HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

December 16, 2020

Edited by:
Alona Nenko
Email

Carl Mercurio
Email

Mary Goddeeris, MA
Email

Lissete Diaz
Email

Scott Silberberg
Email

THIS WEEK

THE WEEKLY ROUNDUP WILL RETURN JANUARY 6. HAPPY HOLIDAYS!

IN FOCUS

2020 IN REVIEW: TOP MEDICARE-MEDICAID INTEGRATION TRENDS AND POLICIES

This week, our *In Focus* section focuses on five critical policy and program trends to provide integrated care to dual-eligible individuals for Medicare and Medicaid. Both federal and state governments continue to look for ways to improve coordination and integration for this population. We anticipate the emphasis on innovative approaches to whole person, person-centered care, care management and coordination, care transitions, and regulatory oversight to persist. 2020 has been an active year of policymaking by the Centers for

Medicare & Medicaid Services (CMS) and states. HMA distilled the themes and their strategic implications in this article. We continue to assist clients in tracking new policies and industry trends, developing innovative plans and strategies, and delivering high quality care and services to this population.

1. **The Federal government strengthened requirements for the integration of Medicare and Medicaid programs in State Medicaid Agency Contracts (SMACs). States increasingly use SMACs as a vehicle to promote state specific integration priorities for Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).**

   Synopsis: D-SNPs are required to have a SMAC in order to conduct business in a state. The SMAC must contain federally-required provisions including Medicare-Medicaid integration requirements that are described in a 2019 Final Rule[i] and further clarified in CMS guidance.[ii] In addition to required components, more states are now using the SMAC process to add additional contract provisions to further state integration goals between Medicare and Medicaid for dual-eligible individuals. Notable provisions that states have included in their SMACs and other states may adopt include the following:

   - Ensuring information sharing and transition of care follow up (TN)
   - Requiring Highly Integrated D-SNPs (also known as HIDE SNP[iii]) to share hospital and nursing home admissions data where it was not required by CMS (WA)
   - Prohibiting D-SNPs from marketing to beneficiaries residing in geographies where Medicare-Medicaid plans (MMPs) offer capitated financial alignment demonstrations or dual demonstration programs (OH)
   - Requiring Medicare default enrollment[iv] for D-SNPs that also contract with the state for their Medicaid managed long-term services and supports program (AZ, NY)
   - Requiring D-SNPs to offer at least one supplemental benefit that is complementary to benefits offered in the Medicaid program (UT)

---

[i] CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

[ii] Sharon Donovan, Dual Eligible Special Needs Plans, "Additional Guidance on CY2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)", memorandum, January 17,2020, Program Alignment Group. Retrieved from https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

[iii] A D-SNP may meet the criteria for designation as a HIDE SNP if it covers, consistent with state policy, either (1) LTSS or (2) Medicaid behavioral health services, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP." Sharon Donovan, Dual Eligible Special Needs Plans, "Additional Guidance on CY2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)", memorandum, January 17, 2020, Program Alignment Group. Retrieved from https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

[iv] Enrollments of an organization's Medicaid managed care enrollees into an affiliated dual eligible special needs plan (D-SNP) upon the individuals' initial eligibility for Medicare.

Implications: D-SNPs should review their current SMAC to ensure compliance with the existing requirements. Existing and new D-SNPs should anticipate the creation of 2022 SMACs, evaluate organizational integration strategies, review industry best practices and determine whether there are provisions that enable D-SNPs to further state integration goals. HMA continues to monitor innovations in various states. HMA Information Services (HMAIS) maintains a current library of select SMACs and is available to subscribers.

2. **Congress and CMS have granted new flexibilities under four different authorities for Medicare Advantage plans, including D-SNPs, to offer innovative supplemental benefits. Dual eligible individuals have higher rates of chronic illness and other social risk factors and may benefit from these additional flexibilities.**

   Synopsis: Congress and CMS have recently expanded the definition of supplemental benefit policies to grant Medicare Advantage (MA) plans more flexibility than ever before to design and target these benefits. These include: 1) expansion of the definition of "primarily health-related;" 2) the ability to target benefits to certain sub-populations only (i.e., offer them non-uniformly); 3) implementation of the value-based insurance design (VBID) demonstration; and 4) establishment of special supplemental benefits for the chronically ill (SSBCI).[v] While all four benefit flexibilities allow greater tailoring of benefits to the needs of the population, SSBCI is the only type of supplemental benefit that allows the inclusion of non-medical benefits.

   2020 was the first year that health plans could offer SSBCI, permitting supplemental benefits that are "non-primarily health-related" for individuals with one or more of 15 designated chronic conditions.[vi] This flexibility enables plans to offer supplemental benefits that are intended to address social needs, such as non-medical transportations and home modifications. Sixty percent of dual eligible individuals have multiple chronic conditions[vii] and other social risk factors and may benefit from non-primarily health-related services. Only six percent or approximately 1.4 million individuals are enrolled in plans offering SSBCI in 2020. One-third of plans offering SSBCI are SNPs, most of which are dual eligible SNPs (D-SNP).[viii] HMA continues to track the landscape and adoption of supplemental benefits.

---

[v] Narda Ipakchi, Jonathan Blum, Eric Hammelman and Mary Hsieh, "Medicare Advantage Supplemental Benefit Flexibilities: Adoption of an Access to Newly Expanded Supplemental Benefits in 2020", May 2020. Retrieved from https://www.healthmanagement.com/wp-content/uploads/Medicare_Advantage_Supplemental_Benefit_Flexibilities_Issue_Brief_2-27-20_HMA.pdf

[vi] Qualifying chronic conditions include: chronic alcohol and other dependence, autoimmune disorders, cancer (excluding pre-cancer conditions), cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, end-stage liver disease, End-Stage Renal Disease (ESRD) requiring dialysis, severe hematologic disorders, HIV/AIDS, chronic lung disorders, chronic and disabling mental health conditions, neurologic disorders, stroke.

[vii] Medicare-Medicaid Coordination Office, "People Dually Eligible for Medicare and Medicaid", Fact Sheet, March 2020, Centers for Medicare & Medicaid Services. Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

[viii] Narda Ipakchi, Jonathan Blum, Eric Hammelman and Mary Hsieh, "Medicare Advantage Supplemental Benefit Flexibilities: Adoption of an Access to Newly Expanded Supplemental

Implications: As part of the product planning and development cycle for 2022, D-SNPs may be considering adding expanded supplemental benefits to fill a need in for its members and attract prospective members. We anticipate the availability of these benefits to evolve over time, especially if Medicare beneficiaries gravitate to MA plans offering these benefits and they demonstrate increased quality and lower health care costs. D-SNPs and traditional Medicare Advantage plans should review benefits offered in current and potential markets while developing its supplemental benefit designs for 2022.

3. **In addition to the Medicare Advantage flexibilities to address social determinates of health (SDOH) described above, states are increasingly requesting respondents to Medicaid requests for proposal including dual-eligible individuals to address SDOH needs in their responses, particularly as needs of dual eligible individuals have been amplified by the COVID pandemic.**

   Synopsis: The impact of Social Determinates of Health on dual-eligible individuals has been a concern for Federal and State officials prior to the pandemic and data released by CMS showed that dual-eligible individuals are even more susceptible to poor health and death during a public health crisis/pandemic. The data showed that dual-eligible individuals are more likely to contract and be hospitalized for COVID-19 than Medicare-only individuals and that dual-eligible individuals are hospitalized with COVID-19 complications at a rate of more than four times higher than Medicare-only individuals. [ix] HMA has observed an increase in States' focus on responders addressing SDOH needs of dual-eligible individuals in its Medicaid managed care requests for proposals, e.g., coordinating with employment programs, addressing food insecurity, and other SDOH. Managed Care Organizations (MCOs) expecting a state Medicaid procurement or re-procurement including dual-eligible individuals will want to prepare for the increased scrutiny in this area by having available data supporting their efforts to address SDOH and/or implement programs targeting SDOH. This may include developing relationships with community based organizations that specialize in meeting SDOH needs such as housing agencies and home delivered meals providers and vendors that offer services like pest control.

   Implications: In developing benefits or services to address SDOH of members, in addition to its usual product development work, health plan should review State's Managed Long-Term Services and Supports (MLTSS) program services effectiveness to deliver complementary and enhanced benefits to those benefits offered by Medicaid.

4. **CMS will not grant contracts to new D-SNP look-alike plans in 2022 and will not renew D-SNP look-alike plans in states with MMPs and/or D-SNPs for 2023.**

Benefits in 2020", May 2020. Retrieved from https://www.healthmanagement.com/wp-content/uploads/Medicare_Advantage_Supplemental_Benefit_Flexibilities_Issue_Brief_2-27-20_HMA.pdf

[ix] Seema Verma, 'Medicare COVID-19 Data Release Blog", blog post, June 22,2020. Centers for Medicare & Medicaid Services. Retrieved from https://www.cms.gov/blog/medicare-covid-19-data-release-blog#_ftn2

Synopsis: D-SNP look-alike plans are traditional Medicare Advantage plans that are designed to attract dual-eligible individuals through coverage of supplemental benefits such as dental, vision, and hearing services and generous value-added benefits such as over the counter cards. This type of plan circumvents the requirement of having a State Medicaid Agency Contract (SMAC) to coordinate and integrate benefits and care between Medicare and Medicaid, among other D-SNP statutory and regulatory requirements. The criteria for identifying a D-SNP look-alike plan is the percentage of dual-eligible individuals enrolled in the plan. If dual-eligible individuals comprise 80 percent of more of the plan enrollment, it is considered a D-SNP look-alike plan.

D-SNP look-alike plans were often created by health plans that wanted to serve their dual-eligible membership but were not contracted to participate in a State's MMP or Medicaid managed care programs and could not receive a SMAC from the State. D-SNP look-alike plans have grown across the country but are especially focused in California, Florida and New York, as some of these states prohibit D-SNPs in areas where Medicare-Medicaid Plans are offered or are unwilling to sign SMACs for organizations that do not participate in the state's Medicaid managed care program.

Implication: There is no explicit CMS approved process to transfer members from D-SNP look-alike plans to other plan options so strategic planning is important. Health plans should determine if any of their products qualify as a D-SNP look-alike plans. If a health plan with a D-SNP look-alike plan is offering a D-SNP or MMP in the same service, evaluate why those plan options are not attracting membership and modify the product offering. Those organizations with a D-SNP look-alike product without a D-SNP or MMP should look to create a D-SNP.

5. **CMS recently released data on the multiple categories of D-SNPs highlighting the varying levels of integration, different D-SNP types and where they operate. This information provides plans with important insights for 2022 and 2023 business and strategic planning.**

   Synopsis: The table below outlines the Medicare Medicaid Coordination Office's finding upon completing their review of the 2021 SMACs, which included new mandated requirements for integration. D-SNPs are now categorized by FIDE, HIDE, Coordinated-Only D-SNPs and Applicable Integrated Plans. This categorization, which is described in a 2019 Final Rule[x] and further clarified in the CMS guidance[xi], provides insight into whether and the extent to which states include in their SMAC nursing facility care, behavioral health benefits and/or long term services and supports, and whether the level of benefits meets the Highly Integrated

[x] CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[xi] Sharon Donovan, Dual Eligible Special Needs Plans, "Additional Guidance on CY2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)", memorandum, January 17,2020, Program Alignment Group. Retrieved from https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf

Dual Eligible (HIDE) SNP or the Fully Integrated Dual Eligible (FIDE[xii]) SNP designations. States may allow multiple types of D-SNPs to operate or limit to a certain type of D-SNP (e.g. HIDE SNP or FIDE SNP) to do business in the state. HMA is examining this data in conjunction with our available CMS county level data to support D-SNP targeted market strategies.

Implication: The newly available aggregate information supports planning for MA organizations currently operating or interested in applying for a D-SNP and for entities considering launching a D-SNP in a new state.

D-SNPs (November 2020)[xiii]		
SNP Information	**Number**	**States**
MA-PD and RPPO Contracts offering D-SNPs (parent organizations)	272	N/A
D-SNP Plan Benefit Package (PBP[xiv])	602	N/A
FIDE SNP PBP	69	AZ, CA, FL, ID, MA, MN, NJ, NY, PA, TN, VA, and WI
HIDE SNP PBP	190	AZ, FL, HI, KS, KY, MN, NM, NY, OR, PA, PR, TX, VA, WA, and WI
Applicable Integrated Plan PBPs	95	CA, FL, ID, MA, MN, NJ, NY, PR, TN, VA, and WI
Coordinated-Only D-SNP PBPs	343	AL, AR, CA, CO, CT, DC, FL, GA, IA, IN, KY, LA, MD, ME, MI, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, TN. TX, UT, VA, WA, WI, and WV
HIDE/FIDE SNP PBPs that provide behavioral health services under a capitated contract with state Medicaid agencies	227	AZ, FL, HI, ID, KS, KY, MA, MN, NE, NJ, NM, OR, PR, TN, TX, VA, WA, and WI
HIDE/FIDE SNP PBPs that provide long term supports and services under a capitated contract with the state Medicaid agency	117	AZ, CA, FL, HI, ID, KS, KY, MA, MN, NJ, NM, NY, PA, TN, TX, VA, and WI

[xii] A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization (MCO) to provide Medicaid benefits, including long-term services and supports (LTSS) and behavioral health benefits, consistent with state policy. Sharon Donovan, Dual Eligible Special Needs Plans, "CY2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)", memorandum, October 7, 2019, Program Alignment Group. Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf

[xiii] Sharon Donovan, Dual Eligible Special Needs Plans, "Results from the CY2021 State Medicaid Agency Contract (SMAC) Review and Release of the Dual Eligible Special Needs Plan (D-SNP) Management Module in the Health Plan Management System (HPMS)", memorandum, November 24, 2020, Program Alignment Group. Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

[xiv] A set of benefits for a defined Medicare Advantage service area.

Next Steps

HMA continues to analyze Medicare Advantage and Medicaid policies and practices for dual-eligible individuals. For more information or questions about this update or D-SNP related polices, please contact Julie Faulhaber, Mary Hsieh, or Sarah Barth.

HMA Medicaid Roundup

District of Columbia

Washington, DC Judge Rules Medicaid Managed Care Procurement Violated Law. *The Washington Post* reported on December 16, 2020, that a District of Columbia Contract Appeals Board judge has ordered the District to reassess its Medicaid managed care contracts after finding procurement law violations. The $1.5 billion contracts were awarded to AmeriHealth Caritas, CareFirst Blue Cross Blue Shield Community Health Plan (formerly known as Trusted Health Plan), and MedStar Family Choice. Incumbent Anthem/Amerigroup challenged the decision after failing to secure a contract. Judge Nicholas Majett sided with Amerigroup, which had disputed the bid scoring. All beneficiaries may stay on their current plans through the end of September 2021. Read More

Florida

Florida Medicaid Finds $89.6 Million Differential Between Prices Paid to PBMs, Prices Paid to Pharmacies. The Florida Agency for Health Care Administration (AHCA) released on December 1, 2020, a report on pharmacy benefit management (PBM) pricing practices, finding that the difference between health plan-to-pharmacy benefit management (PBM) payments and PBM-to-pharmacy payments in the Florida Medicaid program was $89.6 million over the most recent 12-month period. Plans in spread arrangements pay PBMs $91.20 per claim, and PBMs reimburse pharmacies $82.56 per claim, a 9.5 percent spread. The spread in pass-through contracts is zero; however, plans do pay PBMs a small dispensing fee.

Hawaii

Hawaii Medicaid Plans Sought to Limit Number of Award Winners in Current Procurement. *Health Payer Specialist* reported on December 14, 2020, that some Medicaid plans sought to limit the number of winners in the Hawaii QUEST Integration Medicaid managed care procurement. Awards are expected to be announced in February with a July 2021 start date. Earlier this year, plans like Ohana Health Plan (Centene) and Hawaii Medical Service Association encouraged the state to limit the number of winning plans to four. Plans like Lana'i Community Health Center and Pacific Medical Administrative Group wanted more than four plans chosen. Plans calling for limits were among the winners announced earlier this year in a procurement that the state later rescinded in part because of COVID-19. Read More

Hawaii Health Plan Names President As Medicaid Managed Care Procurement Looms. *Health Payer Specialist* reported on December 16, 2020, that Kaiser Permanente has named Greg Christian president of its Hawaii division, overseeing the organization's health plans and hospitals. Christian, who replaces interim president Ron Vance, is also chief operating officer of Kaiser's health plan and hospital division in southern California. He reports to Julie Miller-Phipps, who oversees operations in southern California and Hawaii. Read More

Illinois

Illinois Shoots Down Plan to Close Mercy Hospital in Chicago. *The Associated Press* reported on December 15, 2020, that the Illinois Health Facilities and Services Review Board unanimously rejected a plan by Trinity Health to close Mercy Hospital in the historically Black Bronzeville neighborhood of Chicago. Trinity Health said it will return to the board in 2021. Read More

Louisiana

Nursing Homes to Receive Rate Increase. *The Associated Press* reported on December 9, 2020, that a change in payment formula will allow Louisiana's 260 nursing homes to receive about $6 million in additional reimbursements annually. State legislators have indicated they will not block the change from taking effect as scheduled on December 20. Read More

Louisiana to Release Medicaid Managed Care RFP in Spring 2021. The Louisiana Department of Health (LDH) on December 9, 2020, announced plans to release a request for proposals (RFP) for its Medicaid managed care program in spring 2021 and is seeking feedback. The deadline for all feedback is December 29, 2020. Louisiana rescinded Medicaid managed care contract awards announced last year over claims of bias by state officials and inconsistencies in the state's scoring methods. Beneficiaries continue to be served by current plans CVS/Aetna Better Health, AmeriHealth Caritas, Anthem/Healthy Blue, Centene/Louisiana Healthcare Connections, and UnitedHealthcare under emergency contract extensions, which will be extended until new contracts are awarded and implemented. Read More

Massachusetts

Massachusetts Seeks Feedback on Section 1115 Demonstration Waiver Renewal Request. The Massachusetts Executive Office of Health and Human Services announced on December 11, 2020, that it is seeking feedback on a Medicaid Section 1115 Demonstration Waiver renewal request, which it plans to submit to the Centers for Medicare & Medicaid Services (CMS) in the summer of 2021. The current waiver expires on June 30, 2022. Read More

Michigan

BCBS-Michigan to Sub-Capitate With ChenMed for Primacy Care Services Provided to Dual Eligibles. *Modern Healthcare* reported on December 14, 2020, that Blue Cross Blue Shield of Michigan has entered into an sub-capitation agreement with Florida-based ChenMed for dual eligible members in Wayne County, MI. ChenMed's Dedicated Senior Medical Centers will equip six primary care clinics with about 200 providers and staff, initially serving individual Medicare Advantage members who are seniors of moderate to low income. Dedicated will assume the risk for all inpatient and outpatient costs of care that exceed the risk-adjusted capitated payment. The new centers, which are expected to open in 2021, will offer physical and behavioral health services, coordinate with mental health providers in the BCBS-MI network, and address social determinants of health. Read More

Missouri

Missouri Announces Public Comment Period for Medicaid Waiver Renewals, Amendments. The Missouri Department of Social Services announced on December 11, 2020, the start of a public comments period for the state's Comprehensive and Community Support Medicaid waiver renewal applications as well as the Children with Developmental Disabilities (MOCDD) and Partnership for Hope (PFH) waiver amendment applications. The end of the public comment period is January 11, 2021. Read More

Oklahoma

Oklahoma Lawmakers Urge Governor to Back Away From Transition to Medicaid Managed Care. *The Tulsa World* reported on December 12, 2020, that Oklahoma lawmakers are urging Governor Kevin Stitt to back away from a plan to transition to Medicaid managed care effective October 1, 2021. More than two dozen lawmakers from mostly rural areas said in a letter to Stitt that administrative costs in the state's fee-for-service Medicaid program are only around 4 percent and are seen as a model for other states. Stitt said he hopes to have contracts in place for the program, called SoonerSelect Plan, by late winter. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Faces Lawsuit From Long-term Care Advocacy Groups Over Withholding of Funds. *CBS Pittsburgh* reported on December 8, 2020, that long-term care advocacy groups have filed a lawsuit against Pennsylvania, claiming that the state has withheld $153 million in funds from nursing homes during the COVID-19 pandemic. LeadingAge PA, the Pennsylvania Health Care Association, and the Pennsylvania Coalition of Affiliated Healthcare and Living Communities argue the funds could be used for personal protective equipment, testing, and the distribution of a vaccine. The lawsuit was filed in Commonwealth Court. Read More

South Carolina

South Carolina Medicaid Director to Step Down. *The Lexington Herald-Leader/The Associated Press* reported on December 15, 2020, that South Carolina Medicaid director Joshua Baker will step down on January 11, 2021. Governor Henry McMaster has not yet named a successor. Read More

Texas

Texas Sees High Early Turn Out for Exchange Open Enrollment. *The Dallas Morning News* reported on December 14, 2020, that average daily enrollment in Texas Exchange plans rose 22 percent statewide from November to December 5, compared to last year. It is the largest increase of any state and twice the nationwide average. Over 1.1 million Texans selected an exchange plan for this year. The number of options available is also up, with six different insurers offering plans on the Exchange in Texas, twice as many as two years ago. About 86 percent of Texans who selected an Exchange plan last year qualified for subsidies. Read More

Virginia

Virginia Medicaid Expansion Costs Help Drive Overall State Spending Increase, Report Finds. *The Center Square* reported on December 8, 2020, that Medicaid expansion costs in Virginia helped drive a 16.2 percent increase in total state expenditures in fiscal 2020, according to a report by the National Association of State Budget Officers (NASBO). Federal COVID-19 relief funds were also a driver. Read More

National

HHS Releases Proposed Interoperability Rule for Medicaid, CHIP, Exchange Plans. *Modern Healthcare* reported on December 15, 2020, that the U.S. Department of Health and Human Services (HHS) released a proposed interoperability rule that would require Medicaid, Children's Health Insurance Program (CHIP), and Exchange plans on the federal platform to implement application program interface guidelines aimed at improving health information exchange and speeding up prior authorization. HHS hopes to implement the rule, which would apply to managed care plans and fee-for-service programs, by January 1, 2023. Public comments are due January 4, 2021. Read More

MACPAC Releases 2020 MACStats Medicaid, CHIP Data Book. The Medicaid and CHIP Payment and Access Commission (MACPAC) released on December 16, 2020, the 2020 edition of the *MACStats: Medicaid and CHIP Data Book,* which includes Medicaid and Children's Health Insurance Program (CHIP) data on eligibility and enrollment, benefits, service use, access to care, and state and federal spending. Highlights from the report include:

- Medicaid and CHIP enrollment increased 5.6 percent from July 2019 to July 2020.
- About half of Medicaid spending for beneficiaries was for managed care capitation payments.

- Drug rebates reduced gross drug spending by over half in fiscal 2019, with 63.3 percent of Medicaid gross spending for drugs occurring under managed care.
- Medicaid and CHIP together accounted for 16.9 percent of national health expenditures in 2018, compared to 20.6 percent for Medicare or 34.1 percent for private insurance. Read More

Stopgap Funding Bill Temporarily Staves Off Government Shutdown. *Politico* reported on December 11, 2020, that the U.S. Senate passed a one-week stopgap funding bill, averting a government shutdown and buying Congress more time to negotiate a $1.4 trillion omnibus spending package and billions of dollars in pandemic assistance. Congress has until December 18 to finalize the funding package. Read More

States Can Regulate Pharmacy Benefits Management Companies, Supreme Court Rules. *USA Today* reported on December 10, 2020, that states can regulate pharmacy benefit management (PBM) companies, the U.S. Supreme Court ruled. Judges were unanimous that federal law does not supplant state regulation of PBMs. At least 40 states have laws or regulations governing PBMs. Read More

CMS Proposes Rule to Streamline Prior Authorization, Improve Data Exchange. *Modern Healthcare* reported on December 10, 2020, that the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule aimed at streamlining prior authorization and improving data sharing between payers and providers. The rule, which would take effect on January 1, 2023, would require Medicaid, Children's Health Insurance Program (CHIP), and Exchange plans to build application programming interfaces for data exchange and prior authorization. The deadline for public comment on the proposed rule is January 4, 2021. CMS is considering a similar proposal for Medicare Advantage plans. Read More

HHS Issues Final Rule on 340B Dispute Resolution Process. *Modern Healthcare* reported on December 10, 2020, that the U.S. Department of Health and Human Services (HHS) issued a final rule establishing a dispute resolution process for the 340B drug discount program. The final rule allows 340B covered entities to force drug makers into a dispute resolution process that would result in a binding decision by HHS. Read More

HHS Has Two Years to Review 2,400 Health Regulations Under Proposed Rule. *Kaiser Health News* reported on December 10, 2020, the U.S. Department of Health and Human Services (HHS) would review about 2,400 regulations by 2023 and automatically void those not assessed in time under a proposed rule. HHS estimates the reviews could cost up to $19 million over two years. If the rule is finalized before Inauguration Day on January 20, 2021, the incoming Biden administration would be able to undo it. Read More

HHS Faces Lawsuit Over Relaxed Medicare 340B Drug Discount Program Enforcement. *Modern Healthcare* reported on December 12, 2020, that the U.S. Department of Health and Human Services (HHS) is facing a lawsuit from six healthcare provider associations and three hospitals, accusing HHS of not enforcing requirements that drug companies provide discounted drugs to hospitals in the Medicare 340B drug pricing program. The group is seeking an order that HHS require drug companies to provide 340B discounts on drugs dispensed at community-based pharmacies, refunds to hospitals that were refused discounts, and penalties against drug companies involved. Read More

Industry News

BayMark Acquires Maine-based Liberty Bay. BayMark announced on December 15, 2020, the acquisition of substance use disorder (SUD) residential treatment facility Liberty Bay in Portland, ME. Currently, BayMark has one other residential treatment facility in Ontario, Canada and two medication-assisted treatment facilities in Maine. BayMark serves over 53,000 patients in recovery from SUD in the United States and Canada. Read More

Federal Judge's Ruling Clears Way for Merger of Jefferson Health, Albert Einstein Healthcare Network. *Modern Healthcare* reported on December 8, 2020, that U.S. District Court Judge Gerald Pappert dismissed an antitrust lawsuit brought by the Federal Trade Commission and the Pennsylvania Attorney General that sought to block a merger between Jefferson Health and Albert Einstein Healthcare Network. The deal will add three acute care hospitals and a rehab hospital to Jefferson's 14-hospital network. Read More

Centene to Acquire PANTHERx. Centene announced on December 15, 2020, that it has signed a definitive agreement to acquire PANTHERx, a specialty pharmacy focusing on orphan drugs and rare diseases. PANTHERx will become part of Centene's Envolve Pharmacy Solutions, which offers integrated pharmacy benefit management and specialty pharmacy services. The deal is expected to close by the end of 2020. Read More

Adult Day Care Providers Struggle With Limits on Capacity, Funding. *Home Health Care News* reported on December 10, 2020, that adult day operators are struggling with the financial impact of COVID-19, including limits on capacity and a lack of major federal funding. Adult day care providers did not receive phase one relief funds and only limited access to phase two funds. There are about 5,500 adult day service providers nationwide. Read More

Addus HomeCare Corporation Acquires AZ-based SunLife HomeCare. Hospice care provider Addus HomeCare Corporation announced on December 7, 2020, the acquisition of Arizona-based personal care provider SunLife HomeCare. Addus, which completed four acquisitions this year, provides hospice, home health, and personal care services to approximately 44,000 patients in 25 states. Read More

Acadia, Henry Ford Health System to Open Behavioral Health Hospital in Detroit Area. *Modern Healthcare* reported on December 9, 2020, that behavioral health provider Acadia Healthcare and Henry Ford Health System will open a behavioral health hospital in suburban Detroit by late 2022. The 192-bed hospital would be approximately 20 percent owned by Henry Ford, which will contribute land adjacent to its West Bloomfield Hospital campus. Acadia will pay $50 million in projected construction, equipment, and annual operating costs. Read More

CareFinders Acquires PA-Based Home Care Provider. CareFinders Total Care announced on December 9, 2020, that it has acquired Union Home Care, a provider of in-home healthcare, further expanding its presence in Pennsylvania. Mila Mendel, the founder of Union Home Care, will become the executive director of CareFinders' Philadelphia Division. CareFinders provides services to more than 8,500 patients in New Jersey, Connecticut, and Pennsylvania.

Encompass Health Evaluates Options for Home Health, Hospice Business. *Modern Healthcare* reported on December 9, 2020, that Encompass Health, an inpatient rehabilitation hospital and home health provider, is evaluating options for its home health and hospice business, including a potential public offering, spin-off, merger, sale, or other transactions. The Alabama-based provider operates 137 hospitals, 242 home health locations, and 83 hospice locations in 39 states and Puerto Rico. Read More

LogistiCare Announces Partnership with Lyft, Care Finders Total Care to Transport Home Health Aides. LogistiCare announced on December 10, 2020, that it is partnering with Care Finders Total Care, the largest non-medical homecare agency in New Jersey, and Lyft in a pilot program to transport home health aides to patients' homes. This partnership, which has garnered the support of the Home Care & Hospice Association of New Jersey, further expands LogistiCare's relationship with the New Jersey Department of Human Services, which began with transportation of Medicaid patients and expanded to include the delivery of food and groceries. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
December 23, 2020	North Dakota Expansion	Proposals Due	19,800
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 1, 2021	Oklahoma	Awards	742,000
February 2, 2021	North Carolina - BH IDD Tailored Plans	Proposals Due	*NA*
February 8, 2021	Hawaii Community Care Services	Awards	4,500
February 15, 2021	Hawaii Quest Integration	Proposals Due	378,000
March 15, 2021	Hawaii Quest Integration	Awards	378,000
Spring 2021	Louisiana	RFP Release	1,550,000
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	378,000
July 1, 2021	Hawaii Community Care Services	Implementation	4,500
October 1, 2021	Oklahoma	Implementation	742,000
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 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

AddictionFreeCA Website Updated. In support of four ongoing projects in California to address opioid use disorder (OUD), substance use disorder (SUD), and medications for addiction treatment (MAT), the website, **AddictionFreeCA.org**, has been updated and relaunched to better serve program participants, legislators, public agency leaders, and additional government stakeholders.

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Special Needs Plans (SNP) Enrollment by State and Plan, Nov-20 Data
- U.S. Historical Medicaid, Expansion Enrollment by State, 2013-Jun-19
- Alabama SNP Membership at 87,096, Nov-20 Data
- Arkansas SNP Membership at 62,767, Nov-20 Data
- Arizona SNP Membership at 119,908, Nov-20 Data
- Colorado SNP Membership at 24,406, Nov-20 Data
- Florida SNP Membership at 474,560, Nov-20 Data
- Idaho SNP Membership at 11,753, Nov-20 Data
- Idaho Dual Eligible Enrollment Is Up 28.1%, 2020 Data
- Missouri Section 1915c Draft Waiver Amendments, Dec-20
- Ohio Dual Demo Enrollment is Up 11.6%, Nov-20 Data
- Ohio Medicaid Managed Care Enrollment is Up 13.1%, Nov-20 Data
- Pennsylvania Medicaid Community HealthChoices Enrollment at 379,031, Oct-20 Data
- Rhode Island Dual Demo Enrollment is Down 8.4%, Nov-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Ohio Medicaid Advanced Data Analytics Tool RFP, Dec-20

Medicaid Program Reports, Data and Updates:

- CMS Actuarial Report on the Financial Outlook for Medicaid, 2017-18
- CMS Comprehensive Medicaid Integrity Plan, FY 2014-23
- CMS Medicare-Medicaid Coordination Report to Congress, FY 2017-19
- Florida PBM Pricing Practices in Medicaid Managed Care Report, Dec-20
- Indiana Medicaid Advisory Committee Meeting Materials, Nov-20
- Louisiana Health Insurance Surveys, 2011-19
- MACPAC MACStats Medicaid and CHIP Data Books, 2018-20
- Maryland Medicaid Advisory Committee Meeting Materials, Nov-20
- Pennsylvania Medical Assistance Advisory Committee (MAAC) Meeting Materials, Dec-20
- Pennsylvania OVR MLTSS Subcommittee Meeting Materials, Dec-20
- Rhode Island Medical Care Advisory Committee Meeting Materials, Dec-20
- South Dakota Medicaid Advisory Committee Meeting Materials, Nov-20

- Texas Superior HealthPlan Nursing Facility STAR+PLUS Outlier Processing Audit, Nov-20
- Washington Medicaid Title XIX Advisory Committee Meeting Materials, Nov-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

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With 22 offices and over 200 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.