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NAVIGATION

Summary of Key Updates

The bipartisan infrastructure bill advancing through the Senate will not divert unspent COVID-19 relief funds, as had been previously considered (Fierce Healthcare, July 28).

On July 29, CMS announced Medicare pay increases for inpatient rehabilitation, inpatient psychiatric, hospices, and skilled nursing facilities (Modern Healthcare, July 29; Becker's Hospital Review, July 30).

CMS published a proposed rule that would allow states to bolster the home health care workforce by allowing states to use a portion of a provider's Medicaid payments for independent home health worker's payments related to health care benefits and training (Inside Health Policy, July 30).

From July 28 to August 3, CMS approved nine SPAs, five of which are COVID-19 disaster relief SPAs.

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Federal Updates

Federal Regulation

- On August 2, the Centers for Medicare and Medicaid Services (CMS) released its Medicare Inpatient Prospective Payment System final rule for CY2022. The rule includes a 2.5% reimbursement rate increase for inpatient hospital services. The final rule also eliminates a requirement that providers disclose their contract terms with Medicare Advantage payers. The rule does not include changes to organ acquisition payments or graduate medical education slots, issues CMS intends to address with future rulemaking (Federal Register, August 2; Modern Healthcare, August 2).
- On July 29, CMS announced Medicare pay increases for inpatient rehabilitation, inpatient psychiatric, hospices, and skilled nursing facilities. Inpatient rehab facilities will get a 1.9% pay bump in 2022, raising their reimbursements by $130 million. Inpatient psychiatric facilities and hospices will get a 2% hike, increasing their reimbursements by $80 million and $480 million, respectively. Finally, skilled nursing facilities will get a rate increase of 1.2% or $410 million. CMS is also requiring health care facilities to report the number of clinical workers who are vaccinated against COVID-19. While CMS did not advance any health equity quality measures, it will likely include them in next year's payment rules (Modern Healthcare, July 29; Becker's Hospital Review, July 30).
- On July 30, CMS published a proposed rule that would allow states to bolster the home health care workforce by allowing states to use a portion of a provider's Medicaid payments for independent home health worker's payments related to health care benefits, training, and other customary employee benefits. This rule seeks to reinstate an Obama-era policy where states can make payments to third parties to benefit providers for health care benefits, training, and other employee benefits, if the provider consents to such payments to third parties on the provider's behalf. According to CMS, these payment arrangements would continue to be optional for states, and states could continue to use existing processes to pay for benefits. The home health field faces high turnover, low pay, and inconsistent benefits, but as home and community-based services (HCBS) become a more popularized option for beneficiaries, the demand for these workers will grow (Inside Health Policy, July 30).

Federal Legislation

- On July 29, Senators Michael Bennett (D-CO) and Kevin Cramer (R-ND) introduced a new bill entitled the Provider Relief Fund Deadline Extension Act which proposes to extend the provider relief spending deadline for certain providers through the end of 2021, or the end of the Public Health Emergency (PHE) period. Providers may spend the funds in four different periods, depending upon when providers received their relief dollars. This bill applies to providers who received money between April 10, 2020 and June 30, 2020, having until September 30, 2021 to submit their financial information to the Department of Health and Human Services (HHS) or return any unspent funds. It is unclear whether this bill or another proposed bill will extend the spending deadline for those who received relief dollars between July 1, 2020 and December 31, 2020 (Inside Health Policy, July 30; Rev Cycle Intelligence, July 29).
- The bipartisan infrastructure bill advancing through the Senate will not divert unspent COVID-19 relief funds, as had been previously considered. The bill will, however, include a further delay for a rule that would eliminate a safe harbor for Medicare Part D rebates, replacing them with point of sale discounts. The Biden administration had delayed the rule's implementation until January 1, 2023. It is unclear how long the additional delay would last, but the delay is intended to help offset the cost of the infrastructure measure (Fierce Healthcare, July 28).

Federal Litigation

- On July 26, 14 teaching hospitals joined in a suit against Xavier Becerra in the U.S. District Court for the District of Columbia. The plaintiffs allege HHS's applications of certain regulations reduce the calculation of a hospital's Direct Graduate Medical Education (DGME) beyond what is intended in the Medicare statute. This is the second recent case challenging HHS's utilization of the DGME formula. In May 2021, a U.S. District Court for the District of Columbia judge granted a motion of summary judgement in favor of the plaintiff hospital in its allegation that the formula for determining DGME payments violated the weighting factors Congress established. If the plaintiffs in the current suit prevail, HHS may need to adjust its formula and recalculate DGME payments to the teaching hospitals. Stakeholders note hospitals are particularly interested in enhancing DGME payments as there is a nationwide physician shortage and a lack of funding in residency programs is currently an exacerbating factor of that shortage (*Hospital for Special Surgery, et al. v. Xavier Becerra*, July 26; Modern Healthcare, July 28).

COVID-19

- One week after dozens of health professional associations released joint statements urging vaccine mandates, Kaiser Permanente, Ascension, and 57 other health systems have mandated COVID-19 vaccination for their workforces. The vaccination policies of these and other providers include exemptions for medical, religious, or other legally protected reasons. Conversely, some health systems are strongly encouraging vaccines instead of imposing mandates due to fears of exacerbating nursing staff shortages (Fierce Healthcare, August 2).
- President Biden is asking states and local governments to use American Rescue Plan (ARP) Act funding to incentivize vaccine uptake by offering individuals $100 payments for COVID-19 vaccinations. The administration's call for cash incentives comes as new cases of COVID-19 surge across the country due to the rise in the Delta variant (Becker's Hospital Review, July 30).

Waivers

- Section 1115
    - On July 14, Texas submitted a request to extend its Healthcare Transformation and Quality Improvement Section 1115 demonstration until September 30, 2030. This demonstration authorizes enrollment in managed care through its managed care programs, STAR, STAR+PLUS, and STAR Kids. The state is proposing to continue the demonstration, including the current Uncompensated Care Pool, and add a new public health provider - Charity Care Program Pool. The extension request reflects the same terms and conditions that were approved on January 15, 2021, and requests incorporation of any amendments approved thereafter. CMS will accept comments on the renewal application through August 30.
- Section 1135
    - On July 22, CMS granted Kansas an initial approval to temporarily waive written consent required under HCBS programs under 42 C.F.R. § 441.301(c)(2)(ix) for 1915(c) waiver programs, 42 C.F.R. § 441.725(b)(9) for 1915(i) HCBS state plan programs, and 42 C.F.R. § 441.540(b)(9) for 1915(k) Community First Choice programs that require person-centered service plans receive written consent from beneficiaries and be signed by beneficiaries and all providers responsible for its implementation and permit documented verbal consent as an alternate. This waiver has an effective date of March 1, 2020 and will terminate at the end of the PHE.

- Section 1915(c) Appendix K
    - Indiana
        - Temporarily increases reimbursement for direct support professionals and increases the waiver capped budget.
    - North Carolina
        - Temporarily extends timeframes for submission of CMS 372s and evidentiary packages for the NC Innovations (I/DD) waiver; permits suspension of data collection for performance measures other than those identified for the Health and Welfare assurance.
    - North Carolina
        - Temporarily allows payment for services rendered by relatives of NC TBI (Traumatic Brain Injury) waiver participants; allows relatives to provide services for 90 days without completing a background check or training.

SPAs

- Service SPAs
    - Arkansas (AR-21-0007, effective August 1, 2021): Corrects an error regarding the required frequency of contacts between targeted case managers and beneficiaries.
    - Minnesota (MN-21-0010, effective October 1, 2020 – September 30, 2025): Adds Medication Assisted Treatment (MAT), associated counseling, and behavioral health therapies to treat opioid use disorders as a mandatory benefit in the Medicaid state plan, pursuant to 1905(a)(29) of the Social Security Act and Section 1006(b) of the SUPPORT Act.
- Payment SPAs
    - Colorado (CO-20-0024, effective October 1, 2020): Updates disproportionate share hospital (DSH) methodology, revises inpatient hospital supplemental payments, establishes the Hospital Transformation Program, and establishes the Rural Support Payment for outpatient hospital services.
    - Colorado (CO-21-0011, effective April 1, 2021): Rebalances specified behavioral health fee-for-service rates.
- COVID-19 SPAs
    - California (CA-21-0042, effective January 1, 2021): Extends COVID-19 Emergency Sick Leave Benefits for In-Home Support Services (IHSS) providers. This time-limited COVID-19 SPA terminates September 30, 2021 or at the end of the PHE, whichever is sooner.
    - Michigan (MI-21-0007, effective January 1, 2021): Covers and sets reimbursement rates for the administration of the FDA Emergency Use Authority (EUA) monoclonal antibody COVID-19 treatment by authorized EMS providers to state-defined eligible beneficiaries. This time-limited COVID-19 SPA terminates at the end of the PHE.
    - Oklahoma (OK-21-0028, effective July 1, 2021): Aligns the Expansion Adult Alternative Benefit Plans (ABP) with previously approved disaster relief SPAs 20-0032, 20-0040, 20-0042, and 21-0011. This time-limited COVID-19 SPA terminates at the end of the PHE.
    - Pennsylvania (PA-21-0015, effective April 1, 2021): Expands the provider types authorized to administer the SARS-CoV-2 vaccines and amends the payment methodology for the administration of the vaccines to Medicaid beneficiaries who are homebound. This time-limited COVID-19 SPA terminates at the end of the PHE.

- Texas (TX-21-0029, effective March 20, 2020 – March 1, 2021): Provides additional payments to eligible providers for reserving beds in an intermediate care facility for individuals with an intellectual disability (ICF/IID) for eligible residents during leaves of absence taken to reduce the risk of COVID-19 transmission.

State Updates

- A study published by JAMA found Medicaid expansion not only provides more people with health insurance but also considerably cuts medical debt. Since the Affordable Care Act (ACA) offered states federal funds to expand Medicaid eligibility in 2014, new medical debt in states that expanded in 2014 fell 44%. Conversely, new medical debt in states that did not expand only decreased 10%. Research shows people have more access to care and better self-reported health after Medicaid expansion in their state. A working paper released by the National Bureau of Economic Research in 2019 showed that states' refusal to expand Medicaid has led to more than 15,000 deaths in one year that would not have occurred otherwise. Congress is working on a proposal to cover the four million uninsured people in non-expansion states who would otherwise be insured through Medicaid expansion as incentives under ARP did not persuade most of the holdout states to expand Medicaid (Vox, July 29).
- An opioid lawsuit filed by the city of Huntington and Cabell County, West Virginia against AmerisourceBergen Corp, McKesson Corp, and Cardinal Health, Inc. is coming to a close. After a three-month non-jury trial before a judge, the parties are presenting closing arguments and will wrap up the case in the next several weeks. The plaintiffs claim the three drug distributors ignored red flags of opioids being diverted through illegal supply chains, which flooded the state with millions of highly addictive pills. This created a health crisis in the city and county leading to an estimated 10% of the current population suffering from opioid use disorder. The city and county are seeking more than $2.5 billion from the lawsuit to go toward abatement efforts. The defendants argue that "poor communication and pill quotas set by federal agents were to blame, along with a rise in prescriptions written by doctors." Separately, a nationwide settlement was reached on July 21 to resolve all opioids litigation brought by states and local governments. The plaintiffs in the West Virginia litigation believe they will fair out better by pursuing the litigation and not participating in the nationwide settlement. In the nationwide settlement, the distributors will pay $21 billion over 18 years, and the manufacturer (Johnson & Johnson) will pay $5 billion over 9 years. A majority of the settlement fund will go directly to state and local governments for current and future abatement efforts (Modern Healthcare, July 27; National Opioid Settlement, July 21).
- On July 20, Arkansas submitted its 1115 waiver renewal to CMS in which it proposes incentivizing work for its Medicaid expansion population with added benefits (i.e., dental, vision, OTC coverage). The work incentive clause comes after the state's previous 1115 waiver renewal was rescinded by CMS on the grounds that it mandated Medicaid work requirements for its beneficiaries. The proposed incentive system, similar to Nebraska's proposed tiered benefit system, rewards work rather than requiring work as a condition of coverage for beneficiaries (Inside Health Policy, July 30).
- CKF Addiction Treatment has partnered with multiple Kansas Medicaid managed care organizations to roll out a new low cost, high impact, telehealth model designed to connect patients with primary care providers. CKF developed the program to enhance identification, assist medical providers, and get more patients access to treatment resources and services. This telehealth model addresses the barriers that stand between people suffering from addiction and accessing services and extends to all outpatient services, facilitated by licensed counselors and certified peer mentors. A 2015 National Survey on Drug Use and Health showed only 10% of people with a substance use disorder receive any type of specialty treatment, and most patients are lacking access within their communities. The health care industry learned the benefits of using telehealth during the COVID-19 pandemic, and CKF was able to apply that growth to their new model (Salina Journal, July 28; mHealth Intelligence, July 29).

- On July 28, state health insurance exchange Covered California announced preliminary rates will increase by an average of 1.8% in 2022, up from a 0.6% increase in 2021 and a 0.8% increase in 2020. The exchange also announced that every resident will have a choice of two insurers as several existing carriers expand their coverage areas and one new insurer, Bright Healthcare, joins the marketplace. Covered California stressed the significant savings on premiums made possible by ARP: the state saw an increase in premium tax credits for existing consumers and the removal of the "subsidy cliff' that blocked people earning more than 400% FPL from subsidies, leading 700,000 Californians to sign up for plans with $1 premiums since the legislation's enactment in April. Undocumented Californians aged 50 and older will also be eligible Medi-Cal benefits in 2022, eventually costing taxpayers $1.3 billion per year. The new policy, a component of the state budget signed by Governor Newsom last week, will grant Medi-Cal eligibility to an estimated 235,000 people (Inside Health Policy, July 28; Modern Healthcare, July 27).
- Connecticut will be the first state to provide direct Medicaid funds to address gun violence and other violent crimes through community-based violence prevention services. These programs usually involve intervention at the hospital after a gun-related incident with a focus on intensive case management and breaking the cycle of violence. The new law requires the Department of Social Services to amend the state's Medicaid plan to cover the cost of community violence prevention services. Governor Ned Lamont signed a new law aimed at reducing gun violence overall. This follows another law first passed in 1999 that helps authorities remove guns and ammunition from individuals who are a danger to themselves or others. The new law also has a provision that prevents someone who is deemed a danger from purchasing a firearm and requiring individuals to petition to have firearms returned to them after a one-year period (Modern Healthcare, July 27).

Private Sector Updates

- Avera Health sold its telemedicine services unit, Avera eCare, to private investment firm Aquiline Capital Partners for an undisclosed sum. Avera eCare delivers telehealth services to over 600 sites across 32 states, with offerings including behavioral health, correctional health, pharmacy, senior care, and intensive care. Its virtual specialty consults will remain with Avera Health, a system of 35 hospitals spanning five states based in Sioux Falls, South Dakota. Avera eCare's name will change to Avel eCare upon closing but will continue providing its services to the health system with no interruption to patients and will maintain its headquarters in Sioux Falls. The deal is expected to close in the final quarter of 2021 (Fierce Healthcare, July 29).
- Anthem and Humana purchased a minority stake in a new pharmacy benefit manager (PBM) platform, DomaniRx, for $138.3 million. Fintech firm SS&C Technologies holds 80.2% interest in the platform and plans to use its existing claims processing platform, RxNova, as the new PBM's technological backbone. The new venture comes as more payers begin to question the "spread pricing" models of dominant PBMs, which charge payers more than they reimburse pharmacies for specific drugs and retain the difference. DomaniRx aims to champion industry transparency by supporting up-and-coming companies with its cloud-native, API-driven claims adjudication platform. Anthem and Humana hold a non-exclusive license to DomaniRx and can exit the joint venture if the platform fails to launch. Humana, which currently operates its own PBM, will serve as DomaniRx's first customer (Modern Healthcare, July 26; Fierce Healthcare, July 23).

Sellers Dorsey Updates

- Sellers Dorsey has been assisting clients for over 20 years with identifying, developing, and implementing innovative strategies to fund and strengthen their Medicaid programs. Working at the intersection of industry and government, our services include developing programs that improve the access and quality of health care and increase reimbursement for Medicaid services in both managed care and fee-for-

service environments. To speak to any of our Medicaid experts about issues facing your organization, contact us here.

- Sellers Dorsey members are excited to attend the HIMSS21 conference in Las Vegas August 9-13 and MESC 2021 conference in Boston August 9-11, and look forward to hearing experts speak on population health strategies, telehealth, social determinants of health, member experience, and more. We hope to see you there!

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