services	Proposals Due	4,500
January 25, 2021	Ohio	Awards	2,450,000
February 2, 2021	North Carolina - BH IDD Tailored Plans	Proposals Due	*NA*
February 8, 2021	Hawaii Community Care Services	Awards	4,500
February 2021	Hawaii Quest Integration	Proposals Due	340,000
February 1, 2021	Oklahoma	Awards	742,000
March 2021	Hawaii Quest Integration	Awards	340,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
May 21, 2021	North Dakota Expansion	Awards	19,800
June 11, 2021	North Carolina - BH IDD Tailored Plans	Awards	*NA*
July 1, 2021	North Carolina - Phase 1 & 2	Implementation	1,500,000
July 1, 2021	Hawaii Quest Integration	Implementation	340,000
July 1, 2021	Hawaii Community Care Services	Implementation	4,500
October 1, 2021	Oklahoma	Implementation	742,000
January 1, 2022	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2022	North Dakota Expansion	Implementation	19,800
January 5, 2022	Ohio	Implementation	2,450,000
July 1, 2022	North Carolina - BH IDD Tailored Plans	Implementation	*NA*
Early 2022 – Mid 2022	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Awards	1,640,000
Early 2022 – Mid 2022	California GMC - Sacramento, San Diego	Awards	1,091,000
Early 2022 – Mid 2022	California Imperial	Awards	75,000
Early 2022 – Mid 2022	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Awards	286,000
Early 2022 – Mid 2022	California San Benito	Awards	7,600
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

HMA Colleagues Make Case for Two-Generation Approach. Focused on addressing inequities and building more sustainable and vital futures for low-income families in Washington, D.C., and the state of Maryland, colleagues from Health Management Associates (HMA) authored two case studies under the auspices of Ascend at the Aspen Institute, a hub for breakthrough ideas and collaborations that move children and their parents toward educational success and economic security. Read more

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Georgia Medicaid Management Care Enrollment is Up 21.3%, Nov-20 Data
- Iowa Medicaid Managed Care Enrollment is Up 11%, Nov-20 Data
- Kentucky Medicaid Managed Care Enrollment is Up 10.4%, Nov-20 Data
- New Jersey Medicaid Managed Care Enrollment is Up 13.7%, Oct-20 Data
- Ohio Medicaid Enrollment by Eligibility Category, 2016-19, Oct-20
- Ohio Medicaid Managed Care Enrollment is Up 12.3%, Oct-20 Data
- Oregon Medicaid Managed Care Enrollment is Up 12.1%, Sep-20 Data
- Utah Medicaid Managed Care Enrollment is Up 43.3%, Nov-20 Data
- Washington Medicaid Managed Care Enrollment is Up 9.3%, Oct-20 Data
- West Virginia Medicaid Managed Care Enrollment is Up 16.2%, Nov-20 Data
- MLRs at DC Medicare Advantage MCOs Average 81.1%, 2019 Data
- MLRs at Idaho Medicare Advantage MCOs Average 86.3%, 2019 Data
- MLRs at Iowa Medicare Advantage MCOs Average 84.1%, 2019 Data
- MLRs at Kansas Medicare Advantage MCOs Average 82.6%, 2019 Data
- MLRs at Maine Medicare Advantage MCOs Average 88.3%, 2019 Data
- MLRs at Maryland Medicare Advantage MCOs Average 87.1%, 2019 Data
- MLRs at Mississippi Medicare Advantage MCOs Average 79.4%, 2019 Data
- MLRs at Montana Medicare Advantage MCOs Average 85.6%, 2019 Data
- MLRs at Nebraska Medicare Advantage MCOs Average 82.8%, 2019 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- North Carolina Behavioral Health and Intellectual/Developmental Disability Tailored Plans RFA, Attachments, and Q&As, Nov-20
- Ohio Medicaid Managed Care RFA and Related Documents, Sep-20
- Oregon MMIS Contract Extension Requests, Nov-20
- Wisconsin Medicaid Recovery Audit Services RFP, Nov-20

Medicaid Program Reports, Data and Updates:

- U.S. Medicaid, CHIP Enrollment at 75.5 Million, Jul-20 Data
- California Budget Fiscal Outlook Report, FY 2021-22
- Colorado Medicaid Accountable Care Collaborative (ACC) PIAC Meeting Materials, Oct-20
- Connecticut Medical Assistance Program Oversight Council Meeting Materials, Sep-20

- Delaware DHSS Budget Hearing Presentation, FY 2021-22
- Illinois Medicaid Managed Care Program Map, Sep-20
- Kentucky 1115 SUD Demonstration Waiver Proposed Incarceration Amendment and Presentation, Sep-20
- Maryland HealthChoice Actuarial Rate Certification, CY 2019-21
- Nevada Medicaid FFS Monitoring Healthcare Access Plan, Aug-20
- Nevada Medicaid Managed Care Network Adequacy Validation Report, FY 2020
- Ohio OBM Monthly Financial Reports, 2020
- Pennsylvania OVR MLTSS Subcommittee Meeting Materials, Nov-20
- South Dakota Department of Social Services Medicaid Annual Reports, 2012-20
- Texas OIG Audit of Parkland Community Health Plan's PBM, Aug-20
- Texas Quarterly Reports from the HHS Ombudsman Managed Care Assistance Team, FY 2019-20
- Vermont Green Mountain Care Board Advisory Committee Meeting Materials, Oct-20

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

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