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NAVIGATION

Summary of Key Updates

On October 28, 2020, the Centers for Medicare and Medicaid Services (CMS) publicly announced an Interim Final Rule (IFC). Despite a 60- day comment period, the rule will become effective on the date it is published in the Federal Register, with most provisions remaining applicable for the duration of the national public health emergency (PHE). Sellers Dorsey summarized provisions identified as particularly relevant for our clients. Click here to review the summary.

CMS issued a final rule (CMS-1730-F) that updates Medicare home health payment rates for CY21, implements Medicare enrollment policies and CY 21 infusion therapy supplier rates, and excludes home infusion therapy services from home health services as required by law. The final rule also maintains the telehealth provisions in the proposed version that allow home health agencies to permanently use telehealth, as long as any provision of remote patient care monitoring or other services furnished via a telecommunications system or audio-only technology are included in the patient's plan of care. The final rule also implements an aggregate 1.9% ($390 million) increase to home health agency payments and maintains the proposed Value Based Purchasing Model (CMS, October 29).

CMS issued its final rule that will require nearly all health insurers in the group and individual market and self-insured plans to disclose pricing and cost-sharing information, including in-network and out-of-network rates they negotiate with providers. Payers will have until January 1, 2023 to create an online tool that lists 500 shoppable services and their rates and an additional year to add all other items and services. Short-term limited-duration insurance and health reimbursement arrangements are exempt from the new transparency requirements (CMS, October 29).

CMS opened its Federal Health Insurance Exchange (a.k.a. the Marketplace) Open Enrollment period on November 1 for coverage beginning January 1, 2021. The open enrollment period will remain open through December 15, 2020. CMS has focused on improving the customer experience for this open enrollment period by adding more agents, brokers, and private sector partners (CMS, November 1).

Summary of Key Updates (Continued)

A judge in the U.S. District Court for the Northern District of Illinois held the Trump administration "public charge rule" violates the Administrative Procedure Act and therefore vacated the rule nationwide. The rule, finalized in August, expands federal immigration authorities' ability to deny green cards or visas to legal immigrants based on their potential use of government benefits such as Medicaid. Given the unusual injunctive remedy and the national impact of the ruling, there is likely to be continued litigation around the rule (Inside Health Policy, November 2).

CMS approved Georgia's 1332 Waiver application, allowing the state to transition away from HealthCare.gov for its ACA Marketplace plans.

CMS approved a 10-year extension of Indiana's 1115 waiver.

From October 27 through November 4, CMS has approved 13 SPAs, two of which are time-limited COVID-19 disaster relief SPAs. Of note, Alabama's COVID-19 relief SPA rescinds flexibilities approved earlier in the public health emergency.

The Kaiser Family Foundation (KFF) published a report that reviewed the Medicare Advantage (MA) offerings for 2021. As Americans age and the use of managed care expands nationwide, MA offerings have increased in tandem. For 2021, the average Medicare beneficiary had access to 33 plans, an increase from 28 plans in 2020. Nationwide, there are more plans offered this year (3,550) than in any other year, with HMOs continuing to make up the majority of MA products. Humana and UnitedHealthcare will continue to be industry leaders with Humana's MA plans available in 84% of counties and UnitedHealthcare's in 66%. Within the plan offerings, more plans are offering Special Needs Plans, which indicates a particular focus on high-need, vulnerable beneficiaries who often correlate to high-cost traditional Medicare patients (KFF, October 29).

Federal Updates

News

- On October 28, 2020, the Centers for Medicare and Medicaid Services (CMS) publicly announced an Interim Final Rule (IFC). Despite a 60- day comment period, the rule will become effective on the date it is published in the Federal Register, with most provisions remaining applicable for the duration of the national public health emergency (PHE). Sellers Dorsey summarized provisions we have identified as particularly relevant for Sellers Dorsey's clients. The summary is available here.
- On October 28 HHS announced the distribution of $333 million in performance incentive payments to more than 10,000 nursing facilities for "demonstrating significant reductions in COVID-19 related infections and deaths between August and September." HHS data shows that, among incentive program participants, 76% met infection control and mortality criteria and reported fewer new cases and deaths in the September than August.
- On October 30, CMS launched its new Nursing Home Resource Center which is intended to be a hub site with data, guidance, and other useful information for nursing facility providers, consumers, and advocates. The new site also collects data and updates related to COVID-19.
- MACPAC held its October meeting on October 29-30. Commission members considered the following topics:

- Mandated Report on Non-Emergency Medical Transportation (NEMT): Work Plan and Preliminary Findings
  - The commission reviewed preliminary findings from its report on NEMT which included:
    - An inventory of delivery models that included: third-party broker (35 states), managed care (26 states), and in-house (at least 12 states). The report noted the use of managed care has increased in recent years.
    - No consensus on which delivery model is most likely to lead to improved beneficiary satisfaction, efficiency, or value.
    - Coordination of transportation can help reduce costs and improve services.
    - States with formal, sustained consumer engagement processes tend to have better-performing programs.
    - Transportation network companies like Uber and Lyft are increasingly included in NEMT provider networks.
    - Federal oversight authorities have identified NEMT as high risk for fraud and abuse, but program integrity appears to have improved in recent years.
  - The commission also considered whether to recommend NEMT to Congress as a mandatory Medicaid benefit.
- Changes in Nursing Facility Acuity Adjustment Methods
  - The commission members reviewed different methodologies states use to adjust acuity within nursing facility rates.
- Access to Mental Health Services for Adults in Medicaid
  - Commission members discussed current coverage and opportunities under existing authorities to improve coverage for adult mental health services.
- Extending Postpartum Coverage
  - Commission members reviewed recent state and federal actions on postpartum coverage and considered the following potential recommendations:
    - A mandatory extension of the postpartum eligibility period.
    - A state option to extend the postpartum eligibility period.
    - An extension of the postpartum period, regardless of eligibility pathway.
    - Align recommendation for coverage under the State Children's Health Insurance Program (CHIP).
    - Reiterate a prior recommendation that states align Medicaid benefits for all pregnant women.
- Required Annual Analysis of Disproportionate Share Hospital (DSH) Allotments
  - The commission reports found scheduled DSH reductions total $4 billion in FY 2021, $8 billion in each of FYs 2022–2025.
  - Some states have made accelerated DSH payments to offset financial disruptions for hospitals.
  - Because total DSH payments are limited by the states' federal allotment, the enhanced FMAP under the Families First Coronavirus Response Act may reduce total DSH payments hospitals receive.
- Addressing High-Cost Drugs and Pipeline Analysis
  - The commission heard a presentation on high-cost drugs and the pipeline of additional high-cost drugs that may soon become available.
- Comment on Secretary's Report to Congress on Reducing Barriers to Substance Use Disorder Services Using Telehealth for Pediatric Populations under Medicaid

    - The presentation summarized key findings in the report to Congress. The commission determined it would submit comments to Congress on this report.

- On October 30, CMS released the 2020 Medicaid and CHIP scorecard. CMS initially released the scorecard in 2018 and has continued to provide updates and enhancements each year. The 2020 scorecard includes a new way to view state-specific data on the Medicaid.gov State Profile "Quality of Care" section. CMS also updated the user interface to improve usability.

Federal Regulations

- CMS issued a proposed rule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that makes three main changes. CMS will accept comments on the proposed rule until January 4, 2021. The main changes include:
    - Adjusts the fee schedule amounts using information from the Medicare DMEPOS competitive bidding program for either items furnished after April 1, 2021 or the day after the Public Health Emergency ends (whichever is later).
    - Proposes to classify continuing glucose monitors as DME under Medicare Part B and establishes a fee schedule amount for these items and related accessories.
    - Expands interpretation of the appropriate "for use in the home" requirement specifically for external infusion pumps (Federal Register, November 4).
- HHS has released two technology facing provisions. The Health Information Technology (HIT) roadmap, which will focus on strategies and initiatives among and within federal agencies, and the ONC delay of the information blocking and interoperability regulations to grant more flexibility to private providers.
    - HHS has released its five year federal HIT roadmap made up of four overarching objectives: (1) promoting health and wellness, (2) enhancing care delivery, (3) building a data-driven ecosystem to accelerate research and innovation, and (4) better connecting health care services with health data. The 2020-2025 roadmap updates a previous federal health IT plan that ran from 2015-2020 (Modern Healthcare, October 30).
    - HHS has issued an interim final rule that extends the compliance deadlines for health care information blocking and interoperability regulations for the second time due to COVID-19. The rule, if finalized as proposed, will require electronic health data be made available to patients at no cost. It also defines exceptions to data blocking. Under the rule, the new standardized API functionality will not be required until December 2022. Stakeholders support delaying the rule's effective date given providers' reallocation of resources due to the COVID-19 pandemic (Fierce Healthcare, October 29).
- On October 27, CMS released a proposed rule (CMS-1738-P) updating the CY 2021 Medicare fee schedules for DMEPOS. The proposed rule also updates the benefit determination and pricing process for DMEPOS to streamline and accelerate adding new DMEPOS to Medicare. The rule also expands coverage for Continuous Glucose Monitors (CGMs).

Letters

- In an October 28 letter to CMS, the Association for Community Affiliated Plans and Alliance of Community Health Plans urged Secretary Seema Verma to exercise discretion in enforcement of the Interoperability Final Rule. The groups strongly urged CMS to extend the compliance timeframe by six months due to the public health emergency.

COVID-19

- CMS has asked for feedback on a proposal to add coronavirus vaccination rates to performance measures that determine whether MA plans and Part D plans receive bonuses. If implemented, CMS would add questions to the CAHPS survey administered in 2022 (Inside Health Policy, October 30).
- HHS determined providers may use CARES Act Provider Relief Fund grant dollars to pay for supplies needed for COVID-19 vaccine distribution, including refrigerators, personnel, and transportation costs not otherwise reimbursed for vaccine distribution. To prepare for vaccine receipt and administration, providers may start to use these funds before the vaccine is actually available (Modern Healthcare, October 30).

Waivers

- Section 1332
    - Georgia
        - On November 1, CMS approved Georgia's Section 1332 State Innovation Waiver. Georgia becomes the sixteenth state to receive approval for a 1332 waiver. The approval is effective January 1, 2022 through December 31, 2026, and:
            - Waives the single risk pool requirement, allowing the state to implement the Georgia Reinsurance Program.
            - Transitions the individual market from the federally facilitated Exchange to the Georgia Access Model, which will allow private carriers, agents, and brokers to market to consumers. The state asserts this will improve competition and customer service.
- Section 1115
    - Indiana
        - On October 26, CMS approved an extension of Indiana's Healthy Indiana Plan (HIP) 1115 demonstration waiver, granting a ten year extension through 2030, the longest 1115 extension CMS has yet granted. The HIP approval conditionally approves the community engagement aspects of the demonstration, pending the outcome of litigation and extends the substance use disorder and severe mental illness elements of the demonstration through 2025 (Modern Healthcare, October 27).
- Section 1135
    - Massachusetts
        - Allow private duty nursing services to be provided by qualified providers under the direction of nurse practitioners, clinical nurse specialists, or physician assistants.
        - Waive the requirement to obtain beneficiary and provider signatures for the HCBS Person-Centered Service Plan.
    - Louisiana (Hurricane Laura)
        - Extend preexisting authorizations for previously authorized services through the end of the public health emergency.
        - Suspend Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessments for 30 days.
        - Waive or extend state fair hearing requests and appeal timelines.
        - Allow temporary enrollment of providers who are enrolled with another state Medicaid agency or Medicare for the duration of the public health emergency.
        - Allow provisional, temporary provider enrollment for providers not currently enrolled in Medicaid.

        - Temporarily cease revalidation of providers located in Louisiana or who are otherwise directly impacted by the emergency.
    - Minnesota
        - Allow use of legally responsible individuals to render personal care services.

- Section 1915(c) Appendix K
    - New Mexico
        - Temporarily expand allowable service settings.
        - Temporarily modify provider qualifications.
        - Temporarily modify level of care processes.
        - Temporarily increase payment rates.
        - Temporarily modify person centered planning processes.
        - Temporarily allow payment for services rendered in an acute care setting.
        - Modify waiver reporting deadlines.
        - Add electronic service delivery for some services.
        - Allow virtual assessments and service planning.
        - Allow electronic signatures.
    - Louisiana
        - Temporarily modify service scope or coverage.
        - Temporarily expand allowable service settings.
        - Temporarily provide services in out of state settings.
        - Allow electronic service delivery for some services.
    - Indiana
        - Temporarily modify service scope or coverage.
        - Temporarily exceed service limitations.
        - Temporarily allow services rendered by family members.
        - Temporarily modify provider qualifications.
        - Temporarily increase payment rates.
        - Allow virtual assessments and service planning.
    - Minnesota
        - Temporarily allow services rendered by family members.
        - Temporarily increase payment rates.
    - Missouri
        - Temporarily modify provider qualifications.
        - Apply point in time limitations to waiver capacity.
    - North Carolina
        - Temporarily modify service scope or coverage.
        - Temporarily exceed service limitations.
        - Temporarily modify provider qualifications.
        - Adjust existing provider retainer payments.
    - Alaska
        - Temporarily exceed service limitations.
    - Oklahoma
        - Temporarily exceed service limitations.

SPAs

- Traditional SPAs
    - Colorado (CO-20-0025): Provides a two percent increase to the statewide average Medicaid Management Information System (MMIS) reimbursement rate for nursing facility services. This SPA has an effective date of July 31, 2020.
    - Illinois (IL-20-0008): Changes the long-term care regional wage adjustor. This SPA has an effective date of July 1, 2020.
    - Indiana (IN-20-0015): Updates the Medicaid reimbursement rate for medical equipment and medical supplies subject to the Cures Act. This SPA has an effective date of January 1, 2021.
    - Missouri (MO-20-0018): Updates the provider fee schedule and adds a modifier for individual, family, and group psychotherapy procedure codes to pay an enhanced rate for providers certified in certain practices that provide evidence-based treatment to children presenting with trauma. This SPA has an effective date of July 1, 2020.
    - Maine (ME-20-0007): Updates the performance standards, presumptive eligibility time period, application, and training material for hospital presumptive eligibility. This SPA has an effective date of November 1, 2020.
    - Nebraska (NE-20-0003): Add Medically Monitored Withdrawal services to the state plan. This SPA has an effective date of January 1, 2020.
    - New York (NY-15-0048): Eliminates the reduction to the statewide base price for inpatient hospital services. This SPA has an effective date of April 1, 2015.
    - Oregon (OR-20-0016): Creates a bariatric rate for nursing facilities and establishes a certified nursing assistant staffing ratio requirement related to facilities' bariatric census. This SPA has an effective date of July 1, 2020.
    - Pennsylvania (PA-20-0013): Establishes the annual aggregate limit and continued funding for supplemental, DSH, and direct medical education payments. It also establishes the aggregate cap for direct medical education, Inpatient DSH, and Outpatient Supplemental payments for FY21. This SPA has an effective date of September 27, 2020.
    - Pennsylvania (PA-20-0015): Continues the application of a budget adjustment factor for private and non-state government owned nursing facilities. This SPA has an effective date of July 1, 2020.
    - Virginia (VA-20-0017): Amends the state plan to allow nurse practitioners, clinical nurse specialists, and physician assistants to order and certify home health services. This SPA has an effective date of October 25, 2020.
- COVID-19 Disaster Relief SPAs
    - Alabama (AL-20-0018-A): Rescinds coverage of the optional COVID-19 testing for uninsured individuals that was approved by CMS through AL SPA-20-0007. This SPA has an effective date of March 18, 2020.
    - New Mexico (NM-20-0021): Increases reimbursement for services provided under the Family Infant Toddler (FIT) program. This SPA has an effective date of July 1, 2020.

State Updates

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

News

- New Jersey and Pennsylvania will join 13 other states that have moved from the federal exchange (Healthcare.gov) to operating their own state-based exchanges. Starting November 1, the new exchanges "Pennie" (PA) and Get Covered New Jersey will go live, allowing residents to explore health plans and pricing before open enrollment begins for the 2021 plan year. Maine, Virginia, and New Mexico are also looking to move in this direction (Inside Health Policy, October 30).
    - Get Covered New Jersey will run six weeks longer than Healthcare.gov and allow residents to check their eligibility for the Affordable Care Act's (ACA) tax credits and new state-level subsidies. Pennie will run four weeks longer than Healthcare.gov and will assist consumers through "Pennie Ambassadors," whose responsibilities include raising awareness of the open enrollment and helping residents with their migration into the new exchange. In addition to Pennie, a state-level reinsurance program was created by PA that is funded by user fees charged to insurers selling plans through the state exchange. PA's insurance department and Pennie officials reported premiums were down three percent on average due to the reinsurance program.

COVID-19 Bill

- The House and Senate remain at a standstill regarding passage of a future relief bill. House Speaker Pelosi sent a letter to Treasury Secretary Mnuchin calling out Republicans for failed talks spanning three months on a relief bill. According to Pelosi, a testing plan, aid to state and local governments, funding for schools, jobless benefits, and a GOP-sought shield against coronavirus-related lawsuits are all obstacles preventing an agreement (Modern Healthcare, October 29).

Private Sector Updates

- All 36 members of the Blue Cross Blue Shield Association (BCBSA) signed off on an antitrust settlement with consumers. All association members have given preliminary approval to the $2.7 million settlement. They are waiting for a final review conducted by U.S. District Court Judge R. David Proctor. The deal is considered historic because it was initiated entirely by the plaintiffs' bar as part of a class-action lawsuit for consumers, though BCBSA rejected the claims made by the plaintiffs (Health Payer Specialist, November 2).
- Medical clinics for chronically ill seniors have expanded rapidly across the country. Clinic operators ChenMed, Oak Street Health, and Partners in Primary Care are among companies that have recently unveiled plans to bring senior-focused medical centers to new communities. "Where you have the biggest opportunity for improvement is where the biggest problem in health care is, which is around chronic illness and adverse social determinants," said Dr. Griffin Myers, Oak Street's Chief Medical Officer (Modern Healthcare, October 31).
- Blue Cross and Blue Shield of North Carolina is partnering with Caravan Health to bring its Blue Premier program, a value-based care initiative, to community and rural providers in North Carolina. The two companies will establish a joint accountable care organization (ACO) that will allow Blue Premier to reach community and rural hospitals. Through the new ACO, rural providers will receive assistance with care coordination and chronic care management and will be able to share in the savings achieved through

more value-based care. In the program's first year, Blue Cross NC paid $85 million in incentive payments to providers and generated $153 million in savings (Fierce Healthcare, October 30).

- Blue Cross and Blue Shield of Illinois has launched a major health equity initiative called the Health Equity Hospital Quality Incentive Pilot Program. BCBS of Illinois will partner with providers that seek to strengthen "health care outcomes in minority groups." This initiative comes as the COVID-19 pandemic disproportionately impacted people of color in the U.S. The campaign will focus on "increasing the diversity and cultural competency of the physician workforce and advancing awareness of implicit bias, "which BCBS of Illinois defines as "the unconscious attitudes and stereotypes that can influence behavior." The payer's strategy includes replacing an existing financial bonus system for in-network hospital performance with a new $100 million program that will reward providers for making care equity progress over a three-year time frame (Health Payer Specialist, October 30).
- Universal Health Services' (UHS) profits increased by 150% in the third quarter of this year, despite the growing infection rate of COVID-19 cases and a reversal in federal grants. UHS reported a significant increase in COVID-19 patients during the third quarter compared to the second quarter. Of the $213 million in CARES Act funding, $161 million went to UHS' acute-care hospitals and $52 million to its behavioral health division which recently settled a sweeping federal lawsuit over allegedly admitting patients unnecessarily and holding them for as long as their insurance paid out. UHS is recovering from a cyberattack that prompted the company to temporarily take all of its U.S. information technology networks offline, including systems for medical records, laboratories, and pharmacies (Modern Healthcare, October 29).
- Tufts Health Plan and Harvard Pilgrim Health received approval from the Massachusetts attorney general to combine their operations. The combination will be the second and sixth-largest managed care payers in Massachusetts. The current CEO of Tufts Health will preside over the combined operation. The Massachusetts Division of Insurance will still have to approve the transaction, according to The Boston Business Journal. Tufts trails leader Blue Cross and Blue Shield of Massachusetts in market share with 20%. (Health Payer Specialist, October 29).
- According to an HHS announcement, Aetna has been fined $1 million for three privacy breaches. One of the breaches, which occurred in April 2017, involved two web services Aetna used to show health plan members plan-related documents. The breach affected more than 5,000 individuals whose protected health information (PHI) disclosed names, insurance identification numbers, dates of service, and more. The Office for Civil Rights found Aetna failed to regularly evaluate how operational changes impacted its PHI and failed to implement procedures to verify the identity of entities seeking access to PHI. In addition to the fine, Aetna must undertake a corrective action plan (Health Payer Specialist, October 29).
- Anthem has plans to reduce physical office space and implement more artificial intelligence (AI) and technology. CEO Gail Boudreaux announced the company is making major investments in its Medicare business to boost customer service and improve CMS Star ratings. Money from the repealed federal health insurance fee will fund the improvements. Part of this deal includes reducing office space, and it is possible some might close for good (Health Payer Specialist, October 28).

Sellers Dorsey Updates

- Sellers Dorsey is a proud sponsor of the upcoming virtual NAMD Conference starting on November 9. Participants from Sellers Dorsey include former Medicaid directors Gary Jessee, Leesa Allen, and Nancy

Smith-Leslie, along with several of our policy subject matter experts. We look forward to setting up meetings in our virtual booth. Click here to learn about more events Sellers Dorsey attends.

- As the health care landscape shifts toward value-based care, Sellers Dorsey collaborates with policy makers to develop and negotiate state Medicaid reform initiatives, and we help providers and payers to understand and leverage value-based purchasing and alternative payment model requirements and opportunities. Learn more about our expertise and service offerings in the area of value-based care.

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