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Issue 6 | October 22, 2020

NAVIGATION

Summary of Key Updates

House Speaker Nancy Pelosi (D-CA) and Trump Administration Treasury Secretary Steven Mnuchin continue to negotiate the otherwise stalled coronavirus relief package. Most recently, the House passed a version of the bill which is likely to die in the GOP-controlled Senate. House Democrats have named the $1.8 - $2.2 trillion package a top concern, though Senate Republicans are opposed to such a large spending bill so close to the General Election and based on renewed pressure on the U.S. economy (Washington Post, October 15).

CMS expanded the list of Medicare covered telehealth services and released a supplemental update to help states expand telehealth in Medicaid. The additional services include cardiac and pulmonary rehab which are temporary additions for the public health emergency (PHE) (CMS, October 14).

The American Hospital Association (AHA) presented oral arguments to the U.S. Court of Appeals for the District of Columbia arguing that the Department of Health and Human Services (HHS) should not have been allowed to finalize a rule requiring hospitals to disclose their payer-negotiated rates for 300 charges by January 1, 2021. The appellants (AHA) have appealed to the Court of Appeals since the U.S. District Court for the District of Columbia sided with HHS in the original suit. AHA offered a two-pronged complaint. First, AHA claimed HHS misinterpreted a provision in the ACA that requires hospitals to post their chargemaster rates which are different from negotiated fee schedules. Second, AHA believes that HHS' final rule as written may lead to confusion for patients, as hospitals are allowed to put "N/A" on their published list, meaning the charge is not available; however, patients might read this as the service being unavailable. The Appeals judges initially appeared skeptical of AHA's arguments, especially around patient confusion and the administrative burden the rule places on hospitals (Fierce Healthcare, October 15).

From October 13 through October 20, CMS approved five SPAs, two of which are time-limited, COVID-19 response SPAs.

CMS approved Georgia's partial Medicaid expansion through an 1115 waiver that includes work requirements (CMS, October 15).

Summary of Key Updates (continued)

On October 14 Kaiser Family Foundation (KFF) and the National Association of Medicaid Directors released their 20th annual survey of Medicaid directors in 43 states which found that most policy changes and issues identified for states during FY 2021 are related to responding to COVID-19 PHE. The survey also identified that Medicaid enrollment is expected to grow by 8.2% in fiscal year 2021, with total Medicaid spending growth of 8.4% in FY 2021 compared to growth of 6.3% in FY 2020. Estimates regarding state budgets show a potential $110 billion shortfall in FY 2020 and up to $290 billion shortfall in FY 2021. Uncertainty regarding the duration of the PHE and the enhanced FMAP, as well as whether Congress will consider additional fiscal relief, and the outcome of the elections will all play a role in formalizing state budgets and policy and program priorities for FY 2021 and beyond. (KFF, October 14).

KFF published an issue brief analyzing trends in overall and Non-COVID-19 Hospital admissions to better assess the economic impact of the pandemic on hospitals. Key findings include:

- Total hospital admissions dropped to as low as 68.6% of predicted admissions during the week of April 11, 2020 and then increased to a high of 94.3% of predicted levels by the week of July 11, 2020. As of August 8, 2020, admission volume has dipped slightly to 90.8% of predicted levels.
- Overall, the number of hospitalizations lost due to declines in admissions between March 8 and August 8, 2020 represent 6.9% of the total expected admissions for 2020 (KFF, October 19).

Federal Updates

News

- In remarks at a virtual meeting of the Healthcare Payment Learning and Action Network on October 13, CMS Administrator Seema Verma expressed doubt regarding the Center for Medicare and Medicaid Innovation's (CMMI) future, noting that "the bottom line is CMMI models are losing money, generating large losses, and a weak return on investment for taxpayers. The center stands in need of a course correction in model design and portfolio selection if value-based care is to advance." She added that "financial benchmarks have been too generous with considerable local variation," which requires some "course correction."
- On October 15, CMS announced the addition of 11 codes that may be delivered via telehealth during the PHE in Medicare fee-for-service. The new codes include certain neurostimulator analysis and programming services, as well as cardiac and pulmonary rehabilitation services. These new codes were added using a new process implemented under the May 1 CMS Interim Final Rule that allows expedited consideration and adoption of telehealth services during the PHE.
- In an October 15 press release, CMS announced a supplemental update to its Medicaid telehealth toolkit. The supplement includes updated, frequently asked questions and resources for states. Concurrently, CMS released a data snapshot (comprising data collected through June 30, 2020) showing telehealth utilization during the PHE. Notably, the data shows:
    - More than 34.5 million services were delivered via telehealth to Medicaid and CHIP beneficiaries between March and June, an increase of more than 2,600% compared to the same period from the prior year.
    - Adults ages 19-64 received the most services delivered via telehealth.
    - There is marked variation among states in telehealth utilization.
- A CMS report released on October 19 shows that average premium rates for the benchmark Exchange plans offered through Healthcare.gov dropped by two percent. The report touts an eight percent

reduction in average premium rates since 2018. The report also shows that 22 more issuers will offer coverage in 2021, for a total of 181 issuers. The CMS analysis only relates to plans offered through HealthCare.gov.

- A KFF analysis of insurer rate filings ahead of November 1 ACA marketplace open enrollment, however, reveals wide variation in premium rate changes, "rang[ing] from a -42.0% decrease to a 25.6% increase, though half fall between a 3.5% decrease and 4.6% increase." The analysis found that the median premium rate change for 2021 was a 1.1% increase.

Federal Legislation

- The House has introduced several health care related bills all of which are currently sitting with the Committee on Energy and Commerce. This is an early stage in a bill's lifecycle and will need to pass through both House and Senate votes before reaching President Trump's desk.
  - HR 8555 will require the HHS Secretary to submit to Congress a weekly report of COVID-19 vaccine distribution.
  - HR 8561 will amend title XIX of the Social Security Act (SSA) and sunset the increased FMAP for newly eligible mandatory individuals.
  - HR 8568 will amend titles XVIII and XIX of SSA to codify certain infection control and emergency preparedness regulations and prohibit reduction in the frequency of SNF surveys and reporting requirements.
  - HR 8573 will prohibit group, individual, Medicaid managed care organizations, and TRICARE plans from applying a deductible to outpatient pediatric services - also sitting in Committee on Ways and Means, the Committee on Education and Labor and the Committee on Armed Services.
  - HR 8574 will amend titles XVIII and XIX of SSA to increase Medicaid and Medicare enforcement for nursing facilities during the COVID-19 emergency period.
  - HR8586 will amend title XIX of SSA to allow State Medicaid programs the option to cover inpatient substance abuse treatment services for individuals between the age of 22 and 64.

Federal Regulations

- CMMI designed a direct contracting program as an evolution of the accountable care organization (ACO) arrangement under which providers have new waivers, beneficiary engagement tools, and other flexibilities to contain costs. The direct contracting model presents two risk options.
  - First, the "professional" model offers a 50% shared savings/shared losses risk arrangement where providers must select primary care capitation. There is no discount to the performance year benchmark.
  - Second, the "global" model offers a 100% shared savings/shared losses risk arrangement where providers may choose either total care capitation or primary care capitation, and performance year benchmarks contain a two percent discount in year one and a five percent discount in year five. ACOs are concerned about the new arrangement since they believe that direct contracting does not offer credit for cost savings achieved under the Medicare Shared Savings Program or the NextGen ACO program. Conversely, providers with significant Medicare Advantage exposure believe they are well prepared to manage risk under direct contracting because of their experience with care coordination and care management strategies (Modern Healthcare, October 10).

Federal Litigation

- This November, SCOTUS will hear California v. Texas, a consolidated set of cases focused on the Affordable Care Act (ACA) which some believe may be at risk if the Senate confirmation of Amy Coney Barrett goes through as planned. In preparation for the suit, the Robert Wood Johnson Foundation estimated that more than 21 million people could lose their health insurance by 2022 if SCOTUS invalidates the ACA in its entirety. This will significantly impact an individual's access to care, as well as hospitals and physician practices, which researchers forecast will have a 74% increase in uncompensated care (MedCityNews.com, October 15).

Letters

- In an October 13 letter to CMS, the Association for Community Affiliated Plans (ACAP) and the Alliance of Community Health Plans (ACHP) requested Administrator Seema Verma extend 2021 Open Enrollment for Exchange plans through January 2021, or create a special enrollment period to allow consumers impacted by the PHE to enroll in coverage in early 2021.

COVID-19

- Effective January 1, 2021, Medicare will adjust its COVID-19 lab reimbursement rates. CMS will decrease the base rate to $75 (25% reduction) and continue to pay $100 for COVID-19 tests only to labs that complete high throughput COVID-19 tests. High-throughput testing means (a) the lab completes the test at issue within two calendar days, and (b) the lab completes the majority of their COVID-19 diagnostic tests that use high throughput technology in two calendar days or less for all patients (not just Medicare) in the previous month.
    - Previously, CMS had increased the reimbursement rate from $51 to $100 per test effective in April 2020 (CMS, October 15).
- The Trump Administration announced a partnership with CVS and Walgreens to distribute a COVID-19 vaccine, when available, to the country's most vulnerable citizens, including seniors. Under the program, a skilled nursing facility (SNF) can opt-in and partner with eligible CVS and Walgreens pharmacies which will then schedule and coordinate clinic dates directly with each facility. The program officially launched on October 18. HHS expects that each facility will need two months to fully deliver both doses of vaccines to residents and staff. Vaccines will be free of charge to recipients, though pharmacies may bill Medicare for their administration. Currently Medicare has set reimbursement at $17 per vaccine (The Hill, October 16).
- Johnson & Johnson and Eli Lilly have both paused their clinical trials related to COVID-19 vaccine development and antibody treatment, respectively. Johnson & Johnson decided to pause its trials after a participant became sick with an "unexplained illness," though the company has not stated the illness is definitively a side effect of the vaccine. Other drug manufacturers have similarly paused their trials in the past to respond to illnesses or out of an abundance of caution, in Eli Lilly's case. Johnson & Johnson remains a part of the Trump administration's Operation Warp Speed and is currently in Phase 3 of its testing (NPR, October 13).

Waivers

- Section 1115
    - On October 15, CMS approved the state of Georgia's 1115 waiver application, "Pathways to Coverage," which leverages many of the flexibilities outlined in the Healthy Adult Opportunity (HAO) guidance that CMS released earlier this year to expand Medicaid eligibility for the adult population.

- The demonstration applies to individuals who are between the ages of 19 through 64 with income up to and including 95% of the federal poverty level (FPL). (The state notes that the 95% FPL is effectively 100% FPL with a 5% income disregard.)
- It is estimated that over 30,000 individuals will receive Medicaid coverage during the first year of the demonstration and nearly 65,000 Georgians will enroll in Medicaid or receive Medicaid premium assistance for coverage through Employer Sponsored Insurance (ESI) over the five-year demonstration.
- To qualify, individuals must comply with specific requirements, including participating in 80 hours a month of work or other qualifying activities.
    - Beneficiary advocates in Georgia are expected to sue the State over these work requirements.
- Most individuals with income between 50% and 95% of the FPL will be required to make initial and ongoing monthly premium payments.
- CMS did not approve Georgia's request to receive an enhanced federal Medicaid match for the demonstration population.
- The CMS press release notes that Georgia is also pursuing a "complimentary" Section 1332 waiver, which is currently under CMS review.

SPAs

- Traditional SPAs
    - Nebraska (NE-20-0009): Rebases ICF/IID payment rates for SFY21. This SPA has an effective date of July 1, 2020.
    - New Mexico (NM-20-011): Increases rates for the Family Infant Toddler (FIT) program. This SPA has an effective date of August 1, 2020.
    - Oklahoma (OK-20-0028): Updates nursing facility and standard and specialized ICF/IID rates for the state fiscal year by rebasing the base and add on rates and quality metric updates. This SPA has an effective date of July 1, 2020.
- COVID-19 Response SPAs
    - Oklahoma (OK-20-0041): Allows supplemental reimbursement for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) related to ventilator dependent patients in four Nursing Facilities (NFs) to avoid any difficulty of transitioning the patients from inpatient to nursing facility care. This time limited, COVID-19 response SPA has an effective date of July 1, 2020.
    - Puerto Rico (PR-20-0010): Covers Remdesivir and Convalescent Plasma therapy treatment for hospitalized patients with confirmed or suspected COVID-19. This time limited, COVID-19 response SPA has an effective date of October 1, 2020.

State Updates

Click here to view Sellers Dorsey's state budget tracking summaries.

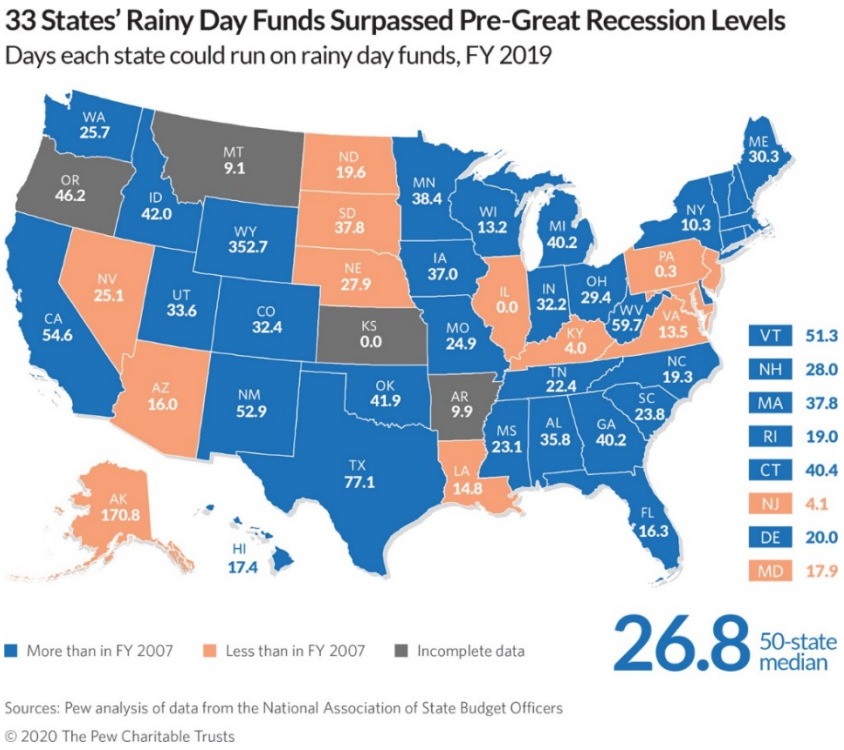
- Florida Governor Ron DeSantis appointed Shevaun Harris as acting secretary of the state Agency for Health Care Administration (AHCA) following the departure of Mary Mayhew on October 2. Harris has served as assistant deputy secretary for Medicaid policy and quality since 2017 (FLGov, October 15).
- Oklahoma has announced two new RFPs for managed care payers to run medical and dental plans for its Medicaid program. This announcement comes several months after voters approved plans to expand Medicaid eligibility in Oklahoma. The State plans to hire at least two managed care insurers, and recipients will include children, pregnant women, caretaker relatives, low-income adults, and current and

former foster care children. The State's Medicaid market was valued at nearly $5 billion in 2018. At this time, the total value of the state Medicaid contracts is unknown (Health Payer Specialist, October 16).

- Michigan's Medicaid coverage rates have increased due to the number of beneficiaries covered under the State's Medicaid managed care plans. From January to August, rates have climbed 12%. The bump in rates has reversed the enrollment losses in recent years. Meridian Health Plan of Michigan, Michigan's largest Medicaid managed care plan, has seen a 7.4% surge in Medicaid members in 2020 (Health Payer Specialist, October 19).

Budgets

- At the start of fiscal year 2020, state rainy day funds nationally amounted to $75.2 billion, the largest fiscal cushion in the last 20 years. According to a report by The Pew Charitable Trusts, at least ten states (Alaska, Delaware, Maryland, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Oklahoma, and Rhode Island) used these funds in fiscal year 2020 to help close budget gaps caused by COVID-19. Nevada and New Jersey completely emptied their rainy day funds while Alaska and Rhode Island used roughly half of their funds. At least seven other states (Arizona, California, Georgia, Iowa, Maine, Nebraska, and Washington) made or authorized withdrawals in fiscal year 2020 in response to the pandemic. Some states, such as Arkansas, did not utilize their rainy day funds. The image below outlines the number of days each state could operate on their respective rainy day funds (The Pew Charitable Trusts, October 13).



- States anticipate groups such as children, parents, and other expansion adults to be more sensitive to changes in economic conditions and will grow faster compared to the elderly and those with disabilities. The survey reports that in 2021, nearly all states expect the anticipated increase in enrollment to grow spending, but under half stated that utilization would cause downward pressure, reflecting decreased service use due to the pandemic. In a similar report from KFF on how state Medicaid programs will respond to meet COVID-19 challenges, the report notes the following:

- "The ability of states to sustain policies adopted in response to the pandemic (including through emergency authorities) may be tied to the duration of the PHE as well as the availability of additional federal fiscal relief and support. There is great uncertainty regarding the future course of the pandemic, the scope and length of federal fiscal relief efforts, and what the 'new normal' will be in terms of service provision and demand. Results of the November 2020 elections could also have significant implications for the direction of federal Medicaid policy in the years ahead" (KFF, October 14).

Private Sector Updates

- Many major insurers are expanding their ACA exchange presence for 2021. Experts say payers have expanded their presence due to the profitability of the exchanges, expected increase in enrollment due to COVID-19, as well as a continuation of a marketplace rebound that began last year. UnitedHealthcare confirmed its expansion into the ACA marketplace in Arizona, making it the seventh state the insurer has entered for next year. Centene is also offering plans in two new states and nearly 400 new counties. Further, Cigna is expanding its services to approximately 80 new counties (Health Payer Specialist, October 19).
- CareSource has announced a new Executive Vice President of strategy and business development. Sanjoy Musunuri, a veteran health care industry entrepreneur, will lead the advancement of innovative strategies as the payer enters new service markets. Before joining CareSource, Musunuri spearheaded an advisory group that works with health care private equity companies, and he has held various executive positions at naviHealth, Aetna, WellCare, and Humana (Health Payer Specialist, October 19).
- Rite Aid is modernizing its stores to put pharmacists "front and center" to double down on its pharmacy business, according to Jim Peters, Rite Aid's chief operating officer. RIteAid operates 2,400 drugstores in 18 states, and some of the revamped stores will open this month. The stores will feature a pharmacy that resembles an Apple Store Genius Bar, which looks like virtual care rooms that will enable consumers to remotely connect with care teams. The rebrand comes as Rite Aid competes with CVS and Walgreens, along with new digital players such as Amazon's PillPack and e-pharmacy startups Capsule and NowRx (Fierce Healthcare, October 15).
- Ohana Health Plan, a subsidiary of Centene, and Samsung have partnered to expand telehealth access for individuals and families in rural and underserved communities in Hawaii. Ohana Health Plan will implement this initiative by supplying local health care providers with Samsung smartphones to distribute to patients who otherwise would not have access to virtual health care services. They will provide the smartphones to several federally qualified health centers (FQHCs).
- Centene's subsidiary Magnolia Health is also expanding telehealth services in Mississippi, a primarily rural state, by providing FQHCs and rural providers with high-speed broadband services, specifically FirstNet. Medical providers use FirstNet to provide telehealth and other remote services. In addition to Mississippi and Hawaii, Centene is providing broadband services to providers in Georgia, Arkansas, and Kansas (Health Payer Specialist, October 16).
- Following an investigation of delayed specialist care in L.A. County's public hospital system, the California Department of Health Care Services (DHCS) is reviewing whether Medicaid payers have violated their state contracts by allegedly failing to provide timely access to care. The top Medicaid managed care payers that serve L.A. County's public hospital system include L.A. Care, Centene's HealthNet affiliate, Anthem, Kaiser Permanente, and more (Health Payer Specialist, October 16).

Sellers Dorsey Updates

- Check out our Q&A with Brian Dees, Senior Consultant, who comes from the Texas Health and Human Services Commission. Brian is one of our policy experts, and he plays a key role on Sellers Dorsey's research team. Learn more about Brian and his work.
- The Sellers Dorsey research team analyzes Medicaid infrastructure at the federal and state levels to better understand how programmatic and environmental changes impact our state, provider, plan, and investor clients. Sellers Dorsey uses analysis of historical trends to inform outlooks that help clients to devise and implement value-based care strategies and strategically expand offerings through organic and transactional growth.

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