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NAVIGATION

Summary of Key Updates

The Department of Health and Human Services (HHS) extended the deadlines for providers to spend money received through the Provider Relief Fund authorized under the CARES Act. The new deadlines apply to providers that received funds after June 30, 2020 (HHS, June 11; Modern Healthcare, June 11; Becker's Hospital Review, June 11).

HHS named Dean Winslow to lead the Department's COVID-19 Testing and Diagnostic Working Group (Politico, June 11).

The Association of American Medical Colleges (AAMC) projects an estimated shortage of between 37,800 and 124,000 physicians by 2034, a slight decrease from last year's projected shortage. The Consolidation Appropriations Act of 2021 boosted graduate medical education (GME) completions by making more GME slots available to physicians, and the number of advanced practice registered nurses and physician assistants is expected to more than double in the next 15 years (Modern Healthcare, June 11; AAMC, June 11; Becker's Hospital Review, June 11).

From June 9 to June 15, CMS approved 11 SPAs, 2 of which are COVID-19 disaster relief SPAs. No new waivers were approved.

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Federal Updates

News

- The Medicare Payment Advisory Commission (MedPAC) recommended Congress eliminate and replace the skilled nursing facility value-based purchasing (VBP) program. The current VBP program, passed in 2014, measures performance through hospital readmissions alone. MedPAC discovered the program's failure to capture quality of care indicators and variations in patient populations between facilities disproportionately punished skilled nursing facilities with a high share of low-income, medically complex patients or dual-eligible beneficiaries. MedPAC recommended a replacement program include more performance measures and account for differences in patients' risk factors, which it argues would increase payments for skilled nursing facilities with better performance while reducing payments to those with worse performance (Modern Healthcare, June 15).
- On June 11, HHS announced it will distribute $424.7 million in American Rescue Plan (ARP) funding to more than 4,200 rural health clinics (RHCs) through the Health Resources and Services Administration (HRSA). Funds may be used for COVID-19 testing and mitigation. Clinics are eligible to receive $100,000 per clinical site. HRSA will distribute an additional $35.3 million later this summer (HHS, June 11; Fierce Healthcare, June 11).
- On June 11, HHS issued new deadlines for providers to spend money received through the Provider Relief Fund authorized under the CARES Act. The new deadlines apply to providers that received funds after June 30, 2020. The new spending and reporting deadlines are as follows (Modern Healthcare, June 11; Becker's Hospital Review, June 11):

	Payment Received Period	Deadline to Use Funds	Reporting Time Period
Period 1	4/10/20 – 6/30/20	6/30/21	7/1/21 – 9/30/21
Period 2	7/1/20 – 12/31/20	12/31/21	1/1/22 – 3/31/22
Period 3	1/1/21 – 6/30/21	6/30/22	7/1/22 – 9/30/22
Period 4	7/1/21 – 12/31/21	12/31/22	1/1/23 – 3/31/23

- The Consolidated Appropriations Act of 2021 includes a provision calling for rural hospitals to close inpatient beds and revamp as standalone emergency rooms. The New Rural Emergency Hospital (REH) Designation measure states hospitals that obtain this designation will receive more funding. Rural hospitals with less than 50 beds are encouraged to apply so that additional funding can take effect in 2023. The provision was introduced by Senators Amy Klobuchar (D), Check Grassley (R), and Cory Gardner (R), who recently sent a letter to CMS urging the agency to prioritize the designation's implementation (Becker's Hospital Review, June 10; American Hospital Association, December 22).
- The number of nursing facilities accredited by the Joint Commission has increased by about 70% in the last five years, according to *McKnight's Long-Term Care News*. Joint Commission staff attribute this increase to health plan incentives and bonuses that reward facilities for achieving accreditation, as well as health plans that now require accreditation as a condition of network participation. Accreditation through the Joint Commission is a rigorous and costly process for facilities, with higher standards and expectations than are set by CMS and a per building cost of about $4,500 annually. The Joint Commission will offer a new accreditation program for assisted living facilities starting July 1 (McKnight's Long-Term Care News, June 9).

Federal Litigation

- On June 17, the Supreme Court of the United States issued its opinion in *California v. Texas,* dismissing the challenge to the Affordable Care Act (ACA) for lack of standing. The Court did not address the merits of the plaintiff's arguments alleging the 2010 law is unconstitutional. Rather, the court held "plaintiffs do not have standing to challenge…[the] minimum essential coverage provision because they have not shown a past or future injury fairly traceable to… enforcing the specific statutory provision they attack as unconstitutional." This decision comes after almost ten years of litigation, including previous decisions by lower courts striking down the ACA entirely (District Court, Northern District of Texas) and just the individual mandate (Court of Appeals for the 5th Circuit). Justice Stephen Breyer penned the opinion and was joined by six other justices, including Justice Clarence Thomas who wrote a concurring opinion. Justices Samuel Alito and Neil Gorsuch dissented, concluding the plaintiffs did, in fact, have standing and agreed with the District Court in invalidating the entire law (California, et. al. v. Texas, et. al., June 17; Politico, June 17).

Studies and Reports

- A study published in *Medical Care* found poorly designed electronic health record (EHR) systems can accelerate clinician burnout and increase safety risks for surgical patients. The study judged EHR usability through nurses' responses to survey questions about EHR systems. Results found nurses working with EHR systems with poor usability were 41% more likely to experience burnout than those with better EHRs; 61% were more likely to be dissatisfied with their jobs; and 31% were more likely to leave their positions. Additionally, post-surgical patients receiving hospital care with poor EHR usability were 21% more likely to die, and 6% were more likely to be readmitted within 30 days than patients treated in hospitals with better EHR systems (Modern Healthcare, June 10).
- The Association of American Medical Colleges (AAMC) projects an estimated shortage of between 37,800 and 124,000 physicians by 2034, a slight decrease from last year's projected shortage. The Consolidation Appropriations Act of 2021 boosted GME slots available to physicians, and the number of advanced practice registered nurses and physician assistants is expected to more than double in the next 15 years. However, given current trends, these gains are not sufficient to build the workforce needed to care for a rapidly growing and aging U.S. population. Two out of five physicians will be older than 65 within the next ten years, paving the way for a retirement boom. The burnout associated with COVID-19 is pushing younger physicians to retire early or scale back to part-time work. Underserved populations, especially those in rural areas, already struggle to access basic medical care, and projected provider shortages will exacerbate health disparities in these communities as physicians and advanced practice practitioners increasingly seek employment with high-volume urban providers. The Resident Physician Shortage Reduction Act of 2021, bipartisan legislation recently introduced in the House and Senate, aims to combat the projected shortage by funding additional GME slots, but critics worry bolder action is needed to assist providers in underserved communities with recruitment and retention (Modern Healthcare, June 11; AAMC, June 11; Becker's Hospital Review, June 11).
- The Kaiser Family Foundation (KFF) conducted an analysis that examines trends in Medicaid outpatient prescription drug utilization and spending before rebates over the period of 2015-2019. Key takeaways from the analysis include the following:
    - Drug utilization, in terms of number of prescriptions, increased by 5% from 2015-2017 and declined in the years after.
        - Analgesics/antipyretics, psychotherapeutic agents, cardiac drugs, antibiotics, and anticonvulsants made up the top five drug groups by utilization every year.
        - Opioid prescription used to treat pain declined by 41%, while prescriptions to treat opioid addition and overdose increased during the same period.

  - Medicaid spending on prescription drugs before rebates increased by 23% from 2015-2019.
    - Spending in molecular targeted therapy drugs, antidiabetics, and antivirals grew during this time with the latter being the costliest drug group before rebates every year.
  - Generic drugs accounted for a vast majority of prescriptions while brand drugs accounted for a vast majority of spending over 2015-2019.
  - Biological products accounted for approximately 1% of drug utilization every year but were 15%-21% of Medicaid spending over 2015-2019.

- The PwC Health Research Institute is projecting a 6.5% increase in health care costs in 2022, which is lower than the 7% trend projected for 2021, and higher than the trend between 2016 and 2020, which was below 6%. This comes as individuals who deferred care during the pandemic are expected to seek care as states reopen and reflects continued high health care costs; worsening population health indicators related to COVID-19; and elevated demand for mental health and substance use disorder services. The report identifies drug spending, cybersecurity, and surprise billing as healthcare trends to watch in 2022 (PwC, June 9; Modern Healthcare, June 9).

COVID-19

- HHS named Dean Winslow to lead the Department's COVID-19 Testing and Diagnostic Working Group. Winslow will replace Michael Iademarco as part of the Department's broader reorganization of the government's pandemic response (Politico, June 11).
- Late-stage trials conducted in the U.S. and Mexico have shown the Novavax COVID-19 vaccine to be 90% effective. Novavax is one of many pharmaceutical companies that is developing a COVID-19 vaccine under Operation Warp Speed. Under the initiative, the federal government purchased 100 million doses of the Novavax vaccine for $1.6 billion. The company will seek the Food and Drug Administration (FDA) authorization of its two-dose vaccine in the third quarter of 2021 (Politico, June 14).
- On June 10, Moderna asked the FDA to authorize use of its COVID-19 vaccine for teens ages 12 to 17. Expanding vaccination options to this age group could make it easier for schools to reopen in-person and full time and help Americans resume normal activities. The Moderna vaccine was found to be 100% effective after two doses in a trial with approximately 3,700 teens enrolled (Politico, June 10).
- The FDA is increasing the shelf life of Johnson & Johnson's COVID-19 vaccine from three months to four and a half months. This announcement comes before hundreds of thousands of doses were set to expire at the end of June. Health officials under the Biden administration say the original expiration dates of the vaccines were conservative because the shots are new. However, further studies show the vaccines are stable in refrigerators for longer periods of time (Politico, June 10).

SPAs

- Service SPAs
  - Arkansas (AR-21-0003, effective October 10, 2020 to September 30, 2025): Establishes Medication Assisted Treatment (MAT) and MAT behavioral health counseling as a mandatory benefit for all individuals who are Medicaid eligible through state plan or plan waiver authority, in compliance with Section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).
  - District of Columbia (DC-21-0004, effective October 1, 2020 to September 30, 2025): Provides MAT for opioid use disorder (OUD), including all FDA approved MAT drugs, FDA licensed MAT biological products, and MAT behavioral counseling, as a mandatory benefit in compliance with Section 1006(b) of the SUPPORT Act.

  - Nevada (NV-21-0002, effective July 1, 2021): Clarifies the individuals responsible for performing the evaluation and reevaluation of needs-based eligibility for state plan 1915(i) home and community-based services (HCBS) and demonstrates how the state complies with HCBS settings requirements.
  - Vermont (VT-21-0005, effective January 1, 2021): Allows physician assistants to enroll directly with Vermont Medicaid as primary care providers.

- Payment SPAs
  - Colorado (CO-20-0028, effective July 1, 2020): Rebalances the behavioral health fee-for-service and Residential Child Care Facility (RCCF) rates to ensure that rates for mental health rehabilitative services are not greater than the estimated costs of providing services.
  - Connecticut (CT-21-0006, effective January 1, 2021): Incorporates the 2021 Healthcare Common Procedural Coding System (HCPCS) changes (additions, deletions, and description changes) to the Independent Radiology and Independent Laboratory fee schedules in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Establishes fixed fees for certain laboratory and X-ray codes that were previously manually priced.
  - Connecticut (CT-21-0007, effective January 1, 2021): Revises the Medical Clinic, Family Planning Clinic, Behavioral Health Clinic, Rehabilitation Clinic, and Ambulatory Surgical Center fee schedules.
  - Maryland (MD-21-0003, effective January 1, 2021): Provides a 3.5% increase for 1915(i) HCBS.
  - New York (NY-20-0023, effective April 1, 2020): Continues UPL supplemental payments to private hospitals for inpatient services in the amount of $193,635,130 for state fiscal year 2021.

- COVID-19 Disaster Relief SPAs
  - Nebraska (NE-21-0004, effective December 1, 2020): Waives federal public notice requirements and modifies the tribal consultation timeline for time-limited COVID-19 related SPAs that do not restrict or limit payments or services. Increases the payment rate for the administration of FDA-approved COVID-19 vaccines. Allows qualified pharmacists, pharmacy interns, and pharmacy technicians to administer COVID-19 vaccines. This time-limited COVID-19 SPA terminates at the end of the public health emergency (PHE).
  - Nebraska (NE-21-0007, effective January 1, 2021): Grants tribes 15 calendar days from the date of SPA submission to initiate a tribal consultation on new SPAs. Provides nursing facilities an additional $20 per day payment per Medicaid beneficiary. This time-limited COVID-19 SPA terminates June 30, 2021 or at the end of the PHE, whichever is sooner.

State Updates

- Arkansas plans to give the federal government the state's renewed Medicaid expansion proposal next month after a federal judge blocked the Arkansas work requirement. The state began accepting public comments on the Medicaid proposal and will hold two public hearings next week. The reconstructed proposal will continue to use Medicaid funds to place beneficiaries on private health insurance and includes incentives for participants to work or meet certain health goals. The state plans to submit its proposal to the Biden administration by July 14 with hopes for federal approval by November or December 2021 (Modern Healthcare, June 15, Arkansas Department of Human Services).

- Nevada Governor Steve Sisolak (D) signed Senate Bill 420, which requires the state's Department of Health and Human Services (the Medicaid Agency), the Executive Director of the Exchange, and the Insurance Commissioner to design, establish, and operate a public insurance option in the state by 2026. Private payers will administer the public option plans where each product must be classified as a qualified

health plan, thereby offering the essential health benefits available to individuals and possibly small employers. The state intends to use the public option to lower health care costs and will do so, in part, through heavily regulated plan premiums. The public option may require the state to seek federal approvals including 1115 or 1332 waivers by 2024. These waivers would give authority to secure federal insurance subsidies or to combine the public option risk pool with the Medicaid risk pool. The bill also requires providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the state's workers' compensation program to enroll in the public option as a participating health care provider. The House of Representatives passed its version of the Senate's bill in May (NASHP, June 14).

- Over 100,000 Oklahomans have signed up for Medicaid since enrollment began on June 1, 2021, under a program expansion voters approved last year. The Oklahoma Health Care Authority reports roughly 60,000 residents from urban areas and 40,000 residents from rural areas have qualified for benefits that are set to begin July 1 (Modern Healthcare, June 13).
- In testimony before the Senate Finance Committee, HHS Secretary Becerra defended CMS' action to rescind approval of or apply additional scrutiny to waivers in Texas, Georgia, and other states, arguing the ultimate goal of putting waivers on hold was to ensure the "goals of getting more people covered at a better price are being achieved." Secretary Becerra vowed to work with these states to honor the goals of the Medicaid program going forward (Health Payer Specialist, June 11).

Private Sector Updates

- Humana announced its acquisition of One Homecare Solutions, a home health care provider, from private equity firm WayPoint Capital Partners. Humana plans to integrate One Homecare and the recently acquired hospice and home health company Kindred at Home into its value-based home health care offerings by leveraging the companies' capitation payment models and network services. The acquisition is expected to close in the second quarter of 2021 (Health Payer Specialist, June 14).
- To combat COVID-19 vaccine hesitancy, Centene is incentivizing providers to schedule vaccine appointments for its members by awarding cash prizes. The top 100 providers to show the greatest improvement in vaccine distribution will be awarded $5,000 to purchase medical equipment. Centene is also launching a public service announcement touting the benefits of the COVID-19 vaccine (Health Payer Specialist, June 11).
- The California Department of Managed Care (DMHC) fined Anthem Blue Cross of California $230,000 for failing to resolve 328 provider payment disputes and failing to receive five others between February 2016 and April 2018. Since the DMHC began penalizing payers in 2000, Anthem Blue Cross received nearly three times as many enforcement actions and fines as any other insurer. Anthem Blue Cross hired additional personnel in its grievance and appeals department in 2018 as a corrective action and has agreed to accept the charge (Health Payer Specialist, June 11).
- Centene settled for $88 million in Ohio and $55 million in Mississippi to resolve claims from 2017 and 2018 related to the company's pharmacy-benefits manager unit, Envolve Pharmacy Solutions. Both states allege Envolve intentionally obscured drug costs and overcharged state Medicaid programs for pharmacy benefits. In response, Centene restructured Envolve to function as a third-party claims processor and denies liability for any of Envolve's practices. The disputes illustrate a growing trend among states to investigate their pharmacy benefit managers; Centene earmarked $1.1 billion in anticipation of future settlements related to Envolve (MarketWatch, June 14; Modern Healthcare, June 14).
- Due to mounting pressure from provider organizations, UnitedHealthcare will suspend a controversial policy that denies coverage for certain emergency room visits at least until the COVID-19 PHE has ended. The policy, originally scheduled to go into effect next month, would allow the insurer to investigate any

factors warranting an emergency room visit, including preexisting medical conditions, and provide coverage only for visits it deems to be due to a true medical emergency. Critics worry this policy will discourage patients from seeking life-saving emergency care, especially given the sustained reluctance of patients to seek emergency care during the COVID-19 pandemic. UnitedHealthcare contends hospitals can attest to patients' emergency needs and patients can appeal a nonurgent designation if they feel the new policy was applied in error (The New York Times, June 10).

Sellers Dorsey Updates

- Check out our recent Staff Spotlight Q&A with Consultant Specialist Janel Myers. Janel works on Sellers Dorsey's quality initiatives and is a member of several internal workgroups at the firm. Learn more about Janel and the work she does to support our clients.
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