HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

January 19, 2022

RFP CALENDAR
HMA News

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IN FOCUS

CMS SEEKS NEW DIRECTION FOR MEDICARE ADVANTAGE AND PART D MARKETS ON HEALTH EQUITY, DUAL ELIGIBLE INTEGRATION

This week, our *In Focus* section highlights the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicare Advantage (MA) and Part D programs for contract year 2023 and how these changes may impact plan applications, bid submissions, and market dynamics for future years. The

analysis and insight reflect the combined expertise of HMA and its companies including the Wakely Consulting Group and The Moran Company.

The proposals for contract year 2023 reflect CMS' policy priorities and signal the future direction for the Medicare Advantage and Part D landscape, including strategies the agency will utilize to address health disparities, controlling prescription drug costs for beneficiaries, and encouraging competition focused on access to and quality of services. We expect the final rule to include modified versions of many proposals to address stakeholders' operational concerns. However, the agency is likely to maintain the overarching policy direction when it finalizes the rule this spring. The emerging trends include:

- CMS is moving to make benefit information more transparent, understandable, and applicable to Medicare beneficiaries diverse health and health-related needs.
- The rule reflects a renewed interest in better integrating care for Medicare and Medicaid dually eligible individuals. This is most evident in the combination of new federal requirements and CMS' creation of pathways for sharing information and partnering with state Medicaid agencies.
- CMS is reverting to more detailed data collection and oversight policies, particularly in areas of notable cost growth or noncompliance such as Medical Loss Ratio. This data collection could compel behavior changes among plans and/or future policy changes.
- Reporting on supplemental benefit expenditures for dental, vision, and hearing services could inform future legislative and regulatory changes with respect to these services.

HMA summarizes and discusses the potential implications of major proposals in the proposed rule below.

Network adequacy. CMS is proposing to revise the timeline for reviewing network submissions for new applicants and plans or those seeking to expand their service. Beginning with contract year 2023, CMS intends to review plans' compliance with network standards during the annual application review process, rather than allowing them to attest to meeting the standard at that point in the process. CMS noted that in recent years plans were adjusting their network service areas later in the review process, creating challenges with meeting the compliance deadline and adjusting bids accordingly. This policy is expected to streamline CMS' review of plan applications by addressing network requirements earlier in plan application and bid review process while providing more certainty around plan specific service areas.

- ***Takeaway***: CMS is proposing to provide applicants a 10-percentage point "credit" for plans that may need more time to build their networks. We expect significant stakeholder input on the feasibility of this requirement as well as the sufficiency of the 10-percentage point credit. While initially onerous to shift the timeline for submission, the earlier review could provide plans more time to address CMS' feedback and incorporate this in bid submissions.

Medical Loss Ratio. CMS proposes to reinstate detailed MLR reporting requirements using the MLR Reporting Tool that was used from 2014 through

2017. CMS also intends to collect additional data on certain categories of expenditures, including MA supplemental benefit expenditures by benefit category.

- ***Takeaway***: Several stakeholders, notably The Medicare Payment Advisory Commission (MedPAC), have highlighted the lack of information about plans' spending and utilization associated with MA supplemental benefits. The new data that CMS is requiring will provide both CMS and external parties more insight into this area of plan operations. It may also allow plans to differentiate their offerings for beneficiaries and compete. This is an area to monitor as additional data on plan expenditures could determine the feasibility of future statutory changes to Medicare benefits.

Prescription drugs. CMS proposes to address costs incurred by Medicare Part D enrollees at the pharmacy point of sale. Specifically, CMS proposes to begin requiring in 2023 that the negotiated price reflect the lowest possible pharmacy reimbursement, inclusive of performance-based payment arrangements, for purposes of determining beneficiary cost-sharing. CMS highlights that it is not interfering with the Part D market by requiring modifications to contracts, but instead mandating that pharmacy price concessions be included in the point-of-sale calculation, which is used to determine beneficiary cost-sharing. However, it remains unclear how plans and PBMs would operationalize this change, and whether the actual point-of-sale payment to the pharmacy would shift to this lower amount with potential bonuses based on performance, or whether plans would continue to pay the current amounts at point-of-sale but submit a different price to CMS.

- ***Takeaway*:** Based on its analysis, CMS expects this proposal to lower average beneficiary cost-sharing by $57 per person and increase average annual premiums by $20**.** While this issue is likely one that will primarily impact the contracting relationship and dynamics between Pharmacy Benefit Managers and pharmacies, there are potential impacts on Part D plans and enrollees. CMS expects this proposal to lower cost-sharing for enrollees. However, it is also possible that the policy could drive changes in plan benefit design that negates the benefits for enrollees. Commenters are expected to address unintended consequences of this proposal on beneficiary costs as well as the potential for plan designs that could exacerbate health inequities.

Maximum Out-of-Pocket (MOOP). CMS proposes that the MOOP must be calculated based on accrual of all cost sharing in the plan benefit, whether paid by the beneficiary, Medicaid, or other secondary insurance (or remains unpaid because of limits on amounts). Currently, plans are only required to consider the enrollee's actual out-of-pocket, which can result in some enrollees never actually reaching the MOOP. CMS is concerned that providers may be reluctant to provide care to high-cost dual-eligible individuals, since in many cases a state uses a 'lesser-of' policy for cost share payments. CMS proposes to require plans to track and alert enrollees and contracted providers when the MOOP limit is reached.

- ***Takeaway***: CMS expects this policy to increase bids, lower state payments, and increase total payments to providers. Currently, roughly half of Dual-eligible Special Needs Plans (D-SNP) apply the full 20 percent coinsurance for physician visits. CMS notes that some D-SNPs

also do not count any cost-sharing toward the MOOP if the payment came from the State. These D-SNPs will likely need higher bids, which could either reduce rebate dollars or put pressure on plan margins. D-SNPs may also need to revisit their physician cost-sharing benefit given the proposed revision to the MOOP calculation.

D-SNPs and the Medicare and Medicaid Dually Eligible Population. The most extensive area of potential policy change is found in the integrated plan options for the Medicare and Medicaid dually eligible population as well as proposals to support dually eligible individuals with selecting a plan. CMS' proposals include definitional changes for certain types of D-SNPs, new requirements for D-SNPs such as a requirement to have an enrollee advisory committee, and new contracting authorities for state Medicaid agencies.

Specifically, starting in contract year 2025, CMS plans to require fully integrated dual eligible (FIDE) SNPs to have exclusively aligned enrollment. In other words, a FIDE SNP would refer to a plan that includes dually eligible individuals enrolled in the D-SNP and receiving coverage of Medicaid benefits from the D-SNP or from a Medicaid MCO that is the same organization or the parent organization of the MA organization offering the D-SNP (or another entity that is owned and controlled by the D-SNP's parent organization). FIDE SNPs would also have to cover Medicaid home health, durable medical equipment, and the vast majority of behavioral health benefits *and* long-term services and supports through a capitated contract with the state Medicaid agency (with limited exceptions). In addition, FIDE SNPs would be required to cover Medicare cost-sharing for acute and primary care for full-benefit dually eligible enrollees.

CMS' proposed changes to HIDE SNPs are intended to help differentiate various types of D-SNPs, clarify options for beneficiaries, and improve integration. A highly integrated dual eligible (HIDE) SNP would include a plan having a capitated contract between the Medicare Advantage organization and a state Medicaid agency. The HIDE SNP must cover the vast majority of Medicaid behavioral health *or* the vast majority of long-term services and supports (with limited exceptions).

Under CMS' proposals, states would gain new authority to require and encourage integration for dually eligible individuals. For example, states could use contracting authority to require certain D-SNPs with exclusively aligned enrollment to (a) establish contracts that only include one or more D-SNPs within a state, and (b) integrate materials and notices for enrollees. CMS also intends to improve coordination with states around monitoring and oversight of D-SNPs, when a state chooses to pursue higher levels of integration. For the first time, CMS proposes to provide states with D-SNPs access to certain information systems.

- ***Takeaway***: These and several other proposed changes in the rule collectively reflect over two decades of experience with D-SNPs and demonstration initiatives to better integrate care for dually eligible individuals. In addition, the proposals are clearly linked to CMS' goals for addressing health equity for this population. Plans and providers should begin to assess and develop strategies to respond to the enhanced requirements for D-SNPs, particularly FIDE and HIDE SNPs. Specific attention is needed to understand the alignment opportunities and how these vary within and across states.

States may need to reassess their strategy to ensure ongoing alignment with plans under the proposed policies. States may also gain authority to execute significant policy and contractual decisions for D-SNPs and pursue the new coordination options with CMS. If finalized, the proposed changes could strengthen integration initiatives in more mature states and give new tools for other states to consider. This will require plans to enhance their coordination and engagement with CMS and states.

Star Ratings. CMS proposes a limited number of changes and largely maintains current policy. All contracts will receive the higher of their 2022 or 2023 Star Rating (and corresponding measure score) for the three HEDIS measures collected through the 2021 HOS survey. CMS intends to address other disaster-related changes concerning 2021 and 2022 Star Ratings in future rulemaking.

- ***Takeaway:*** While this proposed rule includes few major changes to the Star Rating program, CMS may utilize forthcoming guidance to lay the groundwork for other major changes to the program.

HMA's Medicare practice has deep experience with the development and implementation of best practices to improve compliance with Medicare Advantage and Part D regulations. Specifically, we have been working with clients to understand the potential impact of these policy changes to improve Star Rating performance and helping plans achieve economies of scale around maximizing their year-round Medicare stars strategy. For information on our Medicare practice, please contact HMA colleagues Julie Faulhaber, Amy Bassano, Eric Hammelman, Aimee Lashbrook, Andrea Maresca, Tim Courtney or Kevin Kirby.

HMA Medicaid Roundup

Alabama

Alabama Senator Proposes 'Rainy Day' Medicaid Fund. *Yellowhammer News* reported on January 16, 2022, that Alabama Senator Steve Clouse (R-Ozark) proposed investing federal funds in a state Medicaid "rainy day" fund. Clouse, who made the comments in an interview, also did not rule out the possibility of Medicaid expansion but added that it is "hard to say" whether expansion would occur. Read More

California

California Bill to Create a Universal Healthcare System Clears Assembly Health Committee. *The Sacramento Business Journal* reported on January 12, 2022, that the California Assembly Health Committee passed a bill to create CalCare, a state-run, single-payer, universal healthcare plan. To fund CalCare, the bill would impose a 2.3 percent excise tax on businesses with more than $2 million in annual gross receipts, a 1.25 percent payroll tax on employers with 50 or more employees in the state, an additional one percent payroll tax on employees making over $49,900 per year, and a new marginal income tax on individuals making over $149,509 per year. The bill has been referred to the Appropriations Committee. Read More

Governor Plans to Expand Health Coverage to Undocumented Residents. *The Sacramento Business Journal* reported on January 12, 2022, that California Governor Gavin Newsom plans to expand Medicaid coverage to all eligible adults, regardless of immigration status. Newsom has previously extended Medicaid coverage to all eligible individuals under the age of 26 and over 50. The new plan would cover an additional 764,000 individuals between the ages of 26 and 50. The governor projects the cost to be $819.3 million in 2023 and $2.7 billion annually when the program is fully implemented. Read More

Colorado

Colorado Mental Health Providers Report Delays in Medicaid Credentialing. *The Colorado Sun* reported on January 18, 2022, that Colorado mental and behavioral health providers seeking to serve Medicaid beneficiaries are experiencing long credentialing delays from regional accountable entities (RAEs). While the state reported a 35 percent increase in Medicaid mental health providers between 2019 and 2021, some are not yet able to serve patients because of a lack of RAE credentials. Read More

Florida

Florida Will Not Enforce Federal COVID-19 Vaccine Mandate, Governor Says. *McKnight's Long-Term Care News* reported on January 19, 2022, that Florida state surveyors will not check whether healthcare facilities are in compliance with the federal COVID-19 vaccine mandate, according to Governor Rick DeSantis. Separately, many Florida providers are working to comply with the mandate, which was upheld by the U.S. Supreme Court. Read More

Legislators Advance Two Telehealth Bills. *Florida Politics* reported on January 13, 2022, that the Florida House and Senate have each moved respective telehealth bills out of committees. Both bills allow telehealth providers to renew prescriptions for some medications but differ on laws banning audio only devices for telehealth. Read More

Georgia

Georgia Governor's Budget Proposal Includes Funds for New Insurance Exchange, But Not Medicaid Expansion. *Georgia Health News* reported on January 16, 2022, that Georgia Governor Brian Kemp's proposed budget for fiscal 2023 includes $15 million to create an insurance Exchange run by private insurers and brokers, an approach not yet approved by federal regulators. Georgia currently uses the federal Healthcare.gov Exchange. The budget also includes $85 million for higher Medicaid physician rates, $1 million to address rural physician shortages, and additional spending on mental health and developmental disabilities. The proposal does not include Medicaid expansion. Read More

Illinois

Medicaid Department, Nursing Homes Differ on Payment Reform. *Health News Illinois* reported on January 13, 2022, Illinois Senator Ann Gillespie (D-Arlington Heights) and others filed a bill to establish a patient-driven nursing home payment model for Medicaid, including funding for staffing increases and workforce transformation. Gillespie's bill is supported by the state Department of Healthcare and Family Services. However, the state nursing home association opposes the bill and instead has backed legislation proposed by Representative Elizabeth Hernandez (D-Cicero) to increase the skilled nursing facility bed tax as a means of increasing funding. Read More

Kentucky

Kentucky Governor Budget to Fully Fund Medicaid For 2022-24 Biennium. *The Times Tribune* reported on January 14, 2022, that Governor Andy Beshear's proposed budget fully funds the state's Medicaid program for the 2022-24 biennium. The proposal also provides funds for nursing scholarships and additional slots in waivers for supports for community living and for individuals with intellectual or developmental disabilities. Read More

Louisiana

Louisiana Releases Medicaid Pharmacy Benefit Management Services RFP. The Louisiana Department of Health released on January 14, 2022, a request for proposals for a single pharmacy benefit manager (PBM) for the state's five Medicaid managed care organizations (MCOs), serving approximately 1.7 million members. Each MCO currently contracts with a separate PBM. The contract will be executed around May 2, 2022, and run for three years with two one-year renewal options. Read More

Minnesota

Minnesota Releases Medicaid Managed Care, MinnesotaCare RFP For 80 Counties. The Minnesota Department of Human Services (DHS) released on January 18, 2022, a Medicaid managed care request for proposals (RFP) for the state's Families and Children Medical Assistance (MA) and MinnesotaCare Basic Health programs for the 80 counties covering the state outside of the Twin Cities seven-county region. The state will award contracts to at least two MCOs in each county. Contracts will run for one year beginning on January 1, 2023, with five optional years. Proposals are due April 1, 2022. Incumbents are Blue Plus/BCBS of Minnesota, Health Partners, Itasca, PrimeWest Health, South Country Health Alliance, and UCare Minnesota, serving nearly 470,000 members. The state recently awarded contracts for the Twin Cities metro area serving 600,000 members to Blue Plus, HealthPartners, Hennepin Health, Medica, UCare, and UnitedHealthcare. Read More

Missouri

Missouri Receives 3 Bids for MO HealthNet Medicaid Managed Care Program. The Missouri Department of Social Services announced on January 12, 2022, that Centene/Home State Health Plan, Anthem/Healthy Blue, and UnitedHealthcare submitted bids for the recently released request for proposals for MO HealthNet Medicaid program. All three plans are current incumbents. One of the three plans will also win a contract for a single, statewide specialty plan for foster children and children receiving adoption subsidy assistance. MO HealthNet serves almost 900,000 members, including the state's newly implemented Medicaid expansion population. The contract will be effective for one year with four one-year renewal options. Read More

Montana

Montana Nursing Homes Struggle with Low Medicaid Reimbursement Rates, Rising Costs. *The Billings Gazette* reported on January 16, 2022, that nursing homes in Montana are struggling with rising costs and low Medicaid reimbursement rates, exacerbated by the end of CARES act funding in May 2021 and the scheduled end of American Rescue Plan Act funding in May 2022. Read More

New Mexico

New Mexico Moves to Effectuate HCBS Spending Plan. The Centers for Medicare & Medicaid Services announced on January 14, 2022, that New Mexico is seeking waiver amendments necessary to effectuate the home and community-based services outlined in a state spending plan for funds from the American Rescue Plan Act. The changes include an additional 1,000 community benefit allocation slots for individuals not eligible for Medicaid but requiring nursing facility level of care, increased limits on funding for community transition services for individuals moving from institutional to community care, and increased limits on funding for equipment or to modify physical spaces to increase an individual's independence. Public comments will be accepted through February 13. Read More

New Mexico Plans to Extend Medicaid Postpartum Coverage to One Year. *The NM Political Report* announced on January 13, 2022, that the New Mexico Human Services Department announced plans to extend postpartum Medicaid coverage from two months to one year for 17,000 individuals, effective April 1. Governor Michelle Lujan Grisham's proposed budget for fiscal 2023 includes $14.4 million to implement the change. Read More

New York

New York Governor Proposes Competitive Bidding for Medicaid Plan Contracts. New York Governor Kathy Hochul released on January 18, 2022, a budget proposal, which included a plan to competitively procure Medicaid managed care organizations (MCOs), in contrast to the current process in which Medicaid plans simply need state approval to enter the market. The procurements, which would be handled by the state Department of Health (DOH), would involve mainstream Medicaid plans, health and recovery plans, and managed long-term care plans. The state could still contract directly with HIV Special Needs Plans. Under the proposal, the state would halt the current application and renewal process effective April 1, 2022. Requests for proposals would be posted on the DOH website. At least two MCOs would be awarded for each geographic region as defined in the RFP, with no more than five contracts in any one region. The Governor will negotiate her fiscal plan with the state legislature and develop a final budget agreement, which must be approved by April 1, when fiscal 2023 begins.

New York Releases Updated Value-based Payment Roadmap With No Material Changes to Requirements. The New York State Department of Health announced on January 19, 2022, no material changes to the requirements for health plans and providers participating in the state's value-based payment (VBP) initiative. The state released for public comment an updated version of *A Path toward Value Based Payment, New York State Roadmap for Medicaid Payment Reform,* which governs expectations for managed care plans and providers as they move to VBP. The public comment period will run until February 18, 2022. Read More

New York Governor Proposes Medicaid Rate Increases in Fiscal 2023 Budget. New York State Governor Kathy Hochul proposed in her budget address on January 18, 2022, a fiscal 2023 state budget that would allocate $3.7 billion to restore the 1.5 percent Medicaid reimbursement rate reduction from 2021 and to increase the reimbursement rate by an additional 1 percent across the board. Another $2.8 billion is allocated for payments to safety net hospitals. The proposed budget also includes $10 billion to strengthen the healthcare workforce across the state and a $1.6 billion capital program for improvements to healthcare facilities and nursing homes and to expand ambulatory care infrastructure for financially distressed hospitals. Details on the actual provisions will be available when specific budget bills are released. Read More

Correction: New York Healthy Homes Collaborative. The New York Healthy Homes Collaborative project to address the underlying causes of asthma will be funded by the Green & Healthy Homes Initiative (GHHI) and Northern Trust. A prior version of this article incorrectly implied that The JPB Foundation was also directly funding the asthma program. Read More

Ohio

Ohio Failed to Recoup More Than $118 Million in Improper Medicaid Payments. *Richland Source* reported on January 13, 2022, that the Ohio Department of Medicaid failed to recoup more than $118 million in improper payments for individuals who were incarcerated, deceased, or had duplicate identification numbers, according to a recent state audit. The audit also found $84 million in other potentially erroneous payments that require further investigation. Read More

Oregon

Oregon Lawmakers Are Briefed on Progress of Medicaid Waiver Renewal Application. *State of Reform* reported on January 12, 2022, that the Oregon Senate Interim Committee on Health Care was briefed on the status of the the state's Medicaid 1115 waiver renewal application, which focuses on improving access, outcomes, and health equity. The current waiver expires in June 2022, but a federal extension is expected while the state wraps up negotiations. In December 2021, a draft application was published for comment. Read More

Texas

Texas Seeks Repayment of $10 Million in Medicaid Funds from Planned Parenthood. *Jurist* reported on January 14, 2022, that the state of Texas filed a federal lawsuit seeking repayment of $10 million in Medicaid reimbursements from Planned Parenthood. The complaint says that Planned Parenthood improperly continued to receive Medicaid funds after it was terminated from the program in 2017. Read More

Texas Fulfills Outreach, Information Obligations of Medicaid Screening Program for Children, Judge Rules. *Bloomberg Law News* reported on January 13, 2022, that Texas fulfilled the outreach and information obligations of an 11-part corrective action plan for improving early and periodic screening, diagnosis, and treatment (EPSDT) services for children on Medicaid, according to a federal judge. The corrective action plan is part of a settlement of a class action lawsuit brought on behalf of 1.5 million children eligible for the EPSDT program. Read More

Utah

Utah Seeks Approval for Medical Respite, Fertility Preservation Amendments to Primary Care Network Waiver. The Utah Department of Health submitted for federal approval on January 13, 2022, two amendments to the state's Primary Care Network demonstration waiver, which offers primary care services to certain non-disabled adults. The first amendment would provide temporary medical respite care to homeless Medicaid adults. The second amendment would expand Medicaid coverage for fertility preservation services for individuals with cancer. Federal comments for both amendments will be accepted through February 12.

Wisconsin

Wisconsin Releases HCBS Care Management System RFP. The Wisconsin Department of Health Services released on January 14, 2022, a request for proposals for a care management solution that supports the state's Include, Respect, I Self-Direct (IRIS) program. The contract, which is part of the state's broader Medicaid enterprise system procurement, is expected to go live in January 2024, after a one year design, development, and implementation phase. The contract will run for three years. IRIS helps beneficiaries in the design and implementation of home and community-based services as an alternative to institutional care. IRIS serves the frail elderly and adults with physical and developmental disabilities who have long-term care needs and are Medicaid eligible.

National

HHS Provides $13 Million in Funding to Address Behavioral Health Care Access, Health Inequities in Rural Communities. The U.S. Department of Health and Human Services (HHS) announced on January 18, 2022, $13 million in funding to increase access to behavioral health care services and address health inequities in rural areas. Funding will be awarded through the Rural Communities Opioid Response Program – Behavioral Health Care Support. Applications are due April 19, 2022. Read More

MedPAC Votes Against Additional Medicare Payment Rate Increases for Hospitals, Doctors. *Fierce Healthcare* reported on January 13, 2022, that the Medicare Payment Advisory Commission (MedPAC) voted against payment rate increases for acute care hospitals and doctors for 2023 beyond the amounts determined under current law. MedPAC, which estimated that rates will increase by two percent, said that federal COVID-19 relief funds obviated the need for additional pay hikes. The Centers for Medicare & Medicaid Services will publish its update to current payment rates this summer. Read More

MedPAC Outlines Alternative Payment Models With Varying Risk Based on ACO Size. *Modern Healthcare* reported on January 14, 2022, that the Medicare Payment Advisory Commission (MedPAC) outlined a potential alternative payment model for accountable care organizations (ACO), with varying risk levels for small, medium, and large organizations. Independent physician practices, small safety net providers, and rural providers could keep 50 percent of savings with no downside risk. Multi-specialty physician practices and small community hospitals could keep up to 75 percent of savings, with 75 percent downside risk. Large health systems could keep 100 percent of savings, with 100 percent downside risk. Read More

CMS Gives Healthcare Workers Until February 14 to Comply with COVID-19 Vaccine Mandate. *Modern Healthcare* reported on January 14, 2022, that new federal guidance gives healthcare workers until February 14 to get their first COVID-19 vaccine shot and March 15 to get their final shot. The guidance from the Centers for Medicare & Medicaid Services (CMS) specifically applies to 24 states newly subject to the vaccine mandate. Facilities in these states will also need to show they have developed policies and procedures to ensure their employees comply. Read More

HHS Extends COVID-19 Public Health Emergency for 90 Days. *NBC News* reported on January 14, 2022, that Health and Human Services (HHS) Secretary Xavier Becerra extended the COVID-19 public health emergency (PHE) for 90 days, effective January 16. The PHE increases funding for local governments, allows health care providers to access relief through the HHS Provider Relief Fund, and allows states to waive certain regulatory requirements. Read More

SCOTUS OKs COVID-19 Vaccine Mandate for Healthcare Employees in Medical Facilities. *Fierce Healthcare* reported on January 13, 2022, that the U.S. Supreme Court voted to allow the Biden administration to require healthcare employees in medical facilities to be vaccinated against COVID-19 but blocked a broader requirement for employers with at least 100 employees. The decision also allows the Centers for Medicare & Medicaid Services to withhold Medicare funds from providers that do not implement a vaccine requirement for employees. Read More

43 States Have Specified Medicaid Delivery System, Payment Reform Initiatives. The Kaiser Family Foundation (KFF) reported on January 12, 2022, that 43 states had at least one specified delivery system and payment reform initiative to address Medicaid cost and quality as of July 2021. New York and Vermont are the only states to have initiatives in all five specified areas: Patient-Centered Medicaid Home, Affordable Care Act Health Homes, All-Payer Claims Database, Accountable Care Organization, and Episode of Care. Read More

Enrollment in Exchange Plans Reaches 13.8 Million in 2022. *CNN* reported on January 13, 2022, that more than 13.8 million individuals have enrolled in coverage through the state and federal Affordable Care Act Exchanges for 2022 as the deadline nears. Two million of those individuals are enrolled for the first time. States that have not yet implemented Medicaid expansion are seeing the largest increases, with a 23 percent increase in Florida and 33 percent in Texas. Federal Exchange enrollment alone is up 21 percent from last year. Open enrollment ends on January 15, 2022. Read More

MACPAC Virtual Meeting Scheduled for January 20-21. The Medicaid and CHIP Payment and Access Commission (MACPAC) will hold its next meeting virtually on January 20-21. Registration is available on the MACPAC website, and public comments will be accepted during the meeting. Topics include:

- A discussion on an approach to monitoring access to care for Medicaid beneficiaries and proposed recommendations for the June report to Congress
- A review of a draft chapter for the March report to Congress on policy options for improving access to vaccines
- A panel discussion on issues and challenges facing states with Medicaid eligibility redeterminations
- A review of a notice of proposed rulemaking affecting dual-eligible special needs plans
- A discussion about requiring states to develop a formal strategy for integrating care for people who are dually eligible for Medicaid and Medicare
- A review of a draft chapter for the March report on the Money Follows the Person qualified residence criteria
- A panel discussion on bringing the beneficiary voice into Medicaid policymaking

Read More

Industry News

InTandem Capital Partners Invests in Providence Care. Private equity firm InTandem Capital Partners announced an investment in Providence Care, a South Carolina-based post-acute and end-of-life care provider. Providence subsequently announced Larry Nabb as chief executive. Read More

Associates in Pediatric Therapy Acquires Jones Therapy Services. Associates in Pediatric Therapy announced in January 2022, the acquisition of Tennessee-based Jones Therapy Services, which provides speech, occupational, and physical therapy in Tennessee. Associates in Pediatric Therapy is an affiliate of The VersiCare Group and Seven Hills Capital. Read More

New Directions Behavioral Health Acquires Tridiuum. New Directions Behavioral Health announced on January 14, 2022, the acquisition of Tridiuum, a digital behavioral health platform. New Directions is a behavioral health services provider serving more than 15 million individuals. Read More

Behavioral Health Group Acquires Center for Behavioral Health. Behavioral Health Group (BHG) announced on January 13, 2022, the acquisition of Center for Behavioral Health, a network of 20 treatment centers for substance use disorder and behavioral health services. The acquisition expands BHG's network of opioid treatment and recovery centers to five additional states for a total of 24. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
November 5, 2021 - Delayed	Louisiana	Awards	1,600,000
Dec. 2021 - Feb. 2022	Texas STAR+PLUS	RFP Release	538,000
2022	Georgia	RFP Release	1,800,000
2022	Nebraska	RFP Release	331,000
First Quarter 2022	Indiana MLTSS	RFP Release	*NA*
January 28, 2022	Rhode Island	Proposals Due	303,500
February 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	RFP Release	1,640,000
February 2022	California GMC - Sacramento, San Diego	RFP Release	1,091,000
February 2022	California Imperial	RFP Release	75,000
February 2022	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
February 2022	California San Benito	RFP Release	7,600
February 16, 2022	Iowa	RFP Release	745,000
February 18, 2022	Minnesota Senior Health Options, Senior Care Plus	Proposals Due	64,000
February 18, 2022	Minnesota Special Needs BasicCare	Proposals Due	63,000
February 22, 2022	Delaware	Proposals Due	280,000
March 4, 2022	MississippiCAN, CHIP	Proposals Due	480,000
April 1, 2022	Minnesota MA Families and Children, MinnesotaCare	Proposals Due	470,000
May 3, 2022	Delaware	Awards	280,000
May 9, 2022	Minnesota Senior Health Options, Senior Care Plus	Awards	64,000
May 9, 2022	Minnesota Special Needs BasicCare	Awards	63,000
June 2022	Texas STAR Health	Awards	43,700
July 1, 2022	Ohio	Implementation	2,450,000
July 1, 2022	North Carolina - BH IDD Tailored Plans	Implementation	*NA*
July 1, 2022	Missouri	Implementation	850,000
July 1, 2022	Louisiana	Implementation	1,600,000
June 24, 2022	Minnesota MA Families and Children, MinnesotaCare	Awards	470,000
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
Fourth Quarter 2022	Indiana MLTSS	Awards	*NA*
Fall 2022	Florida	RFP Release	3,500,000
Sep. 2022 - Nov. 2022	Texas STAR+PLUS	Awards	538,000
Sep. 2022 - Nov. 2022	Texas STAR & CHIP	RFP Release	3,700,000
May 3, 2022	Delaware	Implementation	280,000
January 1, 2023	Tennessee	Implementation	1,500,000
January 1, 2023	Minnesota MA Families and Children, MinnesotaCare	Implementation	470,000
January 1, 2023	Minnesota Senior Health Options, Senior Care Plus	Implementation	64,000
January 1, 2023	Minnesota Special Needs BasicCare	Implementation	63,000
January 7, 2022	Indiana Hoosier Healthwise and HIP	Awards	1,200,000
Mar. 2023 - May 2023	Texas STAR & CHIP	Awards	3,700,000
Mar. 2023 - May 2023	Texas STAR Kids	RFP Release	166,000
July 1, 2023	Rhode Island	Implementation	303,500
Sep. 2023 - Nov. 2023	Texas STAR Kids	Awards	166,000
Sep. 2023 - Nov. 2023	Texas STAR Health	Implementation	43,700
Sep. 2023 - Nov. 2023	Texas STAR+PLUS	Implementation	538,000
2024	Indiana MLTSS	Implementation	*NA*
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
Jun. 2024 - Aug. 2024	Texas STAR & CHIP	Implementation	3,700,000
Dec. 2024 - Feb. 2025	Texas STAR Kids	Implementation	166,000

HMA NEWS

Federal guidance provides clarity on the opportunity to include mobile crisis intervention services. HMA Federal Policy Principal Andrea Maresca, Managing Principal Gina Eckart, Principal John Volpe, and Senior Consultant Suzanne Rabideau weigh in on the recent changes and HMA experience in crisis intervention services. Read More

New this week on HMA Information Services (HMAIS):

Medicaid Data

- Arizona Medicaid Managed Care Enrollment is Up 8.9%, Nov-21 Data
- Indiana Medicaid Managed Care Enrollment Is Up 14%, Nov-21 Data
- Mississippi Medicaid Managed Care Enrollment is Down 13.1%, 2021 Data
- South Carolina Dual Demo Enrollment is Down 4.4%, Sep-21 Data
- South Carolina Medicaid Managed Care Enrollment is Up 8.1%, Sep-21 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Colorado Medicaid Value Based Payments and Providers of Distinction System RFP, Jan-22
- Idaho Medicaid Vision Service Products RFP, Jan-22
- Indiana Eligibility Determination Services System Maintenance and Operations RFP, Jan-22
- Louisiana Medicaid Pharmacy Benefit Management Services RFP, Jan-22
- Maryland Database Maintenance for Medicaid and HCBS RFP, Jan-22
- Michigan State Medicaid Agency Contract (SMAC) D-SNP Contracts, 2021
- Minnesota Medicaid Families, Children Medical Assistance and MinnesotaCare in Greater Minnesota RFP, Jan-22
- New Jersey D-SNP Contracts, 2016-21
- Virginia Smiles for Children Dental Benefits Administrator Contract and Amendments, 2019-21
- Wisconsin Care Management System RFP, Jan-22

Medicaid Program Reports, Data and Updates:

- Arkansas Works Quarterly Reports, 2021
- Delaware Managed Care External Quality Review Performance Reports, 2016-21
- Ohio Improper Medicaid Capitation Payments State Audit, Dec-21

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